

Kingston Hospital NHS Foundation Trust

Kingston 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 (including older people's care)	Requires improvement	
Surgery	Good	
Critical care	Good	
Maternity and gynaecology	Good	
Services for children and young people	Good	
End of life care	Good	
Outpatients and diagnostic imaging	Requires improvement	

Summary of findings

Letter from the Chief Inspector of Hospitals

Kingston Hospital NHS Foundation Trust provides local services, primarily for people living in and around Kingston-Upon-Thames. The trust provides services to approximately 350,000 people and provides a full range of diagnostic and treatment services, including emergency care, day surgery and maternity services. Our key findings were as follows:

Safe

- Improvements were required for the safe storage of medicines in outpatients, theatres, some wards, and the emergency department. In particular with regard to recording of fridge temperatures, and restricting accessibility to storage facilities.
- Improvements were required to ensure equipment used for patient treatment and care had routine safety and maintenance checks.
- Improvements were required to ensure there was enough surgical instrumentation available in theatres.
- Staff understood their responsibilities to raise concerns, to record safety incidents, and near misses, and to report them. However, incident reporting was not fully embedded in everyday practice within the emergency department.
- Safety goals were set and performance was monitored using information from a range of sources.
- People who used the services were told when they were affected by something that went wrong, and were informed of any actions taken as a result. However, letters written to people did not always contain a formal apology.
- Staff and relevant individuals were involved in thorough and robust investigative reviews, where incidents or adverse events arose.
- With the exception of the emergency department, lessons learned and action taken as a result of investigations were shared with staff and changes in practice implemented.
- The environment in which people received treatment and care was clean and there were reliable systems to prevent and protect people from a healthcare-associated infection. Despite this, staff working in the emergency department did not always follow recommended hand hygiene practices.
- The majority of staff had received effective mandatory training in the safety systems, processes and practices.
- Risk management activities and procedures used by staff helped to ensure people's safety needs were identified and responded to.
- There were sufficient staff with appropriate skills to ensure the safe delivery of treatment and care in most areas.
- There was a high number of new and inexperienced nursing staff in the emergency department and not enough permanent shift leaders or doctors to cover the rota.

Effective

- People's consent to treatment and care was sought in line with legislation and guidance. People were supported to make decisions and where a person lacked mental capacity to consent to treatment or care staff made 'best interest' decisions. However, mental capacity assessments were not always carried out where patients required mechanical restraint on medical wards. Best interest decisions had not always been recorded for the interventions taken.
- Staff generally had an understanding and awareness of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS), but some staff reported not having formal training in either subject.
- People's needs were assessed and care and treatment was delivered in line with legislation, standards and evidence based guidance.
- A multidisciplinary team of staff worked collaboratively, and were supported to deliver effective treatment and care by relevant and current evidence-based guidance, standards, best practice and legislation.
- Monitoring of the effectiveness of services was taking place and outcomes from such activities were generally used to improve standards and quality.

Summary of findings

- People receiving treatment and care were not discriminated against. Individual care needs took into account; age, disability, gender, pregnancy and maternity status, race, religion or belief and sexual orientation.
- People's nutrition, hydration and pain needs were assessed and action was taken by staff to meet their immediate and changing needs.
- Technological equipment was generally available and used by staff to monitor and deliver treatment and care.
- Staff had the right qualifications, skills, knowledge and experience to undertake their roles and responsibilities. They had access to appropriate developmental training and were supported by senior staff through a range of approaches. Staff had opportunities to receive feedback on their performance.

Caring

- People were treated with kindness, dignity, respect and compassion whilst they received care and treatment from staff.
- Staff took into account and respected people's personal, cultural, social and religious needs.
- Staff were observed to take the time to interact with people who used the service and those close to them in a respectful and considerate manner. They showed an encouraging, sensitive and supportive attitude towards people receiving treatment and care, and those close to them.
- People who used the services and those close to them were involved as partners in their care. Staff communicated with people so they understood their care, treatment and condition. They recognised when people needed additional information and support to help them understand and be involved in their care and treatment and facilitated access to this.
- People were given appropriate and timely support and information to cope emotionally with their care, treatment or condition.
- Staff encouraged participation from those close to people who used the services, including carers and dependents. People were encouraged and supported to manage their own health, care and wellbeing and to be as independent as able.

Responsive

- Services had been planned and delivered to meet the needs of people within the local population. Stakeholders and other providers were involved in planning and delivering services.
- The emergency department was not meeting the national target of seeing and treating 95% of patients within four hours of arrival. Ambulance hand over times were not always achieved.
- The facilities and environment were being developed in some areas in order to meet the changing needs of the population using the services. Further improvements were needed in some areas to ensure privacy was not compromised and to meet the needs of particular groups of people. This including patients attending the emergency department with mental health related matters. The Critical Care Unit environment was not conducive to meeting the needs of patients, visitors and staff.
- Services were accessible and took into account the individual needs of people who used them. This included vulnerable individuals and people with a physical disability, learning disabilities, and those living with dementia. Some environmental improvements were needed to areas where people living with dementia were receiving treatment and care.
- People were given the help and support they needed to make a complaint. With the exception of the emergency department, complaints were handled effectively and confidentially, with a regular update for the complainant and a formal record was kept. The outcome was explained appropriately to the individual in an open and transparent manner. Lessons learned from concerns and complaints were acted upon by staff.

Summary of findings

Well-led

- There was a clear vision and a set of values, with quality and safety the top priority, which was understood by staff. Core services had robust, realistic strategies targeted towards achieving the clinical priorities set by the trust and aimed at delivering good quality care; staff knew what their responsibilities were for delivering this. Targets were continuously reviewed.
- The majority of clinical areas were well led, with strong and effective governance arrangements to oversee quality, safety and risk management.
- Most staff reported effective leadership, with approachable and supportive line managers, who operated in an open and responsive culture. Some theatre staff reported challenges with visibility and direction of the main theatres leadership, with a need for more constructive engagement. Theatre leaders had recognised staff morale was an area for improvement and had put in place a number of interventions.
- Staff in the majority of areas reported feeling respected and valued, and were enabled to contribute to service delivery and improvements.
- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. There were arrangements for identifying, recording and managing the majority of risks, along with mitigating actions.

We saw several areas of outstanding practice including:

- The Wolverton Centre, for providing comprehensive sexual health services; for provision of service alerts for vulnerable patients, including young people, and those with a learning disability.
- A comprehensive dementia strategy, which enabled staff to support people living with dementia. A dedicated dementia improvement lead provided visibility and support to staff, ensuring positive interventions were implemented. The carer's support pack, therapeutic activities and a memory café contributed to the enhancement of services.
- The trust's engagement with 'John's campaign', promoted the rights of people living with dementia to be supported by their carers in hospital. To facilitate this, there was open visiting and a free car park for respective carers and relatives. Family members and carers were offered beds to stay overnight if needed.
- The specialist palliative care (SPC) team stood out as highly skilled and effective. They supported staff to provide good quality, sensitive care to patients at the end of life and to the people close to them.
- Staff of all disciplines demonstrated an impressive understanding of their role in addressing the needs of people at the end of life and of providing sensitive and compassionate care.
- The paediatric diabetes team were a top performer in the National Paediatric Diabetes audit 2014 to 2015 due to HbA1C rates being better than the England average.
- The trust participated in the Sentinel Stroke National Audit Programme (SSNAP), and achieved an A rating for the period January 2015 to March 2015.
- The Physiotherapists in the critical care unit had reduced the length of stay for their patients through the early implementation of rehabilitation.
- The engagement and involvement of volunteers was recognised as an invaluable team to support service delivery.
- Patient pathway co-ordinators in outpatients had impacted positively on the effectiveness of appointment arrangements.

However, there were also areas of where the trust needs to make improvements. Importantly, the trust must:

- Ensure that individuals who lack capacity are subjected to a mental capacity assessment and best interest decisions where they require restraint. Such information must be recorded in the patient record.
- Make improvements to ensure medicines are not accessible to unauthorised persons; are stored safely, and in accordance with recommended temperatures.
- Make improvements to the systems for monitoring of equipment maintenance and safety checks in order to assure a responsive service.

Summary of findings

- Ensure that the Duty of Candour is adhered to by including a formal apology within correspondence to relevant persons and that such a record is retained.
- Ensure the management, governance and culture in ED, supports the delivery of high quality care.
- Improve the quality and accuracy of performance data in ED, and increase its use in identifying poor performance and areas for improvement.
- Ensure all identified risks are reflected on the ED risk register and timely action is taken to manage risks.

In addition the trust should:

- Review patient outcome measures to consider how performance can be improved.
- Staff should have timely access to regular training with respect to the Mental Capacity act (2005) and Deprivation of Liberties Safeguarding.
- Review length of stay and ways of decreasing this in care of the elderly and cardiology services.
- Take steps to embed debriefings after operating lists across all surgery services, as part of the World Health Organization (WHO) Surgical Safety Checklist.
- Ensure better compliance with hand hygiene and cleaning of clinical equipment in the emergency department.
- Review the skill mix and flexibility of staff within ED in order to respond to changes in activity levels and demand surges.
- Improve ED staffs understanding and compliance with the trust's incident reporting procedures, complaints handling and application of learning from these.
- Ensure there is accurate performance information in the ED.
- Seek ways of consistently improving patient flow through the ED.
- Ensure the systems for routine safety processes such as recording timely observations of patients, checking resuscitation equipment, and making sure medicines and cleaning chemicals were stored safely.
- Ensure adequate and safe facilities for patients with mental health needs.
- Ensure staff use computers securely in ED and do not share login cards
- Improve staff engagement in main operating theatres.
- Establish a robust system for ensuring required surgical instruments are readily available.
- Increase visibility and leadership engagement within theatres.
- Optimise pre-assessment procedures in order to limit cancellations on the day of scheduled surgery.
- Take steps to ensure all nursing staff understand how to communicate with vulnerable and elderly patients in an appropriate way.
- Improve responsiveness of nursing staff to patient call bells at weekends.
- Consider how the environment and facilities in the CCU could be improved.
- Review CCU records in order that capacity assessments can be documented.
- Explore the benefits of having a follow up services available for patients who have used CCU so they are able to reflect upon their stay and can address long term psychological concerns.
- Review maternity service bed capacity in order to address the increasing activity.
- Ensure midwifery staff have access to required equipment.
- Review staffing levels in maternity services in order to avoid delays of induction and elective caesarean sections.
- Ensure children have an appropriate waiting area in the fracture clinic.
- Review areas used by children and young people with a focus on age appropriate décor.
- Ensure staff working in children's and young people's services have access to up to date editions of the British National Formulary (BNF).
- Ensure registered nursing staff levels in children's and young people's services are in accordance with RCN and BAPM guidelines.
- Review the specialist palliative consultant and nursing presence at the hospital in order to maintain progress towards meeting the provision of excellent end of life care.
- Review the environment of the chapel and multi-faith facilities.

Summary of findings

- Consider how the environment on medical wards and in outpatients can be developed to enhance the experiences of people living with dementia.
- Provide greater privacy for inpatients who attend the CT scanning unit.
- Reinforce best practice around the use of appropriate interpreters.
- Ensure information about chaperones is made easily available in all OPD clinics.
- Ensure waiting times and clinic delays are appropriately displayed and communicated to waiting patients.
- Have a consistent approach to sending reminders to patients about their appointments, to minimised non attendance.
- Ensure that patient examination couches are checked and maintained as appropriate in the general outpatient area.
- Address recommendations made by the Anti-Terrorism Squad for the safe monitoring of radionuclide medicine delivery.
- Ensure proper systems are in place to facilitate governance meetings in each outpatient service.
- Consider how daily cleaning schedules can be completed and quality checks and sign off of these are routinely undertaken.
- Arrangements around equipment storage should be reviewed so that shower rooms are not used.
- Utility rooms containing hazardous chemicals should be locked, with additional provision for secure storage of such products.
- Fire safety precautions should be reinforced with staff to ensure fire doors are not propped open.
- The policy for medicines management is followed to support the use of patients own medicines.
- Review existing arrangements to ensure that suitable governance and assurances mechanisms are in place with regards to the trust's statutory duty to ensure that directors are fit and proper.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

The Emergency Department at Kingston Hospital required improvement.

- There were not enough permanent, experienced staff who understood the ED systems to lead the many newly qualified staff, as well as agency and locum staff.
- The department did not consistently meet the national target of seeing and treating 95% of patients within four hours of arrival, even on days they were not full. The department regularly missed other related targets such as receiving ambulance patients within 15 minutes, although performance had improved enough to reduce the number of financial penalties.
- Staff did not routinely follow recommended systems and processes for keeping people safe from avoidable harm.
- The design of accommodation in some areas did not protect patients' privacy and dignity, or the confidentiality of patient discussions with clinicians.
- The department's comparative performance in national audits about emergency care was not good and they were slow to make improvements.
- Accommodation for mental health patients was poor and they often had long waits in ED.
- There was not a culture of continuous improvement. Staff did not routinely use information from incidents and complaints to provide a better service to patients.

However;

- There were arrangements to protect people from abuse and safeguarding processes were robust.
- We saw staff interacting in a caring and compassionate way with individual patients
- The recognition of the needs of people living with dementia and provision for children were good.

Summary of findings

- ED staff were introducing processes to help staff meet national targets and there had been some improvements.
- Some key senior staff vacancies had been filled which had the potential to improve leadership and governance.

Medical care (including older people's care)

Requires improvement



Overall we found the medical care services at Kingston Hospital requires improvement.

- We found where patients were unable to consent to a mechanical restraint, no mental capacity assessment had been undertaken and no best interest decisions had been recorded.
- Staff reported they had no specific training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training.
- Patient outcome measures including National Heart Failure Audit, Myocardial Ischemia National Audit Project (MINAP), National Diabetes Inpatient Audit (NaDIA) the trust scored below the England average.
- In care of the elderly and cardiology, which represented the majority of activity, the average length of stay was worse than the England average. In care of the elderly it was 15 days compared to the England average of 10 days and for cardiology it was 9 days compared to 5.6 days which was the England average
- We found equipment was stored in the shower rooms, utility rooms were not locked and hazardous chemicals had not been locked away.
- Fire doors were sometimes propped open.
- Equipment such as blood pressure machines and suction pumps on resuscitation trolleys had not been safety tested within the last 12 months.
- Medication trolleys were not chained to walls or immobilised when not in use.
- The trusts policy for medicines management was not being followed to support the use of patients own medicines (PODs).
- The vacancy rate across all the medical services wards as of 31st January 2015 was 25.8% of nursing staff.

Summary of findings

- Patients' medical notes were not stored securely and regular observations to check mittens were not restricting the patient's circulation were not being recorded. There was no review date on the documentation.
- Staff had access to translation services for patients for whom English was not a first language. Staff we spoke with told us they knew the service was available but they tended to use staff from the hospital who could speak various languages or ask patients relatives to interpret. This is poor practice as staff could not be confident the information that the patient was being told was what staff had wanted to convey to the patient.

However;

- People were cared for by staff that were kind caring and compassionate in their approach.
- Patients and their relatives were positive about their experience of care and the kindness afforded them.
- There was a positive culture of incident reporting and there were established processes for investigating incidents.
- Staff were aware of their role in relation to safeguarding children and adults living in vulnerable circumstances.
- The trust was one of 13 trusts awarded with an A rating in the Sentinel Stroke National Audit Programme (SSNAP) for their performance in January to March 2015.
- The hospital's endoscopy services were Joint Advisory Group (JAG) accredited.
- The service had responded to the needs of an ageing population and were developing services to improve the experience of patients living with dementia.
- A number of initiatives had been developed to ensure the service met people's individual needs and those of vulnerable groups.
- Across medical specialities complaints were discussed at monthly clinical governance meetings, these identified learning and action points

Summary of findings

- There was good leadership and management within the medical specialities with clear strategies on how the services were to develop.
- There was an appropriate system of clinical governance in the medical specialities, which identified quality and risk issues. Trends could be readily identified and learning was disseminated to staff.
- We found staff and patients were engaged with the development of medical specialities, and saw examples of innovative practice.

Surgery

Good



We found the surgery service at Kingston Hospital was safe, effective, caring, responsive to patients' needs and well-led.

- The surgery service at Kingston Hospital had a good overall safety performance and patients were protected from harm.
- There were low rates of serious incidents and no never events.
- We found good processes for reporting and escalation of incidents and good sharing of learning from incidents.
- Clinical areas were visibly clean and there was good compliance with hygiene processes.
- Staffing needs were based on acuity of patients.
- There was a good understanding of the trust's duty of candour and major incident policies amongst clinical staff.
- There were good patient outcomes across surgical specialties and care was delivered in line with relevant national guidelines.
- The trust performed well in national clinical audits.
- There were short length of stay and low readmission rates.
- Patients had effective and timely pain relief.
- Doctors in training and newly qualified nurses felt well supported with good supervision and good training opportunities.

Summary of findings

- There was good multidisciplinary team (MDT) working between doctors, nurses and allied health professionals.
- Staff across the surgery service were friendly, caring and professional, and patients were treated with dignity.
- Friends and Family Test results were consistently very good across surgery wards with a good response rate.
- The trust provided a number of services to improve outcomes for local people.
- Patient flow from admissions, through theatres and onto to surgery wards was satisfactory and bed availability was managed effectively.
- There were very good systems and provision of care for patients with complex needs, such as those living with learning disabilities and dementia.
- We found a cohesive and supportive leadership team, with well-established members of staff.
- There was a clearly defined strategic plan for each of the surgery service lines.
- Matrons and ward managers were very visible on the wards and the consultant body within the service provided clear clinical direction.
- There were comprehensive and robust governance and risk management processes in place.
- The World Health Organization (WHO) Surgical Safety Checklist was well-embedded in theatres but we did not find evidence of end of list debriefings to complete the five steps.

However;

- There was insufficient availability of sterile equipment and mechanical faults on equipment in theatres.
- There were some challenges with low staff morale in theatres.

Summary of findings

- There were some incidents of sub-optimal pre-assessment leading to cancellations on the day scheduled for the operation.
- Some patients felt the provision of information for elderly patients could be improved.

Critical care

Good



The Critical Care Unit (CCU) was good in a number of areas; however, current facilities were inadequate and did not meet the standards required. The unit environment was no longer fit for purpose. The bed spaces did not comply with HBN0402 critical care environment requirements; the unit was cramped, with limited storage space for necessary equipment and supplies. There were very few windows and little natural daylight. There were no toilets or shower rooms for patients and staff, visitors and patients all use the same toilet facilities. There were no current plans in place to improve this.

- Staffing levels were reviewed continually using an established acuity tool and there were enough staff to provide care and treatment in accordance with guidelines. Nurse staffing levels had been managed well and improving the skill mix was a high priority with appropriate strategies in place to mitigate risk. We observed good multidisciplinary working to ensure high quality patient care and good patient outcomes.
- Infection prevention and control was considered by all staff to be a high priority and there were robust systems in place to ensure compliance. Audit outcomes and low infection rates demonstrated high standards.
- Staff at all levels demonstrated a culture in which patients and relatives were involved in aspects of their care when appropriate. Staff were caring and compassionate to patients, relatives and colleagues.
- Staff in the department told us they felt respected, valued and supported by the matron and clinical lead. The matron was seen to have a visible and active approach to supporting and developing staff in the unit. We

Summary of findings

observed a friendly, open and honest culture throughout critical care, where staff felt able to ask questions and seek support and guidance when needed.

Maternity and gynaecology

Good



Overall we rated maternity and gynaecology services as good. This was because:

- We found the service provided safe and effective care in accordance with recommended practices.
- Women could give birth at home, in the midwife-led unit or in the consultant-led delivery suite.
- There was a separate gynaecology ward, which provided support for other female patients who could not be accommodated on one of the medical wards.
- Staff were confident about reporting incidents and dealing with emergencies, knowing these would be reviewed and any lessons learned would be shared with colleagues.
- Leadership was strong and well respected.
- There was a culture of learning and a desire to improve the service.
- The response of the service to the alert on perinatal mortality was thorough and it was grasped as an opportunity for additional learning and improvement.
- Staffing levels were appropriate on ward areas. Additional midwives had been recruited and their numbers could be increased if the unit became busy.
- Community midwife services were operating well but were nearing full capacity.
- The individual needs of women were taken into account and they were offered compassionate care and emotional support from staff.
- Equipment was sufficient to meet the needs of women and their babies.
- The new bereavement room and services had been welcomed by women and midwives. The written feedback from women and their families was positive.

Summary of findings

- Staff were positive about the hospital and the services they were able to offer women and their families. They were proud to be part of the team and committed to providing high standards of care.
- There was some pressure on bed capacity and the service was unable to increase the number of births per year without additional space in which to expand the service.
- The service would also need additional medical staff to support a greater number of births and greater support in the community.

Services for children and young people

Good



We found children and young people's services were good overall.

- Children and young people who were at risk of deteriorating were monitored and systems were in place to ensure that a doctor or specialist nurse was called to provide the patient and ward staff with additional support.
- The service had an open culture and was prepared to learn from clinical incidents.
- Across children and young people's services there were enough medical and nursing staff to keep patients safe. The trust found it difficult to recruit new nursing staff; but was able to effectively fill gaps by using bank and agency staff.
- Attendance at mandatory training was above the 90% trust target.
- We found care was provided in line with national and local best practice guidelines.
- Clinical audit was undertaken and there was good participation in national and local audit that demonstrated good outcomes for children and young people.
- We observed good clinical practice by clinicians during our inspection. There was a good knowledge of the issues around consent among staff.
- Children and young people received compassionate care and were treated with dignity and respect. All of the children, young people and relatives we spoke with said they felt involved in their care and were complimentary about the staff looking after them. One person

Summary of findings

told us: “The care has been excellent. I’m really happy with all the levels of care.” The children and young people’s division had good results in the children’s survey.

- The division were effective at responding to the needs of its community.
- Children and young people’s care pathways had been well designed to ensure children and young people were assessed and supported with all their medical and social needs.
- The paediatric admissions unit (PAU) provided effective alternate pathways for GPs and other referrers.
- Children and young people’s services were well led; divisional senior managers had a clear understanding of the key risks and issues in their area.
- The service had an effective meeting structure for managing the key clinical and non-clinical operational issues on a day to day basis.
- The service had a risk register which covered most of the key risks.
- Staff spoke positively about the high quality care and services they provided for patients. They described the hospital as a good place to work and as having an open culture.

End of life care

Good



We found end of life care at Kingston hospital was well-led, effective and safe. Caring was outstanding.

- Hospital services were arranged to enable all aspects of end of life care to be delivered holistically, with care and compassion as a basic principle.
- Staff of all disciplines and levels of seniority demonstrated an impressive understanding of their role in addressing the needs of needs of people near the end of life and those close to them. The specialist team and ward staff provided care and support sensitively and compassionately.
- The Specialist Palliative Care team were highly skilled and responsive. The hospital guide to care for people in the last days of life followed national good practice and the SPC team was leading its rapid and effective implementation across the hospital. They provided an extensive

Summary of findings

training programme, advice, information and tools to support the use of the guide. Hospital staff, including senior nursing staff, consultants, trainee doctors, nurses and health care assistants understood their role in providing this care.

- There was trust wide commitment to developing excellent end of life care at the hospital. The end of life steering group effectively contributed to and monitored the trust end of life strategy. The group had broad membership, including members of the public, external agencies and a non-executive member of the trust board.
- There were many examples of multi-disciplinary work to improve practice, for example on care of older people wards, the intensive care unit and the acute assessment unit. There was collaboration between the specialist team, ward staff, the chaplaincy service and the pain team to meet the physical and non-physical needs of patients. The specialist team worked with the local authority, and hospice and community health services to provide a seamless service. This included discharging people from hospital to their preferred place of dying.
- Surgical services were taking steps to improve awareness of the need to treat patients holistically and of when to consider ending active treatment. The SPC team were moving their focus to wards that made fewer referrals to them in order to address gaps in knowledge and awareness.
- The bereavement officer was responsive to the needs of relatives after the death of a patient. Mortuary and porter staff provided a safe and dignified service for the deceased.
- The SPC team, ward staff, and the mortuary and bereavement staff were aware of the varied needs and expectations of different cultures at the end of life and after death.
- The trust undertook regular audits of Do Not Attempt Cardiopulmonary Resuscitation orders

Summary of findings

and there had been improvements to practice, such as senior medical staff leading the discussions with patients or those close to them.

However;

- At the time of our inspection the trust had not allocated funds to increase specialist palliative consultant and nursing presence at the hospital. This is needed to maintain progress towards meeting the aim of providing excellent end of life care.
- The environment of the chapel and multi-faith facilities needed improvement.
- Staff sometimes used relatives instead of interpreters to have important conversations with people at the end of life who did not speak English.

Outpatients and diagnostic imaging

Requires improvement



We rated the outpatients and diagnostic imaging services provided at Kingston Hospital as requiring improvement, as the services were not always safe and responsive.

- Medicines were not always stored safely and checks on emergency resuscitation equipment were not performed routinely. Other items of equipment used for patient care had not always received and annual service or maintenance check.
- Incidents and adverse events were reported and investigated. Lessons arising from these were learned and improvements had been made when needed. However, people did not always receive a written apology in accordance with the duty of candour.
- The method for tracking medical records was reliable; however, patient original records were not always available prior to appointments.
- Peoples privacy was not always achieved in outpatient and diagnostic areas.
- People were not always made aware of waiting times.
- There were no designated outpatient areas designed specifically to meet the needs of individuals living with dementia.

However;

Summary of findings

- Cleanliness and infection control procedures were adhered to and potential risks to the service were anticipated and responsive actions planned.
- There were sufficient staff with the right skills to care for patients. Staff who had been provided with induction, mandatory and additional training specific for their roles.
- Staff had appropriate safeguarding awareness and people were safeguarded from abuse.
- The hospital was significantly better than the national average for new to follow up ratios for the period between July 2014 – June 2015.
- Cancer referral targets had improved and most had been met for quarters one to three, 2015/16.
- Referral to treatment times were better than the England average.
- The new to follow up outpatient rates of 29 to 38 against the national figure of 25 to 55, were significantly better than the national average between July 2014 and June 2015.
- Waiting times for echocardiograms and portable monitoring for cardiac patient were three to four weeks at the time of our visit, which was good when compared to other similar services .
- A multidisciplinary team approach was in effect across services provided within the outpatients and diagnostic imaging department.
- Patients treatment and care was delivered in accordance with their individual needs. Patients told us they felt involved in decisions about their care and they were treated with dignity and respect.
- People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.
- The leadership, governance and culture with the outpatient and diagnostic imaging services promoted the delivery of person centred care.
- Staff were supported by their local and divisional managers and were encouraged to contribute to the development of the services.

Summary of findings

- In the main, risks were identified and addressed at local level or escalated to divisional or board level if necessary.
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Kingston Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

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Background to Kingston Hospital

Kingston Hospital location is registered with the commission as Kingston Hospital NHS Foundation Trust. This means that as a foundation trust hospital it is part of the NHS and is expected to treat patients according to NHS principles of free healthcare according to need, not the ability to pay. Being a foundation trust means it is better able to provide and manage its services to meet the needs and priorities of the local community, as the Trust is free from central Government control.

Kingston Hospital is a single site, medium sized hospital located within Kingston-Upon-Thames in south west London, approximately 12 miles from central London. The hospital has 534 beds, 450 of which are general and acute, 72 within maternity and 12 for critical care.

Our visit to the trust took place as part of our comprehensive scheduled inspection programme. During the inspection we reviewed eight core service areas, as follows:

- Urgent & emergency services
- Medical care, including older people's care
- Surgery
- Critical care
- Maternity & Gynaecology
- Children & young people
- End of life care
- Outpatients & Diagnostic Imaging

Our inspection team

Our inspection team was led by:

Chair: David Throssell, Medical Director. Sheffield Teaching Hospitals NHS Foundation Trust.

Head of Hospital Inspection: Nick Mulholland

The team included CQC inspectors and a variety of specialists with the following expertise: Consultants in oral surgery; anaesthetics, medicine, rheumatology, cardiology, paediatrics, fetal medicine and obstetrics. Nurse expertise included; A modern matron for

emergency services; head of nursing in critical care, a theatre nurse, senior manager in paediatrics, nursing sister for medicine, and a care of older person's nurse. In addition, we were supported with the expertise of senior health advisors, a senior quality and risk manager, a national professional advisor for maternity, safeguarding lead, a senior radiographer and a national medical director clinical fellow.

We had two experts by experience assisting us and analytical support.

Detailed findings

How we carried out this inspection

To understand patients' experiences of care, we always ask the following questions:

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

Our inspection was announced in advance to the trust. As part of the preparation and planning stage the trust provided us with a range of information, which was reviewed by our analytics team and inspectors.

We requested and received information from external stakeholders including, Monitor, The General Medical Council, The Nursing and Midwifery Council, The Royal College of Nursing, and The Royal College of Anaesthetists. We received information from NHS England Quality Surveillance Team, NHS England Specialised Commissioning and NHS Health education England. Local clinical commissioning groups for Kingston, Richmond and Wandsworth also shared information with us.

We considered in full information submitted to the CQC from members of the public, including notifications of concern and safeguarding matters.

Members of the public spoke with us at our open days held at the trust on 11 and 12 January 2016.

We held focus group discussions with separate groups of staff on 6 and 7 January 2016. Participants included; allied health professional, administration and clerical

staff, student nurses and student midwives, band 5 and 6 nurses, senior sisters and charge nurses, midwives, midwifery and nursing assistants, volunteers, governors, matrons and clinical nurse specialists, as well as consultants. A focus group discussion with junior doctors was held on 13 January 2016.

Our announced inspection visit took place over the 12 -14 January 2016. We also undertook an unannounced inspection on 25 January and 26 January 2016.

During our inspection we spoke with 104 patients and 7 relatives/friends, who provided feedback on their experiences of using the hospital services. We looked at 73 patient records where it was necessary to support information provided to us.

Whilst on site we interviewed more than 400 staff, which included senior and other staff who had responsibilities for the frontline service areas we inspected, as well as those who supported behind the scene services, and volunteers.

We requested additional documentation in support of information provided where it had not previously been submitted. Additionally, we reviewed information on the trust's intranet and information displayed in various areas of the hospital.

We made observations of staff interactions with each other and with patients and other people using the service. The environment and the provision and access to equipment was assessed.

Facts and data about Kingston Hospital

Population served:

Kingston Hospital provides services to approximately 350,000 people. The trust provides a full range of diagnostic and treatment services, including A&E, day surgery and maternity services.

Deprivation:

The local population served includes the boroughs of Kingston, Richmond, parts of Wandsworth (Roehampton and Putney) and Elmbridge.

Kingston local authority is ranked 255th, Elmbridge 320th, Richmond 285th and Wandsworth 121st most deprived districts out of 326 (1 being the most deprived and 326 being the least) in England in the 2010 Indices of Multiple Deprivation.

The health of people in Kingston as well as Richmond is generally better than the England average. Statutory homelessness is worse than the England average in Kingston, Richmond and Wandsworth districts.

Detailed findings

New Sexually Transmitted Infections (STI) is worse than the England average in Kingston and Wandsworth. Excess winter deaths is worse than the England average in Kingston.

Activity

Between 2014 and 2015 the trust facilitated:

66,338 inpatient admissions

369,859 outpatient attendances

110,473 Accident and Emergency attendances

5,744 babies delivered

Context

The trust serves a population of approximately 350,000 and employs around 2738 staff.

Key intelligence indicators

Safe

- From August 2014 to August 2015 zero MRSA cases per 100 bed days were reported.
- From August 2014 to July 2015 one never event was reported.
 - There were 58 STEIS incidents reported between August 2014 and July 2015, 40% related to pressure ulcers and 28% to slips, trips and falls.
- 96% of National Reporting and Learning System (NRLS) incidents reported led to no or moderate harm.
- Clostridium difficile (C. Diff) cases reported were below the England average for 10 of the 13 months from August 2014 to August 2015.
- Meticillin Susceptible Staphylococcus Aureus (MSSA) cases reported were mostly below or slightly higher than the England average for the 13 months, August 2014 - August 2015.
- Numbers for Pressure Ulcers, Falls and Catheter related Urinary Tract Infections (CUTI) were not significantly high but numbers increased during winter periods.
- The medical staffing skill mix for the trust was mostly in line with national averages but the trust had less middle career staff than the national average.

Effective

- No evidence of risks were identified for any of the mortality indicators.

Caring

- The percentage of friends and family that would recommend the trust in the Friends and Family Test (FFT) were worse than the England average for 10 months in the period August 2014 to July 2015.
- The trust was rated in the middle 60% for the majority of indicators in the Cancer Patient Experience Survey; the trust ranked in the top 20% for five of these Indicators. The trust ranked in the bottom 20% for nine (26%) of the indicators in the Cancer patient Experience Survey.
- The trust scored consistently higher than the England national average in the Patient led Assessment of the Care Environment (PLACE) for the three years 2013-2015.
- An average of 430 complaints per year were received for the financial years 2011/12 to 2014/15. There were no significant outlying years from this set.
- The trust performed within the middle 60% of all trusts in the CQC in patient survey 2013/14.

Responsive

- The trust had 15,462 instances of delayed transfer of care between April 2013 and May 2015. The top two reasons were completion of assessment, and waiting for further NHS acute care. These were the same as the top two reasons nationally.
- Bed occupancy percentages were below the England average for quarter two to quarter four 2013/14. During quarter one and quarter three 2014/15 occupancy rates were higher than the England average and during quarter four 2014/15 the occupancy rate were considerably higher than average (99.4%).

Well-led

- The trust reported sickness absence rates below the national average since January 2011.
- The trust performed as expected in nine survey areas and worse than expected in three of the service areas, namely; induction, feedback and study leave in the General Medical Council National Training Scheme.

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	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Kingston Hospital is also known as the accident and emergency (A&E) department. It provides a 24-hour, seven day a week service.

The department saw about 83000 adult patients during 2015 and 26,000 paediatric patients. About 20% of ED attendances result in admission to hospital.

The ED is divided into six areas:

- A resuscitation unit, or 'Resus',
- Majors for patients with acute illnesses,
- Minors for low risk patients,
- Children's ED,
- Minor injuries and GP service run by the trust as part of ED,
- X-ray unit.

Which area a patient goes to depends on how ill or injured they are.

The resus area has five beds. It is for patients with immediate life threatening illnesses. One bay is equipped for children.

The majors' area has 14 spaces for patients with acute illnesses. Two rooms staff can use to isolate patients, provide privacy, or for women with gynaecological problems. One has an en suite shower. This area also has a psychiatric assessment room.

The minors' area has 10 cubicles, four with trolleys, and six with chairs. This is for patients with non-life threatening illnesses. All cubicles have oxygen and suction. Minors has its own waiting area next to the cubicles.

The children's ED is child friendly. The waiting area is also the play area and toys are available. It has a triage space and eight cubicles, five with beds, including one for high dependency patients, and three cubicles with seats.

There is one GP consulting room and two treatment rooms for patients with minor injuries.

The x-ray unit is open 24 hours. Computerised Tomography (CT) scans are available in the nearby radiology department of the main hospital that is open until 8pm. After that time, any CT requests are on an on call basis.

An emergency eye unit is open on weekdays from 8.15am to 4pm. This unit is in a separate building, part of the main eye department. It has its own waiting area. It sees over 10,000 patients a year, mainly adults (93%). Outside the opening hours, ED doctors can treat patients with minor eye problems in the eye room of the main ED. Doctors see about 100 eye patients a month here. If patients have a more serious eye injury out of hours, staff direct them to a specialist eye department at another hospital.

All walk-in patients register with staff at reception. A nurse streams adult patients to the appropriate area. All children undergo triage with a children's nurse in the paediatric ED.

Urgent and emergency services

Patients arriving by ambulance are taken through a separate entrance. The most seriously ill patients are taken to resus. A nurse in a four bay rapid assessment area assesses the condition of patients who are less seriously ill before transferring them to the appropriate part of ED.

Kingston is a Level 2 trauma unit and is part of a wider trauma network centred on a nearby tertiary centre. The unit treated 95 low acuity trauma cases in 2015. It does not treat patients with severe head injuries or unstable spinal injuries.

We inspected the ED over two days during our announced inspection, and one weekday evening as an unannounced inspection. We saw patients being treated and looked at 20 patients' records. We spoke with over 70 staff including managers, nurses, health care assistants, consultants, doctors, receptionists, security staff, porters, domestic staff, and ambulance crews. We spoke with 14 patients or their relatives who were using the service at the time of the inspection. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also used information provided by the trust and information we asked for afterwards to inform our findings on the inspection.

Summary of findings

The Emergency Department at Kingston Hospital required improvement.

- There were not enough permanent, experienced staff who understood the ED systems to lead the many newly qualified staff, as well as agency and locum staff.
- The department did not consistently meet the national target of seeing and treating 95% of patients within four hours of arrival, even on days they were not full. The department regularly missed other related targets such as receiving ambulance patients within 15 minutes, although performance had improved enough to reduce the number of financial penalties.
- Staff did not routinely follow recommended systems and processes for keeping people safe from avoidable harm.
- Staff did not use appropriate security in using computers.
- The design of accommodation in some areas did not protect patients' privacy and dignity, or the confidentiality of patient discussions with clinicians.
- The department's comparative performance in national audits about emergency care was not good and they were slow to make improvements.
- Accommodation for mental health patients was poor and they often had long waits in ED.
- A culture of continuous improvement was lacking. Staff did not routinely use information from incidents and complaints to provide a better service to patients.
- The quality and accuracy of performance data needed improvement.
- Risks were not always fully identified on the risk register.

However;

- There were arrangements to protect people from abuse and safeguarding processes were robust.
- We saw staff interacting in a caring and compassionate way with individual patients
- The recognition of the needs of people living with dementia and provision for children were good.

Urgent and emergency services

- ED staff were introducing processes to help staff meet national targets and there had been some improvements.
- Some key senior staff vacancies had been filled which had the potential to improve leadership and governance.

Are urgent and emergency services safe?

Requires improvement



We rated safety as requiring improvement. This was because:

- There were not enough permanent nursing shift leaders or doctors for the rota.
- There were high numbers of new and inexperienced nursing staff, as well as high proportions of locum and agency staff which compromised teamwork.
- Managers did not plan staffing to ensure there were more staff on duty on days and at times when the department was known to be busiest.
- Incidents were not analysed promptly and we saw little evidence of learning from incidents to prevent recurrence and make improvements.
- The systems for routine safety processes such as recording timely observations of patients, checking resuscitation equipment, or making sure medicines and cleaning chemicals were stored securely were weak.
- Nurses and doctors did not always follow safe hand hygiene practices.
- Many staff did not make sure they used IT securely and shared login cards.
- The provision for mental health patients was not adequate,

However;

- There were appropriate arrangements for safeguarding child and adult patients from abuse and staff had a good understanding of the needs of most patients in vulnerable circumstances, including those with dementia.
- There was robust planning for potential risks in terms of major incidents and permanent staff were adequately trained.
- Paediatric ED had safe procedures and enough staff with appropriate skill mix.
- We had no safety concerns about the specialist eye ED unit

Incidents

- There were three closed serious incidents (SIs) during 2015, two resulting in permanent harm and one in

Urgent and emergency services

death. We noted staff had initially graded 42 of the 579 incidents reported internally from October 2014 to November 2016 as high severity. Most were downgraded on investigation so we were unclear whether the trust's grading system was accurate. The highest numbers of incidents reported were for security issues, failure to monitor patients or to escalate concerns quickly enough and errors in medication or blood products. Staff had reduced the backlog of open incidents in late 2015, just before our inspection; however, we did not see evidence of learning from incidents to prevent recurrence. We asked some junior nurses to give us examples of learning from incidents but they were not able to do so

- Trainee doctors said they reported incidents and discussed them at handovers. However, they did not think managers always took action to reduce the recurrence of incidents and improve safety. Governors had expressed concern during a focus group that learning from incidents was not always effectively cascaded.
- Some nurses said they had little training in incident reporting. Although staff said serious incidents were reported, nurses said they might not report minor incidents when busy. Staff we spoke with considered that agency and locum staff were less likely to report incidents.
- None of the clinical staff we spoke with were aware of incidents that happened elsewhere in the hospital, and they said they did not always have feedback on incidents in ED. Staff were aware that memos were sometimes displayed in ED to remind staff of processes after incidents, and said they sometimes received emails about incidents..
- Staff in ED were slow to close incidents. Slow closure of incidents can mean, delay in making changes to prevent recurrence. This was on the risk register.
- A departmental noticeboard stated 'Safety' was the theme for January 2016. We did not see any practical evidence of safety issues being prominent and influencing practice in ED. Staff were not aware of safety being a current priority.
- Doctors reviewed mortality and morbidity cases at medical governance meetings. There was no ED specific Mortality and Morbidity meeting.

Duty of candour

- The duty of candour requires senior staff to tell patients and their families about safety incidents that affect

them, give an appropriate apology, tell them about the progress of the investigation, and support them to deal with the consequences. Not all nursing staff we spoke with understood this or that it applied to incidents with moderate harm and psychological harm.

- A senior manager said the nurse in charge or a doctor would take responsibility for speaking to patients or family.
- We saw evidence of duty of candour processes following serious incidents. However, there were no examples where moderate harm incidents or incidents that could have caused harm, followed the same processes of notifying the patient and family, apologising, and recording verbal and written apologies.

Mandatory training

- Mandatory training included refresher updates each year on safeguarding, fire safety, manual handling, and basic life support. The trust target was 80%. Training rates averaged 81% by January 2016. The service manager had oversight of mandatory training compliance.
- The percentage of staff having fire training was below target at 46% in September 2015 but we were told some further training had taken place in December 2015. It was a concern that basic resuscitation training was below target. We considered training in the basic safety systems such as checking resuscitation equipment, labelling sharps containers, and locking away hazardous chemicals was not effective because staff were not carrying out routine processes consistently nor challenging others about this.
- 85% of staff (11 out of 13) had in date APLS or PILS. All shifts have a nurse trained in immediate paediatric life support, in accordance with the Royal College of Paediatric and Child Health Standards, and the majority of shifts having nurses with the Advanced Paediatric Life Support qualification.

Safeguarding

- Staff we spoke with understood their responsibilities to protect vulnerable adults and children. They were aware of how to report concerns. Nurses and doctors had access to patients' previous attendance history and to the child risk registers of relevant local authorities.
- A part-time liaison health visitor supported the children's emergency department with safeguarding. We noted the Safeguarding Annual report April 2014- March 2015 showed there were sometimes delays of up to

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three days in passing on child safeguarding information. This was on the risk register. Changes had been made to staff roles and a process was in place to ensure the higher priority referrals were timely. It was reported by staff that it was not uncommon for there to be a delay over the weekends.

- Safeguarding of young people under 18 who came to ED because of drug or alcohol misuse was managed under child safeguarding procedures. We saw from records that staff had identified safeguarding issues and made appropriate referrals.
- All registered nurses in the paediatric ED had undertaken child safeguarding training to level 3 as required. The policy for identifying safeguarding issues with children was robust. Staff knew how to identify if a child was on a protection plan for one of the local authorities served by the trust; most young people were from Kingston or Richmond. There were age appropriate risk assessments for children and young people. There were safeguarding concerns for about 4% of child attendees a month.
- ED staff were represented at the monthly child safeguarding meetings.
- Doctors knew the name of the named doctor for safeguarding. 52% of doctors had undertaken training in child protection training to level 3; 48% were trained in safeguarding vulnerable adults. The target was 80%.
- Staff did not all know who was responsible for adult safeguarding, although they knew they could find out on the intranet. In June 2015, a number of the 42 incidents reported related to adult safeguarding, even though the actual percentage of adult patients with safeguarding issues was low, less than 1%.
- Nurses we spoke to had limited understanding of domestic violence. This was included in doctor's training.

Cleanliness, infection control and hygiene

- Nurses and healthcare assistants mostly carried hand gel. However, we saw few staff use this, or wash their hands between caring for patients. On our unannounced inspection, there were empty hand gel dispensers, including at the entrance to the department. The trust's hand hygiene target was 95%. Adult ED staff scored 50% on the December 2015 audit, and we noted

results for previous months had been less good than elsewhere in the hospital. We saw no evidence of concerted action to prevent cross infection in ED by raising standards of hand hygiene.

- In clinical areas, staff separated clinical and infectious waste appropriately. However, sharps management did not comply with the Health and Safety (Sharp Instruments) Regulations 2013. Very few sharps containers were labelled with the hospital name, department name, and date opened in line with good practice.
- Staff carried out environmental audits monthly. The adult ED had performed poorly in spot checks for cleanliness of equipment for several months. For example, the Environmental Record in majors' showed that staff had not recorded blood pressure monitoring equipment as cleaned on nine days in November 2015. Although the scores in ED were below trust standards, most staff were unaware of the monthly audit scores, and we saw no action plan to improve the cleaning of equipment.
- Staff we spoke with were aware of trust policies and procedures for infection prevention and control and hand hygiene, but training levels were below the trust target. The overall completion rate for infection control training among nurses in the adult ED was 56%, compared with a trust target of 80%. Training was online not classroom based, including aseptic technique training. We were not convinced of the effectiveness of the training as the evidence of audits and what we observed of staff behaviour indicated that not all aspects of IPC were embedded.
- Cloth curtains hung between bed spaces rather than disposable curtains. According to the cleaning schedule, curtains were changed every three months and more often if soiled. There were no dates on the curtains and staff were unclear about how often curtains were changed.
- The linen trolley in the majors' area was uncovered on the first day of our inspection, but covered on the following day. It was again uncovered during our unannounced inspection. The designated linen cupboard, which had plenty of storage space, was unlocked and we saw staff used this to store their personal bags.
- The sluice in majors was unlocked. On one day, we saw a Haz-tab bottle on the floor, which, as a toxic chemical should be in a locked cupboard or behind a locked

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door. It was smelly and the macerator was broken. There was no spillage kit even though a poster on the sluice wall said staff should use a spillage kit for blood or fluid spills.

- On our unannounced inspection there were no toilets working in ED. Patients were being directed to other toilets in the main hospital which were not very clean at that time. This had been a long running problem. Staff suggested to us that replacing paper towels with hand dryers would reduce the frequency of blockages.
- The ED was clean and tidy. We saw domestic staff cleaning the department throughout the day. We saw cleaning schedules displayed on the door to the cleaner's office. The cleaning audit scores were between 98% and 100% for cleaning by domestic services.
- We saw staff wearing personal protective equipment such as gloves for undertaking invasive nursing procedures.
- Two rooms were available for isolating patients who presented with a possible infection risk.
- Staff were bare below the elbow in line with trust policy, but we noted the requirement did not extend to volunteers working in the unit.
- Hand hygiene results in the children's ED were high and all staff had undertaken infection control training.
- The sluice in the paediatric ED was clean and the commodes were clean and labelled.

Environment and equipment

- The records showed clinical staff rarely checked mobile resuscitation trolleys in any area of adult ED. This was against trust policy and unsafe. Staff had not checked the trolley in the Resuscitation unit for 27 days in March 2015, 23 days in September 2015, and 22 days in December 2015. Staff had not checked the majors' Resus trolley on 11, 12, 15, 18, 20 or 22 January 2016. Staff had only checked the resus trolley in the ambulance assessment unit on three days in January 2016 (1, 11, and 12) and checks had been missed on 17 days in December 2015.
- One drawer of the minor's resuscitation trolley was open during our inspection, so staff could have used and not replaced items from this drawer. Only three checks were recorded in January 2016. In both November and December 2015, the diary showed 18 days without checks. Old checklists from 2012/13 were still on the table by the trolley. On our unannounced inspection,

the door to the treatment room, where this trolley was stored, was locked. Not all staff knew the code for the door and we saw a locum doctor trying to enter the room. This would be high risk in an emergency.

- A memo from the resuscitation team dated February 2015 stated staff must check resuscitation trolleys every day. The senior manager in ED had not responded to this request, and we saw no plan to improve this unsafe situation.
- There was an empty Entonox cylinder in an unlocked treatment room on both days of our announced inspection. The cylinder was not secured in any way.
- The dedicated room for people with mental health difficulties area had several features, which made it unsafe. For example, one of the two doors had a lock, which we found hard to open and a tear in the couch was an infection risk. On the first day of our inspection, the light bulb was hanging out of the light fitting. After inspectors drew attention to this, maintenance staff removed the complete light fitting. However no action was taken on our second concern, also mentioned to staff at the same time: to move the lightweight chair and waste bin in that room, both of which a patient could use as a missile or weapon. A nurse told us that in December 2015 a Mental Health Commission inspection had declared the room did not meet the standards set out by the Psychiatric Liaison Accreditation Network. The trust advised us that action was being taken in response to the recent visit. The room had two panic buttons, which was safe practice.
- Specialist equipment had undergone safety checks by a clinical engineering company within the last year.
- The resuscitation unit was close to the area where ambulances came in, which helped ambulance staff transfer seriously ill patients to the care of the emergency team very quickly. Storage was limited and it appeared untidy and cluttered. A planned upgrade of this unit was on hold for financial reasons.
- Records of a serious incident in 2015 had revealed the resus unit was not fully equipped at that time, and recommended the in-reach teams should bring their own equipment. Since December 2015, anaesthetists had been involved in the layout and identical equipping of the bed spaces that contributed to efficiency in emergencies. One resuscitation bay was additionally

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equipped to resuscitate children. It was not otherwise child friendly. During our inspection, there were two children in resus, so the resuscitation trolley from paediatric ED was in use for the second patient.

- The majors' area was well designed with the doctors and nurses station in the centre, so clinicians could see most of the patients easily. Nurses mainly worked from a desk at the end of the ward. The nurses' station in the minors' area gave less good visibility of all patients.
- Doctors and nurses ordered clinical tests of samples through the electronic patient record system. Barcoded labels were printed for each individual sample. Staff place samples in a box for collection near the nurses' desk. The collection box was very near the mental health assessment room. This posed a potential infection risk as an aggressive patient could grab or spill the contents.
- The paediatric emergency unit was well organised and equipment and records showed the resuscitation trolley had been checked daily between September 2015 and the date of our inspection in January 2016. All equipment had been tested by clinical engineering within the last year.
- The children's ED had a room where staff could treat a patient needing more privacy such as a pregnant teenager. One cubicle was equipped for high dependency child patients.
- The ED was close to CT and MRI facilities. The theatre was some distance away.
- The accommodation was broadly in line with the standards in Department of Health guidance, Health Building Note 15-01: Accident & Emergency Departments.

Medicines

- Medicines were mostly stored safely. The main rooms where medicines were stored had keypads and were locked; but there was an unlocked medicines fridge in the majors' area. However, in the unlocked eye and ear treatment room, four different 'prescription only' medicines were stored in an unlocked cupboard. The September 2014 to March 2015 British National Formulary (guidance on the selection and use of medicines) in that room was two years out of date – the current edition available is January 2016. This could mean a doctor could potentially prescribe medicine using out of date guidelines.

- Controlled drugs (CDs) were stored in line with National Institute for Health and Care Excellence (NICE) guidance. However, in the resuscitation area the checking of CDs was not as robust as possible. Nine separate incidents of missing controlled drugs had been reported in the course of a year. Trust policy required two staff to check stocks of CDs at least once every 24 hours. No checks at all had been carried out on four days in each of November and December 2015, and no checks on three days in January 2016 (out of 13 days before our inspection). On 13 days in December 2015, there had only been one daily check. Ten afternoon checks had not been done in January 2016. The trust had recently installed CCTV over the CD cupboard in resus because drugs had gone missing from the cupboard. Regular checking was important to ensure the correct drugs were always available when needed.
- Staff checked the temperature of medicine fridges each day and recorded these to show that drugs were being stored at a safe temperature.
- The trust had introduced electronic prescribing in 2015 for adult patients. Doctors said it had improved safety as well as sepsis audit times and prevented staff giving medicines to patients with specific allergies. Nurses had completed medicine administration records correctly on the patient notes we reviewed.
- The children's ED did not use electronic prescribing.
- Not all nurses were able to prescribe under patient group directions to support the treatment of common ailments so had to ask doctors to prescribe, leading to delay.
- We found some medicines were not disposed of in accordance with regulations. We found an open glass ampoule of metoprolol (used to treat high blood pressure) beside a computer on a desk in the resuscitation unit, which could have caused a sharps injury. Two empty plastic Lidocaine ampoules (an anaesthetic) were discarded on the floor in the treatment room.

Records

- Reception staff generated a paper record, known as the 'cas card' containing basic patient details, name, address, and initial assessment when patients registered. When the patient was discharged this was returned to reception for filing. The streaming nurse

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logged all treatment records, including observations straight to the patient's electronic computer record (CRS). All patient records at the hospital were held electronically.

- The computer system showed how long patients had been waiting, their location in the department, treatment given, and tests carried out. However, staff told us the system did not fully meet the needs of ED and not all the output was accurate. Managers told us the computer system would soon be upgraded, which should make it meet staff needs better. Doctors and nurses mentioned there were not enough computers, and some did not work, which meant they did not always update the computer record in real time. However we were advised by the trust at the time of inspection that there were 92 computers available to use in ED. More computers had been introduced in July 2015 in response to staff requests. This increased the risk of transcription errors from paper to the electronic record. Doctors did not have mobile access to the hospital's computer system. Reliable computer performance was important for viewing test results and imaging as well as recording treatment.
- We looked at the care records of 20 adult and four paediatric patients to check staff were routinely carrying out risk assessments such as for falls, safeguarding and mental health assessments. The records we reviewed were generally complete, though we were aware from the risk register that nursing records, particularly in adult ED were not always complete. We reviewed the clinical notes for a trauma patient. Staff had completed these appropriately, with a clear management plan and evidence of the lead doctor's involvement.
- All children whose records we checked had a child protection assessment and a pain score recorded on their notes.
- Managers told us electronic measurement of observations was to be trialled which would save time, reduce error and record information automatically in CRS.
- A nurse assessed the condition patients arriving by ambulance who were assessed as lower priority, in the rapid assessment area, after receiving a handover from the ambulance crew. Assessment of patients included a National Early Warning Score (NEWS). Patients with a score of seven or above were admitted to the resus unit. The process required flexible staffing to deal with the arrival of ambulances in quick succession and prioritise patients appropriately.
- We saw flexible staffing operating at night on our unannounced inspection when the unit was very busy. However, we also saw the ED target to take handover from ambulance crews within 15-minutes of arrival missed even when the department was not busy, because there was only one nurse and HCA allocated to the assessment area. Staff did not use the escalation policy to obtain additional support. This caused avoidable delay in assessment of patients brought in by ambulance. Although there had been an improving trend in receiving ambulance patients, the target of 15 minutes was rarely met.
- New standards had been set in June 2015 in the adult ED, for carrying out patient observations within specified time scales. These were known as the Gold Standards and we saw posters about these. However staff were not meeting them consistently. An ED audit early in January 2016 had shown observations of vital signs were only complete in 70% of cases. Nurses had not recorded the level of consciousness in 50% of cases. A complete set of vital signs is important for accurate calculation of the National Early Warning Score (NEWS) and subsequent clinical management decisions. It was also important for the prompt management of sepsis, which was an ED improvement project. For sepsis ED had ensured 50% of patients received antibiotics within an hour by December. This was below the national standard of 90% which they needed to achieve by April 2016.
- The manager did not have a standard process for sharing audit information with nurses or engaging them in any action plan for improvement. Although the January 2016 audit was displayed on the wall on one day during our inspection, it was no longer on display a few days later when we returned unannounced.

Assessing and responding to patient risk

- Just over 1000 patients arrived by ambulance each month. The ambulance crew transferred patients arriving by ambulance as a priority ("blue light") to the resuscitation area or to an allocated cubicle. The ambulance service called the hospital in advance for these cases.

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- The time to initial assessment was a benchmark to compare against the England average. The trust was not able to provide reliable data on the time to assessment between August 2015 and February 2016, but said it had reduced.
 - Walk-in patients registered with a receptionist. A streaming nurse then spoke to patients about their symptoms, took observations, and directed patients to the appropriate waiting area. The streaming nurses did not always meet the 15-minute target for streaming. Patients told us not all streaming nurses offered them pain relief.
 - Reception staff in the main waiting area could visually scan the waiting area to identify any patient whose symptoms indicated that a doctor should see them ahead of other patients. However, senior nurses reported concerns that nurses did not always assess patients in minors' very promptly and doctors we spoke with were not always aware of the range of patients waiting in that area, so nurses or doctors might not spot a deteriorating patient.
 - Nurses assessing patients did not always record of patient risks. For example we saw nurses did not carry out skin and falls assessments in all relevant cases.
 - A paediatric clinician assessed all children in ED. Child triage included a pain score. There was a clear escalation process for deteriorating children. If a doctor had a concern about child safeguarding they would contact social care while the child was in the department.
 - Nurses triaged patients in the emergency eye unit by their conditions: those that a doctor should see immediately, those who should be seen that day, and those that could be managed by a GP. Staff had some discretion within the guidelines in consultation with the consultant of the week. The unit closed at 4pm and staff advised patients with non-urgent conditions to return the following day if there was not time to see them before the unit closed for the day.
- Nursing staffing**
- Data for September 2015 showed the actual staffing levels were lower than the planned levels, both day and night. In September 2015, only 70% of the planned number of Health Care Assistants (HCAs) were in post. Staff told us low staffing was historic in ED and dated back to staff reductions made when the trust gained foundation status. However, despite what some staff told us, we found that the Trust had regularly reviewed the staffing complement. From April 2014 until January 2016, an increase of 29.5 WTE had been made to the staffing establishment.
 - The ED used the professional judgement of the senior nursing team, in conjunction with the ED nursing team to review staffing levels in April 2014. Draft NICE guidance for emergency departments was available in July 2015, and this was used as a tool to assess the overall performance of the ED at that time.
 - A band 8 matron led the nursing team. There were 5.5 WTE band 7 and 10 band 6 permanent nurses. There were not enough band 7 staff to fill a 24/7 rota without staff working overtime. Managers nonetheless required staff to ensure weekend and night shifts were all band 7 led. As a result we observed that shift leaders were stressed, overtired, and demoralised. They worked hard to support their staff and provide good patient care, but felt undervalued by management.
 - Although the role of nurse in charge should be supernumerary, staff shortfalls and the number of inexperienced staff, both band 5 and band 6, meant shift leaders often had to work clinically.
 - The skill mix did not match the acuity of patients' needs during our inspection and this was on the risk register for January 2016. Nurses were inexperienced; 25 newly qualified nurses had been recruited in September and October 2015, and several band 6 staff were newly promoted and not yet confident in their roles.
 - We did not see staff deployed flexibly to support the busiest areas.
 - The ED used bank and agency staff, where possible staff who had worked in ED before. In March 2015, the bank and agency usage had been 48% but this had reduced since newly qualified staff had been employed in the autumn of 2015. In 2015, 29% of shifts in adult ED were filled by agency staff. In the paediatric ED only 2% of shifts were filled by agency staff.
 - We spoke with a number of staff who were leaving for jobs in other hospitals, which offered a wider range of emergency nursing roles. Despite recent recruitment, continuing staff turnover caused a risk that the department could lose more nurses than it had gained. Further recruitment in 2016 was planned.
 - There were not always enough staff to escort patients to x-ray. We noticed several patients having to find their own way.

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- Staff were unable to show us a structured induction checklist for agency staff or evidence that senior staff checked their competencies. This was not safe practice. A nurse told us the induction was by “anyone on the floor”. It covered layout of the unit, how to use the bleep and the computer system for patient records.
- Sometimes nurses were moved at short notice from other parts of the hospital to fill staffing gaps in ED. We saw this on our unannounced inspection. These staff were not necessarily ED trained.
- A nurse streamed patients day and night in the main waiting room. The ambulance assessment area, known as RAP (Rapid Assessment and Plan) was staffed 24/7 by an HCA and a band 5 nurse, and a receptionist for between 11am and 10pm. There was no regular doctor presence in this area, although staff said this had been the original plan.
- Although the trust told us that streaming was carried out by staff at Bands 5,6 and 7 we only observed streaming by band 5 nurses during our inspection. We had some concerns about streaming being carried out by staff who had relatively little experience. Sick patients do not always look obviously ill and we saw two patients re-classified from the GP service to minors within a short period.
- ED had recently recruited some advanced nurse practitioners to cover afternoons in ED, and support primary care until 10pm.
- Nursing handovers took place twice daily at 7.00am and 7pm, led by the nurse in charge. We observed a handover. It was efficient but very quick, but senior staff did not use the opportunity of face-to-face contact for training or safety reminders. This was a missed opportunity when there were so few meetings to share information. No medical staff attended the nursing handover during our inspection.
- The paediatric ED had different staffing levels in winter and summer. There was one more nurse in winter. A supernumerary band 7 nurse led the unit during the day.
- All permanent registered nurses in the paediatric ED were paediatric trained except for one nurse on secondment as part of professional development. Paediatric trained staff supervised this nurse. The unit complied with the recommendations of the Royal

College of Paediatrics and Children’s Health Standards by having a minimum of two registered children’s nurses in the ED at all times. At night, there were two nurses, band 6 and band 5 in the children’s ED.

- Children with mental health difficulties in ED would have one to one support from a paediatric nurse. Young people over 16 would have support from an HCA. If young people were abusive, staff would transfer them to adult ED, to protect young children in the paediatric ED.

Medical staffing

- There were 36 doctors in the emergency department. The ED had fewer Registrars and more Foundation Year 1 and 2 trainee doctors than the England average. The vacancy rate was 9%, but turnover was high at 59%.
- The ED did not always meet the College of Emergency Medicine (CEM) standard that consultants should provide 16 hours emergency cover a day seven days a week. There were six permanent whole time equivalent (WTE) consultants. The hospital was running a 10-person consultant rota, with sessions filled by doctors from other trusts or locums, where possible, while recruitment was continuing. Six consultants were in ED each day, two were supporting professional activities (that is engaged in activities other than direct patient care) such as teaching, audit and research, although time for this was limited, and two were on leave. After midnight until 8am, a consultant was on call from home. Some staff felt the unit needed 24-hour consultant presence. Consultants were working considerably more than their contracted hours, which was not sustainable.
- All shifts had middle grade and trainee doctors on duty, ensuring cover from a doctor of at least ST4 grade. There were three middle grade vacancies and locum staff or internal bank staff covered these. The fact that Kingston ED had lower than average permanent middle grade doctors was on the risk register. There was a rolling recruitment programme for middle grade doctors. Locum use was high, for example, in January 2016 locums filled 30% of trainee doctor sessions during a four-day period. We saw evidence that managers were changing rotas to make medical posts more attractive to staff and improve retention.
- We noted it was difficult to fill short notice gaps in the rota. On our unannounced inspection, at one of the

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known busiest periods in ED (a Monday evening), the medical team was short of three doctors: a consultant, a registrar, and a senior house officer (SHO) due to sickness. The on call psychiatrist was also off sick.

- On night shifts, there was a registrar and SHO. Although the department had funding for two registrars at night, it was not always possible to obtain a doctor of this seniority.
- Doctors in training spoke well of consultant support and said they were "always visible and all join in when help is needed". There was particular praise for consultant support in paediatrics. Earlier in 2015, trainees had reported concerns they were suffering because of stress among consultants from the shortage of staff. A recent survey of junior trainee doctors indicated they felt the rota of eight days or nights in a row was too intense. They also mentioned they could not always attend training.
- One of the emergency consultants was qualified in both paediatric and adult emergency medicine. The paediatric registrar and SHO were on the children's wards so staff called them down to children's ED when more senior or specialist advice was needed. This met the standards for Children and Young People in Emergency Care settings 2012.
- GPs treated patients who did not need care for serious injury or illness. GPs worked in the evening from 6pm to 11pm, 10am -10pm at weekends, and on some weekdays between 11am and 5pm. Staff's awareness of daytime GP attendance was inconsistent. Staff gave us conflicting information about whether a GP was attending on any given day even though GPs we spoke to had been booked to work in ED some time in advance. Some were local GPs and others were locums. A speciality doctor treated patients with minor injuries.
- The consultant led medical handover was well attended. The team systematically and in detail reviewed all patients, including vulnerabilities, in front of the computer showing all patients in ED. Staff taking over the next shift had clear insight into the patient's condition and tests undertaken so far. Clearly recorded care plans were available for each patient. Staffing for the shift was also reviewed.

Eye Unit staffing

- A matron oversaw the eye casualty unit. Nursing staff and HCAs worked in both outpatient clinics and the casualty unit. Four staff examined eyes when the casualty was open, two doctors, and a nurse practitioner. The unit had a consultant of the week.
- Staff morale and retention was good. The turnover was about 6% and sickness 1%.

Major incident awareness and training

- The trust's major incident plan was up to date. The policy was to carry out a live exercise every three years, but a senior manager said there had been two live contamination incidents involving advice from Public Health in the past year. This had meant there was no need to run live exercise.
- We saw action cards setting out the roles and responsibilities of staff. Staff found these, after a short delay, when we asked to see them and understood how an incident would be managed.
- 97% of nurses and 87% of administrative staff had completed chemical, biological, radiological, and nuclear (CBRN) training.
- Equipment for major incidents was stored in a designated locked room. This was close to the area used as a decontamination room if a person presented with signs they may need to be isolated or decontaminated.
- There was also a business continuity plan that prioritised the need to keep ED in operation.

Security

- We spoke to two member of the trust's security team. There was no dedicated ED security despite the high number of security incidents reported. Three security staff were on duty during the day in the hospital. Staff told us two security staff were required to deal with instances of aggression in the ED. There were only two guards at night. CCTV monitored the publicly accessible doors and corridors.
- ED staff had introduced a 'red card' process for regular attenders with challenging behaviour to improve safety of staff and patients.
- There was no Registered Mental Health Nurse for ED to provide 1:1 supervision. Either security guards or an HCA took were given this responsibility. Security staff said they had not had specific training in dealing with patients who were living with dementia or those with mental health issues.

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- There was no locked door between the main hospital and the ED, even at night. The doors to the children's ED did not lock at either end of the unit. We saw swipe card access was planned which would make the unit secure.
- During our inspection, we saw one member of the public walk from the waiting room into the main ED area unchallenged by the three staff at the reception desk. We also saw a second, abusive person try to enter. These were potential risks, particularly because a number of doors in ED were not locked, including the paediatric ED, and treatment rooms where prescription only medicines were available. Reception staff in ED felt more security was needed. There was one panic button among three receptionists. Staff said by the time security came incidents had already happened.
- Computer security was poor. There were no 'read only' computers for staff to view patient information. Staff used 'smart cards' to access and update records on the IT system. During inspection, we saw more than one example of a staff member using another staff member's card to order tests. This meant the electronic patient record would not show which clinician had asked for the test and there would be a false audit trail. Use of others' smart cards was commonplace at all levels. We also saw several unmanned computers over two days with login cards left in them that anyone could amend records. Staff said it was time-consuming logging in and out of computers.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



We rated effectiveness as requiring improvement. This was because:

- The department's comparative performance in national audits was worse than the national average in many areas. For example, performance on the sepsis audit revealed important weaknesses in speed of response.
- One third of the local clinical audits planned for the year ending April 2016 had not yet started in January 2016. Audits we were told had been completed were later found not to be completed, because staff had not developed action plans based on the results.

- Local audits were not actively used to improve the service.
- Patients' treatment and care was not always in line with guidance as set out in trust policies.

However;

- We saw multidisciplinary working with pharmacy and care of the elderly teams.
- Most services were available seven days a week.
- The eye casualty ran smoothly, carried out regular audits and met patients' needs effectively.

Evidence-based care and treatment

- We reviewed a sample of patient notes for people who had attended ED, which mostly showed patients had received care in line with relevant National Institute for Health and Care Excellence (NICE) guidance. However, we also saw a local audit, which showed staff did not always act in accordance with best practice. For example an audit of vital signs observations in early January 2016 showed complete sets of scores were only undertaken for 73% of patients in majors', and for 82% of patients in the resuscitation area. These scores should have been 100%.
- Policies and guidelines were generally based on national best practice, and were dated and had review dates but the process for updating on these dates seemed erratic. Updating of guidelines was sometimes prompted by audit results, for example, the paracetamol overdose guideline had been changed as part of the action plan following the Paracetamol overdose audit. NICE guidance had been updated in 2012.

Nutrition and hydration

- For patients being treated during the day there were packs of sandwiches, crisps, cake, and a drink. Staff said there was no set time to offer patients food and drink. It depended how long they were in ED.
- We were told a healthcare assistant was responsible to ensuring drinks were available to patients. Although during our inspection we saw water jugs in all patient areas, jugs of water were not in evidence in our unannounced inspection until much later in the evening. There were no packs of food for patients in the kitchen during the evening of our unannounced inspection.

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Pain relief

- A check of 10 sets of patient notes on one day of our inspection showed staff had recorded pain scores and followed up appropriately. However, on another day, we spoke to a patient in majors who had stomach pains and had not received pain relief. The trust policy said nurses should offer pain relief at streaming. Nurses we spoke to could not explain why this patient had no pain score taken and no pain relief on arrival. Band 5 nurses were not trained to prescribe pain relief, so streaming nurses had to ask a doctor to prescribe this. This may have contributed to failure to provide pain relief in all cases
- All patients whose notes we saw in Paediatric ED had their pain scored.

Patient outcomes

- Patients making an unplanned return with the same condition within 72 hours averaged 5.4% over the past six months, compared to an England standard of under 5%. The unplanned re-attendance of patients within seven days was 9.4%, worse than the national standard of 1- 5%.
- The unit contributed to the Trauma, Audit and Research Network (TARN) audits. From April 2013 to March 2015, the department performed within the expected range. The number of trauma patients was under 100. Ambulance crews told us they rarely brought trauma patients to Kingston as the main Trauma centre was nearby.
- The trust performance in some College of Emergency Medicine (CEM) national audits was less good than other trusts. For example, in the 2013/4 audit of severe sepsis and septic shock the trust performed worse than average on most measures. For example, only 20% of patients had observations taken within 15 minutes of arrival, 20% had urine output measurement set up and only 44% had blood cultures obtained. The CEM target for all these was 100%.
- The trust had been identified as an outlier for Sepsis mortality in June 2015. Extra training had been arranged and we saw posters on display about managing sepsis. A sepsis lead was to be appointed. The national improvement project (Sepsis CQINN) encouraged all hospitals to screen 90% of appropriate patients and to administer antibiotics within an hour to 90%, by the last quarter of 2015/16. Records showed that screening had

improved at Kingston since 2013/4. Between October and December 2015 (Quarter 3) 53% of relevant patients had been screened for sepsis and 50% had received antibiotics within an hour.

- The total time people spent in ED had been longer than the England average from January 2013 to July 2015. We noted many breaches of the time to treat and discharge patients. We saw slow processing of patients who might have been treated and discharged earlier if the early observations and senior review had been more efficient. Staff were not meeting the timescales set by the unit. These were for a clinical decision maker to see a patient within an hour and for a senior doctor to review the patient within two and half hours.
- Managers reviewed breaches, but did not involve frontline staff in discussing solutions. Such staff might have been able to contribute ideas for treating patients and discharging them more quickly. Few staff seemed to have expectations of regularly meeting the 95% target of treatment and discharge within four hours.
- A small audit of discharge summaries in October 2015 had revealed weak completion of clinical information in discharge summaries, risks and warnings, GP details, discharge medication and medication changes. This was on the agenda for a governance meeting in February 2016 and would be part of doctors' training.
- The ED participated in national audits run by the College of Emergency Medicine (CEM). Other audits were required for Commissioning for Quality and Innovation (CQINN) purposes to report to commissioning organisations that they were improving quality.
- We saw an audit programme for 2015/16 for ED. Of the 12 audits registered, four were complete, four were in progress, and four had not yet started even though it was not long before the end of the year. Most were re-audits of topics from national CEM audits where Kingston's performance needed improvement. We did not see evidence of proactive auditing of treatment or processes to improve clinical care or patient experience. Nurses we spoke with did not think there was a nursing audit programme for the year.
- We saw monthly audits of a sample of children's records with reports and action plans for completion, in line with good practice. We saw good local audits in the eye casualty unit, with plans to re-audit to monitor the impact of actions taken.
- In the 2014/15 CEM audit of the management of mental health in the emergency department, the department

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performed worse on two CEM key indicators: recording mental state and assessing patients for their level of dependency on alcohol or illicit substances. They also did less well than in seeing patients within an hour. They were an outlier in terms of failing to document the mental state of the patient and follow up information. Performance was better than average on risk assessments carried out and recorded in the patient's clinical record and about the same as other trusts for the other indicators. Despite the existence of an action plan there was limited evidence of change.

- Performance in the 2014/15 audit of older people's records, where the basic standard (target 100%) was for everyone over 75 to have an early warning score recorded, was below average: only 71% of patients had this. Patients' cognitive function was only measured in 14% of such patients (target 100%). It was below the RCM standard on communication of the findings to carers, and on communicating with the admittance service (for admitted patients only). Action in response to this was described as being 'in progress and not yet complete.
- Another cause of breaches in the time to treatment resulted from the poor quality of some referrals to x-ray. The radiologist in ED had audited referrals from April to November 2015: 35 x-ray referrals did not provide enough reason for taking an x-ray, 27 were referrals about a different patient to the one presenting for x-ray, 12 were inappropriate x-ray requests, and seven referrals asked for patient x-rays on the wrong side. Imaging staff were not invited to feed this information into ED clinical governance meetings so there was no channel to improve these unsatisfactory referrals and no improvement plan.
- The radiology department carried out an audit of referrals for CT scans between January and March 2015. This had identified some issues: escorts, portering and medical conditions. In response to the audit, the radiology department had introduced an onsite radiologist from 5pm to 10pm. This change reduced the time to scan by avoiding the delay that resulted when staff had to travel to the hospital were on call. The target was to report a result within an hour of the phone call requesting a scan. The revised process was currently being re-audited.
- In the 2013 audit of consultant sign off on discharge, only 6% of patients were seen and signed off by a consultant. A doctor of at least grade ST4 discussed the

discharge of most patients (60%), and 42% were seen by a doctor of this grade. The hospital performance in the consultant sign off audit had been Amber. A new consultant sign off audit was recorded as completed in 2015.

- We reviewed national CEM Audits relating to children. For children's asthma (audit 2013-14), Kingston's performance was much worse than average for eight of 10 measures. These related mainly to the timeliness of various assessments, which nurses should carry out within 15 minutes.

Competent staff

- A professional development nurse had been working in ED since October 2015. This nurse was supporting the many new staff that had started in September and October 2015 to develop their skills. In addition, higher band nurses also supported newly qualified nurses, as well as agency nurses, to share their experiences. Many new staff were still being trained to cannulate and use intravenous drugs.
- A nurse streaming patients was trained in the Manchester Triage System (a widely used clinical risk management tool to manage patient flow). Managers told us staff were developing a workbook for streaming training. There had been plans for consultant-led streaming but the shortage of consultants meant it had not been possible to introduce this.
- Some staff reported having appraisals but an equal number of nurses we spoke to said they had not had an appraisal in two years. The policy was to have an appraisal of their performance each year. The appraisal rate of staff in adult ED was 48% and a higher rate, 82% in children's ED.
- Three paediatric nurses had training in caring for children with learning disabilities (LD). However, LD training was not mandatory in ED, and no staff in the adult ED had had training.
- Staff told us, and we saw from documentation, training in sepsis management for doctors, nurses and health care assistants was planned as part of an improvement project in response to sepsis because ED performance had fallen below expectations in an audit.
- A senior and a junior nurse both mentioned the absence of training in managing mental health patients.
- Staff in the eye unit told us they were encouraged and given opportunities to develop. We spoke to two staff members who came to England from overseas. These

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staff had been developed and trained within the department, and been promoted to more senior technical posts. Trainee and middle grade doctors said they had weekly teaching, their annual leave, and professional exams protected and rostered. They had clinical supervision meetings. We saw the programme for the third study day and noted this included both domestic violence and psychiatry emergencies.

Multidisciplinary working

- Staff we spoke with said that multidisciplinary arrangements worked well most of the time. There were sometimes delays in allocating patients to beds because of delays in speciality doctors coming to ED to review patients and approve admission. Plans had been put in place to reduce these delays.
 - X-ray staff were based in ED; other imaging was in the main radiology department.
 - Staff said relations with pathology were good, although the time to turn around results sometimes delayed decision-making.
 - Staff said they had good relations with the adult assessment unit, to which some elderly patients transferred.
 - Staff were pleased that staff in hospital wards now recognised their roles in helping discharge patients promptly to ensure beds were available for new patients needing admission from ED.
 - The trust had a critical care outreach team made up of senior nurses with a background in intensive and/or acute care. The team could support staff in the resuscitation unit out of hours if required.
 - We spoke to three ambulance crews who reported the handover process at Kingston was usually smooth, although not always within target timescales.
 - Kingston Liaison Psychiatry Service (9.5 staff), run by South West London and St George's NHS Mental Health Trust was based at the hospital. Their remit included seeing patients admitted to ED with a mental health crisis or deliberate self-harm. Since November 2015, a member of the team was available on site 24/7. Staff worked with ED team to provide specialist mental health, safeguarding and capacity assessment and to provide access to psychiatric services for those over 18. They attended 95% of calls within an hour, which minimised the risk to these patients. This figure was not included as part of ED's performance scorecard.
- Although staff mainly reported good working relations between healthcare professionals to provide care to patients, we also saw staff working under a lot of pressure and this led to friction and sometimes to unprofessional behaviour.

Seven-day services

- The children's ED and the main A&E were open seven days a week. X-ray and pathology was available seven days a week. CT scanning was available until 10pm on weekdays and then on call.
- Pharmacy was available every weekday from 9am to 6.30pm. At weekends, they were open reduced hours, 10am until 4pm on Saturday and 10am until 2pm on Sunday.
- ED consultants were on call 24 hours a day. They were generally present for 16 hours each day although there were not enough permanent consultants to provide cover.
- The child and adolescent mental health service (CAMHS) was only available between 9am and 1pm, with no referrals after noon. There was no service at weekends. Managers recognised that this was inadequate and it was on the risk register. The adult mental health liaison team picked up out of hours referrals. Staff said they planned to discuss this unsatisfactory situation with commissioners.
- The mental health liaison team were on site seven days a week. A psychiatrist was on call.

Access to information

- Policies and guidelines were stored on computer.
- Electronic patient records held information about the patient's history at the hospital, including the results of previous blood and other tests. The system flagged issues of behaviour or safeguarding concerns. Blood results and imaging taken in ED were available electronically so could be accessed easily by clinical staff, including agency staff.
- The paediatric ED had a specific area of the hospital intranet from which they could quickly access all key information.
- Information on the electronic patient record was automatically available to ward staff when patients were admitted. ED doctors prepared discharge summaries, which reception staff forwarded electronically to local GPs or by post to patients from outside the area. Clinical Commissioning Groups (CCG) had mentioned to us before the inspection there was not always enough

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information for GPs when people were discharged which could be detrimental to their subsequent treatment. An internal audit in ED showed discharge information was often incomplete and action was planned to improve this.

- Test results took at least 90 minutes to come through. Staff said this sometimes delayed treatment. Urgent and emergency care specifications 2015 recommend results within an hour of the sample being taken.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were available for adults with parental responsibility to consent on behalf of children who were not Gillick competent. Staff were trained on Gillick competence
- Nurses we spoke with showed a working understanding of the legal issues about consent and decision-making. Staff mentioned they had received information about the Mental Capacity Act 2005 with their payslips as a reminder of what they had learned in training. Staff said they could seek advice about the Act from medical staff.
- We saw staff ask patients for consent before they undertook procedures or tests.
- We noted in a doctor's handover that mental capacity was discussed in relation to a patient living with dementia.
- We saw no examples in the patient notes we looked at, of "best interest's" decision-making processes for people who did not have the ability to consent, for example people under the influence of drugs or with a reduced level of consciousness.

Are urgent and emergency services caring?

Good



We rated caring as good. This was because:

- Staff treated patients with respect and in a kindly and professional way.
- Most patients and relatives we spoke to were satisfied the staff had treated them with compassion and helped them understand their condition. Staff respected patient's choices.
- We saw staff and volunteers providing emotional support to patients.

However;

- Patients were not clear who was in charge, which made it difficult for patients and relatives to identify the right person to ask for information or advice.
- Staff did not always find enough time to support family members waiting for news of their relative when the unit was busy.

Compassionate care

- Most of the patients we spoke with told us staff were kind and caring. They said staff introduced themselves but some people said they were confused about the roles of the different staff they met. We watched staff caring for at least 10 patients, and saw staff were friendly and polite.
- We saw staff treating patients with dignity, kindness, and compassion, including providing reassurance to patients who were anxious. Volunteers working in the hospital were also able to support patients, particularly those who were elderly or confused, by talking to them and explaining what was happening.
- In majors and minors' areas, staff drew curtains to maintain privacy during physical or intimate care; however, in the small, seated cubicles in minors, patients were very close together which limited privacy.
- We saw letters and cards with thanks from people who had been treated in the ED.
- In response to the A&E survey 2014 the results at Kingston were similar to other trusts,
- The Friends and Family Test (FFT) is a method used to gauge patient's perception of the care they had received. Patients who completed the survey reported they would be likely or very likely to recommend the ED to their friends and family. The results were above 90%, but the response rates were very low which meant Friends and Family results were too low to be considered reliable. In December 2015 4.8% of patients in A&E responded to the test, but in previous months the response rate had been under 2%. The average between April and September 2015 had been 4%. By comparison, inpatient response rates at the trust were in the region of 30%. In the eye casualty unit, Friends and Family responses were 100%.

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Understanding and involvement of patients and those close to them

- Some patients mentioned how they had to explain what was wrong with them to too many people before they had treatment. However, they were complementary about the explanations they were given about their treatment.
- Two patients mentioned it was not clear who was in charge in ED. There were no photographs or names of senior staff on display. Patients did not understand what the different staff uniforms signified.
- In the A&E survey, the trust performed much worse than average on the opportunities for families or carers to speak to a doctor about the patient's condition.
- Four of five patients we interviewed in majors on one day were satisfied with the level of involvement and communication from staff, and felt staff gave them clear explanations. We also spoke to relatives who reported they had helpful information about the patients' conditions.

Emotional support

- We saw staff providing emotional support to patients and their families and doctors answering questions from patients and families, as well as providing reassurance. However, in the 2014 A&E survey patients reported less help from staff when patients were distressed.
- We did not see any information for patients in ED about the chaplaincy service.
- Staff told us they gave updates to relatives who had a member of their family seriously ill or injured; they said when they had upsetting news they would take family members to the relatives' room to speak to them in private. However, some staff said when very busy they found it difficult to provide effective family liaison. We spoke to a relative in this situation who did not feel well supported in her anxiety.

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

Requires improvement



We rated responsiveness as requiring improvement. This was because:

- There was little information for patients and their families about how long they might wait to be treated.
- Staff did not always treat patients in the main ED within the four-hour standard even when the unit was not busy. Few staff seemed to expect to meet targets such as for treating and discharging patients within four hours. It was unclear where accountability for improvement lay
- Some accommodation did not protect patient confidentiality or privacy. This was the case in the streaming area in the waiting room, in resus, eye casualty, and the rapid assessment area when there were more patients than cubicles.
- Staff did not use information from complaints to make improvements to benefit patients' experience.
- Facilities for patients with mental health difficulties were poor and these patients often had long waits in ED.

However;

- Managers had recently improved their understanding of patient flow and of processes that could help them to treat and discharge patients more quickly. This should support them to make improvements over time.
- There were information leaflets on common conditions.
- Staff gave effective support to patients in different circumstances such as those living with dementia, to children and to patients with eye conditions who attended the eye casualty.

Service planning and delivery to meet the needs of local people

- The trust provided 24/7 accident and emergency services for children and adults in the boroughs of Kingston, Richmond, parts of Wandsworth (Roehampton and Putney) and Elmbridge.
- The environment showed some signs of wear and tear. The accommodation, originally designed for 68,000 patients a year, was not large enough for the current throughput of patients and modern standards.
- About 109,000 patients attended ED each year. The department did not display a public dashboard showing ED performance across the standard clinical quality indicators to give the public a balanced view of ED care at Kingston.
- The hospital had opened a rapid assessment area where lower priority patients coming in by ambulance were assessed. The ambulance crew said this gave patients a better experience than they had previously

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when many patients waited on trolleys in the corridor. However, when there were more patients than cubicles, patients' privacy and dignity was compromised. For example, on our unannounced inspection we saw staff assessing or treating eight patients in a small space where patients could see and overhear others being treated. An observational audit in January 2016 showed patients arriving by ambulance still sometimes queued in corridors.

Meeting people's individual needs

- We had some concerns about privacy and confidentiality. Patients registering with reception in the waiting room could overhear the streaming nurse asking other patients questions about their health. In majors' patients might overhear phone calls about themselves or about other patients because the telephones were in the centre of the ward; and the design of screens in resus provided limited privacy when staff had to undress patients because of gaps in the screens.
- The environment was below standard for patients with mental ill health. The room was poorly decorated. Waiting times for a psychiatric bed could mean patients stayed over 12 hours in ED.
- Women with gynaecology problems were treated in rooms with ensuite facilities that protected their privacy and dignity.
- Forms in ED for patients to report on their experiences were several pages of A4 and there were no boxes to put them in.
- Local communities with possible interpreting needs were Korean, Polish and Bulgarian speakers. We saw no information in any other language, except in the ED x-ray area where there was multilingual information about pregnancy. Staff said they had a contact number for telephone translation but said they rarely needed to use the service as most patients had a good command of English even when it was a second language.
- Information leaflets were available for patients on a range of minor conditions. These were in English only.
- The information screen in the main waiting room displayed information about other medical services and also showed the number of patients currently been seen within the department. Staff did not update this information regularly. We saw the same information displayed every day on our three-day inspection.
- The average waiting time to first treatment between August 2015 and January 2016 was 46 minutes for those under 18 and 39 minutes for those over 18. This was within the target that treatment should begin within 60 minutes. In February 2016, there was a reduction in time to first treatment for under 18s to 34 minutes but the average wait for adults had increased to 49 minutes, so performance on this target was static.
- There were vending machines in the main waiting area, and a water cooler, but there were no cups for the water cooler on two different days. The only hot drink in the waiting room was coffee.
- There were not enough signs in obvious places. Yellow bricks painted on the floor led patients to the GP service. However, there were few signs to the x-ray department, and on two separate days, we saw patients unsure how to find their way. Some doors had incorrect labels several months after their function had changed.
- The computer system flagged specific needs of patients, such as those living in vulnerable circumstances, children on child protection plans, frequent attenders and people with learning disabilities. This helped staff to meet their needs appropriately. However, ED staff had not yet updated protocols for patients with learning disabilities.
- The adult and children's waiting areas were both clean with enough seating. When the minors' unit was busy, additional seats were placed in the nearby corridor.
- The paediatric ED was colourful and had toys and visual stimulus appropriate to young people.
- There was a small but well-appointed relatives' room where families of the most serious ill patients could wait.
- There was adequate viewing room for bereaved families. The viewing room had an external door and could be used as a decontamination room if required. In this case, a tent would be erected outside to increase space. The major incident storeroom was opposite this.
- The environment of children's ED was child-friendly with murals on the walls, a play area, and a seating area. There was a TV in the area for patients to watch.
- Patients appreciated the availability of an eye casualty at Kingston. However, the examination room was cramped, with no curtains between examination areas. Clinicians examined or treated four patients at a time. This helped the flow of patients through the unit, but compromised patients' privacy and confidentiality.

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- Some staff had training in meeting the needs of people living with dementia. Such patients wore a blue wristband to remind staff of their additional support needs. There were dementia friendly clocks had been in the majors' area of ED.
- Management plans were in place for patients receiving end of life care. Staff transferred such patients to single rooms in the main hospital where possible.
- The Eye Department casualty unit met the four-hour standard 97% of the time in December 2015.

Access and flow

- Delivery of services within ED depended on the flow of patients into the department and the flow out of those who were referred to other parts of the hospital or discharged. Managers had not increased staffing levels during the periods known to be busiest, and this combined with poor skill mix and inflexible use of staff between different parts of ED, caused avoidable delays to patients. Trust managers working in partnership with community service providers and commissioners were supporting ED staff to improve the four-hour performance target and flow throughout the hospital and beyond.
- Between April and December 2015, the performance against the four-hour standard was 92.4%. This was below the target of 95%. The objective for 2015/16 was to get back on track. In February 2016, performance in majors had fallen just below 90% although performance was 92% in March 2016 so there had been no further improvement in the two months since our inspection.
- Many patients who required hospital beds after coming to ED had to wait more than four hours for a bed. On average 23% of patients in this category waited over four hours. The trust target was for 95% of admitted patients to have a bed within four hours. We observed that a recent decision that an ED doctor must review all ward transfers had caused delays on a day when the ED was three doctors short. Flexibility was needed in such cases to meet patients' needs, and targets, effectively.
- Bed management meetings took place three times a day and we attended three meetings. The operational team and the clinical team worked dynamically to improve the flow of patients in the hospital. The team had a clear grip on what was happening throughout the hospital and emphasised the need for all wards to aim for efficient discharge.
- Other actions taken to improve flow were:
 - Streaming patients rather than running full triage
 - Introducing a primary care stream to deflect from ED
 - Reducing ambulance time to hand over
 - Opening an ambulance assessment unit which helped ambulance crews to hand over more quickly and improve the experience for patients arriving by ambulance
 - Providing a GP and minor injuries stream in the evening and weekends so the ED team could focus on the seriously ill or injured
- There had been 17 black breaches (times when an ambulance has to wait over an hour to hand over a patient) between 13 Dec 2014 to 13 June 2015. Since June 2015 when an ambulance assessment area opened, there had been no black ambulance breaches. The percentage of ambulances waiting over 30 minutes was only 1.2%. The handover time was just over 15-minute standard which was an improvement in performance earlier in 2015.
- There were 30 breaches of the four-hour standard on the day of our unannounced inspection. On that evening, there were no beds available for women who needed admission. Three doctors were away due to sickness.
- During November 2015, 1726 patients were admitted to wards from the emergency department. Of these patients, 40 had waited over four hours for a bed after medical staff had made decision to admit them to hospital. The hospital admitted a similar number of patients as other emergency departments in the area.
- The percentage of patients who leave the department before being seen by a doctor or nurse is an indicator that patients are dissatisfied with the length of time they have to wait. Nationally 2.8% patients leave without being seen for treatment. Kingston was slightly better than the average, 2.4%.
- Kingston had no clinical decision unit (CDU). This meant patients who did not need admission, but might need a short period of clinical observation for improvement (under 24 hours) or further assessment had to remain in ED. This blocked cubicles that new ED patients could not use.
- Women who attended the department between 10am and midnight with early pregnancy or gynaecological concerns had a specific pathway to the Jasmine Unit (Early Pregnancy and Acute Gynaecology Unit).
- There were effective paediatric pathways, and flow in the children's ED was not a problem.

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- We asked for information about the numbers of patients using the primary care stream, and evidence of whether patients were correctly streamed. We were told data for this group of patients was not differentiated from patients in minors'. It was therefore not possible to assess the impact of the new pilot primary care stream. We would expect that such patients could usually be treated and discharged more quickly than other patients in ED and therefore improve flow in ED.

Learning from complaints and concerns

- ED had received 68 formal complaints between October 2014 and November 2015. This represented 12% of formal complaints to the Trust. Managers told us complaints had begun to reduce during 2015. Clinicians working in ED were not aware either of the number of complaints or their content. This was a missed opportunity for learning.
- Staff handled complaints in line with trust policy but only 70% of people who complained received a response within the trust target of 25 days. The department had recently formalised its process of reviewing complaints once a month at their weekly clinical governance meetings and monitoring was now in place to track trends. We saw this discussed when we attended a clinical governance meeting.
- We saw no information about how to complain on display in the main ED, although we saw some leaflets in reception. Nurses told us they aimed to resolve issues at the time patients raised them. They would give patients information about the complaints system if they remained dissatisfied. However, not all staff we spoke with knew where to find complaints information.
- There was no information in ED about who was in charge to help patients or relatives to identify who to speak to about any concern.
- Staffs did not log informal complaints from patients, or escalate these to managers to help improve the service. For example, reception staff mentioned patients had complained about lack of privacy in streaming arrangements. They advised patients to write to PALS. This meant a number of complaints were unlikely to reach managers.
- An example of how a complaint had changed practice was the development of a new guideline, after a patient complained the staff had no knowledge of Lyme's disease (a disease from tick bites).

Are urgent and emergency services well-led?

Inadequate 

We rated well-led as inadequate. This was because:

- Long term vacancies in key posts and high staff turnover among nurses and doctors had led to weak management and governance. Although senior vacancies had recently been filled, new managers had not been in post long enough to develop a long-term vision and strategy.
- Nurses and trainee doctors had no clear overview of ED performance.
- Identification and escalation of risk was ineffective.
- The quality and accuracy of performance data was not good in all areas and data was not always used to improve performance,
- Senior nurses we spoke with felt managers did not support them or appreciate the challenges of delivering good performance with the skill mix in ED.
- Staff turnover was a challenge to continuous learning and improvement.
- Although the investigations of ED performance, using external management consultants focused on specific short-term targets had helped the service move nearer to meeting targets, staff working in ED did not feel ownership of the changes.
- Staff placed too much reliance on positive responses to the Friends and Family test which had very low response rates. .

However;

- New staff appointments had been made, although not all new staff were in post at the time of our inspection.
- There were early signs that a new manager was tightening governance processes.

Vision and strategy for this service

- We asked senior managers about the vision and strategy for the main ED department. They identified elements of the service they wanted to improve such as the skill mix and achieving a more stable workforce. They also wanted to continue employing GPs in ED, to develop

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closer working with the Adult Assessment Unit, and to improve communications between staff and patients. These were areas that we identified as needing improvement on our inspection.

- While there were several pieces of work in progress, by external and internal staff to improve patient flow, this did not constitute a strategy. Development of a strategy depended on having key posts filled. By contrast, the eye unit had a five-year strategy including its eye casualty service, which was one of its strengths.
- Clinical staff we spoke to in ED could not identify key priorities for the department.
- Few staff working in ED had been involved in discussions about developing the service or its values. They did not receive feedback from management discussions.
- Senior staff told us they planned to re-establish a CDU to help free up cubicles in ED currently blocked by patients who needed a period of observation, but not admission. This would free up beds in majors and help staff to treat and discharge patients more quickly. Nurses in ED were unaware this was under consideration or how it could be effectively staffed given current staff shortages.

Governance, risk management and quality measurement

- A newly appointed Divisional Director would lead Emergency Services as well as having wider responsibilities: for elderly care, gastroenterology, cardiology, and respiratory services. The clinical director for the ED and the Adult Assessment Unit, and the ED service manager and were also newly appointed. The matron had been in post for less than a year.
- New processes were in development. For example, we saw a well-run weekly clinical governance meeting. The format of this meeting was new. It replaced a less structured governance meeting with variable attendance. Records of past clinical governance meetings showed that actions from those meetings had not been recorded or followed up systematically. The new format of clinical governance meetings was to be the main forum for managers to review key ED topics on a rolling programme: complaints, performance in audits, staffing, incidents, and other matters. A monthly management meeting reviewed ED performance against targets. The outcome of these meetings was not yet shared effectively with junior staff.

- Better data would help generate a shared understanding of performance. Some of the ED data was not reliable because of the limitations of the computer system, which could not produce all standard national data. For example, accurate data on time to assessment was not available. The system could not report data on the number of patients streamed to a GP or minor injuries.
- Data accuracy was also affected by staff failing to enter complete data on the system, or not entering it promptly.
- Not all risks were identified and escalated effectively. Risk managers recorded a risk level for each risk and a review date. The top risk was middle grade medical staffing. The next level of risks, all graded nine were: inadequate flow, inaccurate clinical records, timely learning from incidents and staff education. The risk of having so many inexperienced staff working alongside a high number of locum or agency staff was also on the risk register under Professional Development of the Team. Departmental risks graded 12 or over were included in the corporate risk register.
- Staff vacancies, staff turnover, and use of agency and locums were graded risk level 6, (possible risks) on the ED risk register. From the evidence seen on our inspection this grading was low. It appeared to us that the real risk was having so many inexperienced staff working alongside a high number of locum or agency staff. ED managers had not specifically articulated as a risk.
- Another risk we identified was staff morale. The department could not afford to lose its more experienced staff, particularly shift leads, who felt undervalued and unsupported by management.
- Staffing in general was on the corporate risk register, but this did not specifically mention staffing in ED.
- However, we saw that concerns about ED staffing levels were reported in operational reports to the trust Board. There was a disconnection between the risks identified within ED itself and the overview given in reports to the trust Board which mention fragile staffing and inefficiencies from the skill mix as reasons why targets were still not being met.
- Documents the trust sent us after the inspection mentioned changes to nurse rotas to make nursing posts more attractive. These were not developed in

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discussion with staff. Staff we spoke to during the inspection were unaware of any proposals for change although they told us current working patterns were unsustainable.

- The hospital was using a four-hour target tracker to monitor progress on the target that Kingston ED had been failing to meet over a considerable period. Meeting this standard is both a corporate responsibility as well as the responsibility of ED. Some ED clinical staff did not seem to recognise the role that ED's own processes played in improving the rate of treating non-admitted patients. This is also an important aspect of improving flow. Performance against the four-hour target had not improved in the two months following our inspection.
- Managers had worked with an external auditor to design a daily scorecard to monitor performance and quality. It showed patient flows, overall numbers, and tolerances, and a forecast based on actual performance. It was not widely shared with ED staff.
- We did not see information about any national A&E targets, or local targets on display in ED.

Leadership of service

- Staff roles and duties were not clearly defined with the result that many routine safety tasks were not being carried out. Nurses did not seem clear about their individual roles in improving the speed at which patients could be treated and discharged.
- We did not observe staff above band 7 provide support staff by working clinically even at very busy times.
- There had been a number of senior staff changes: a new clinical director took up post in January 2016 and a service manager had been in post two months. It was too early to judge the impact of change. Senior trust managers expressed the hope that the changes would bring stability. The new service manager was visible to ED staff during our visit.
- There were few meetings with nurses and healthcare assistants and no newsletters to keep them engaged and informed. Staff did not use handover as a time to pass on departmental news or use the time for training updates. Written memos and emails about changes in procedures were the main method of cascading information. Staff did not feel engaged in delivering improvement.
- Nurses we spoke with did not consider senior management approachable and said they were not encouraged to raise concerns.

- Senior nurses felt senior managers did not appreciate the challenges of delivering good performance with the skill mix in ED. The Trust advised that it had commissioned and undertaken a Band 7 Leadership Programme in 2015, bespoke to the ED, to develop staff leadership and management skills.
- A general manager provided support to senior nurses during shifts until 10 pm, seven days a week. The general manager assisted by managing flow and troubleshooting.
- Porters reported they liked working with ED staff. Some porters mentioned their own direct managers were inflexible. The porter service was by an external company on contract.

Culture within the service

- Nursing staff and trainee doctors had no clear overview of ED performance.
- Staff were aware of various external reviews of ED in the past year. Some were disappointed that they had not been involved in discussions about how to improve the service. Managers did not ask them for ideas for improving systems and processes. They felt managers did not take their concerns seriously.
- Shift leaders were very committed to patients and to supporting their staff, but they did not feel their contribution was valued by their manager. Their morale was low because of the pressures of working with a sub optimal skill mix and too many temporary staff. Their wellbeing was suffering because of the stressful work environment. This was a risk to retention at a key level.
- There was evidence of high stress levels at times and staff told us that occasionally tempers rose. A senior nurse reported she had been at the brunt of such an incident shortly before our unannounced inspection. Staff did not feel able to record such events in the incident reporting system, although the policy stated abuse should be reported.
- Trainee doctors said they were generally happy with the support they had received from consultants and other senior doctors, however several were reconsidering whether they wanted to remain working in medicine because of the stress.
- The hospital had joined NHS England's 2015 'Breaking the Cycle- Faster Flow, Safer Care' initiative in April 2015. This is a tool for to help staff focus over a short period on blockages preventing patients from being discharged when they are medically ready. Managers said this had

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been helpful in developing new ideas to improve patient flow and improve safety and patient experience. The exercise was intended also to develop staff support for change. However, the turnover of staff meant there was little corporate memory in ED, which made it difficult to embed change.

- Band 5 and 6 nurses said too much communication was in writing. Nurses said they had a lot of information electronically but had limited access to computers and little time to check email. Email communication was not often reinforced with discussion and training.

Public engagement and staff engagement

- We did not see staff offering the Friend and Family Test to patients. The positive results that staff reported were misleading because of the low response rate (2-4%). There were a significant number of complaints to set against the positive results. The trust advised us that they drew on other sources of feedback from volunteers, from Healthwatch visits and the accident and emergency national survey.

- Managers seemed to have overlooked the value of listening to staff and valuing their contributions and acting to improve areas of concern.
- Issues were raised in the staff survey, not specific to ED, about staffing levels and recruitment. To help support ED managers it had the trust had commissioned and undertaken a Band 7 Leadership Programme in 2015, bespoke to the ED to help staff with leadership and management.
- The trust celebrated staff achievements. However, ED seemed to give less prominence to this than some departments. Although some ED staff had received awards in December 2015 it was disappointing to see the ED noticeboard did not display the latest staff recognition information. Data on the board was from June 2015, the previous summer.

Innovation, improvement and sustainability

- The use of volunteers in ED to support patients who were confused or had come in alone was a positive feature. However, volunteers were not always in the Department at times of peak activity.

Medical care (including older people's care)

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

Information about the service

Kingston Hospital is an acute hospital with 230 inpatient beds and provision for 43 day case patients, providing a range of medical care services. These services include cardiology, gastroenterology, respiratory medicine, general medicine, stroke and geriatric medicine.

In the period July 2014 to June 2015 Kingston hospital admitted 17,596 patients; of these 54% were general medicine cases and 22% gastroenterology cases.

We inspected the acute assessment unit (AAU), general medicine wards (Blyth, Kennet), older persons ward (Derwent), respiratory ward (Hamble), gastroenterology ward (Hardy), cardiology and stroke wards (Bronte, Keats), the endoscopy suite, and discharge lounge.

Information provided by the trust prior to our inspection was reviewed and used to inform our inspection approach.

During the inspection visit we spoke with 34 patients including their family members and carers, 73 staff members including nurses, doctors, consultants, senior managers, therapists, and support staff. We observed interactions between patients and staff, considered the environment and looked at 10 care records. We received comments from our listening event and from people who contacted us to tell us about their experiences. To support information provided by staff during the visit, we reviewed documentation and computer based information. We also requested and reviewed additional documentary evidence during and following the inspection.

Summary of findings

Overall we found the medical care services at Kingston Hospital required improvement.

- We found where patients were unable to consent to a mechanical restraint, no mental capacity assessment had been undertaken and no best interest decisions had been recorded.
- Staff reported they had no specific training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training.
- Patient outcome measures including National Heart Failure Audit, Myocardial Ischemia National Audit Project (MINAP), National Diabetes Inpatient Audit (NaDIA) the trust scored below the England average.
- In care of the elderly and cardiology, which represented the majority of activity, the average length of stay was worse than the England average. In care of the elderly it was 15 days compared to the England average of 10 days and for cardiology it was 9 days compared to 5.6 days which was the England average
- We found equipment was stored in the shower rooms, utility rooms were not locked and hazardous chemicals had not been locked away.
- Fire doors were sometimes propped open.

Medical care (including older people's care)

- Equipment such as blood pressure machines and suction pumps on resuscitation trolleys had not been safety tested within the last 12 months.
- Medication trolleys were not chained to walls or immobilised when not in use.
- The trusts policy for medicines management was not being followed to support the use of patients own medicines (PODs).
- Patients' medical notes were not stored securely and regular observations to check mittens were not restricting the patient's circulation were not being recorded. There was no review date on the documentation.
- Staff had access to translation services for patients for whom English was not a first language. Staff we spoke with told us they knew the service was available but they tended to use staff from the hospital who could speak various languages or ask patients relatives to interpret. This is poor practice as staff could not be confident that the information that the patient was being told was what staff had wanted to convey to the patient.

However;

- People were cared for by staff that were kind caring and compassionate in their approach.
- Patients and their relatives were positive about their experience of care and the kindness afforded them.
- There was a positive culture of incident reporting and there were established processes for investigating incidents.
- Staff were aware of their role in relation to safeguarding children and adults living in vulnerable circumstances.
- The trust was one of 13 trusts awarded with an A rating in the Sentinel Stroke National Audit Programme (SSNAP) for their performance in January to March 2015.
- The hospital's endoscopy services were Joint Advisory Group (JAG) accredited.

- The service had responded to the needs of an ageing population and were developing services to improve the experience of patients living with dementia.
- A number of initiatives had been developed to ensure the service met people's individual needs and those of vulnerable groups.
- Across medical specialities complaints were discussed at monthly clinical governance meetings, these identified learning and action points
- There was good leadership and management within the medical specialities with clear strategies on how the services were to develop.
- There was an appropriate system of clinical governance in the medical specialities, which identified quality and risk issues. Trends could be readily identified and learning was disseminated to staff.
- We found staff and patients were engaged with the development of medical specialities, and saw examples of innovative practice.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement 

We rated safe as requires improvement. This was because:

- We found equipment was stored in the shower rooms, utility rooms were not locked and hazardous chemicals had not been locked away.
- Fire doors were sometimes propped open.
- Equipment such as blood pressure machines and suction pumps on resuscitation trolleys had not been safety tested within the last 12 months.
- Medication trolleys were not chained to walls or immobilised when not in use.
- The trusts policy for medicines management was not being followed to support the use of patients own medicines (PODs).
- Maximum and minimum fridge temperatures were not always recorded on a daily basis, and medication room temperatures were not recorded on a daily basis.
- Difficulties in recruiting appropriately qualified and experienced nurse staffing was acknowledged as a risk and was identified on the risk registers for care of the elderly and the AAU. On Hardy Ward the nursing vacancy rate was 23.09% (4.41WTE) as of 31st January 2016.
- The risk register for gastroenterology and endoscopy had not identified recruitment of nursing staff as a risk.
- Patients' medical notes were not stored securely and regular observations to check mittens were not restricting the patient's circulation were not being recorded. There was also no review date on the documentation.

However;

- There was a positive culture of incident reporting and there were established processes for investigating incidents.
- A range of forums were used for staff to receive feedback and learn from investigative outcomes.

- Measures for the prevention and control of infection met national guidance and standards of hand washing and cleanliness were regularly audited.
- Staff were aware of their role in relation to safeguarding children and adults living in vulnerable circumstances.
- Mandatory training helped ensure staff had current knowledge and skills in key safety areas.

Incidents

- The service reported 31 serious incidents requiring investigation the period August 2014 to July 2015. The majority of these were pressure ulcers (51.6%) and falls (35.4%) This represented 36% of all incidents. The most common incidents reported were pressure ulcers (16) grade three and four and slips, trips and falls (11).
- An online computer incident reporting system was used to report incidents and staff told us it was easy to report incidents when they occurred. Staff were encouraged to report incidents and felt there was a good culture in reporting.
- Most staff we talked with said they received feedback and action was taken to reduce the risk of similar incidents occurring in the future. Staff we spoke with at all levels were aware that pressure ulcers and falls were the most common incidents. Learning from incidents was shared in handovers. One ward we visited (Hardy), had regular safety briefings and we saw these were also minuted. On the acute assessment unit (AAU) incidents, falls and risks were also discussed at a daily safety briefing. Learning from incidents was highlighted on staff notice boards and staff read and sign sheets were in place for staff to confirm they had read the information.
- A process was in place for the investigation and escalation of serious incidents. We saw a report into an investigation a serious incident of an unexpected death. Root cause analysis (RCA) had been completed and an action plan that had been put in place was being progressed at the time of our inspection. Incidents were also discussed at monthly multidisciplinary governance meeting.
- Mortality and Morbidity meetings were held regularly. We saw evidence of mortality and mortality and morbidity review meetings for each division. These were comprehensive and action points and lessons learnt were identified.

Medical care (including older people's care)

Duty of Candour

- Duty of candour was considered as part of the investigation into serious incidents. We saw the involvement and support of patients and relatives was documented detailing the actions taken.
- Staff were aware of their responsibilities under duty of candour, which ensured patients and / or their relatives were informed of incidents that had affected their care and treatment and they were given an apology. Wards managers gave us different examples of when they had spoken to relatives to let them know a patient had fallen for example. We saw this had been documented when this had occurred.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheters and associated urinary tract infections (CUTIs). Safety Thermometer data had been collected on a monthly basis and the results were made available to the wards managers. The rates of pressure ulcers (24), falls (10) and C.U.T.I.s (12) reported via the patient safety thermometer were varied and showed no distinct trends between November 2014 and November 2015.
- Safety Thermometer results were not displayed centrally on the wards, which meant this information was not available to patients and their families. Wards managers advised they feedback the wards performance at handover to staff.
- Safety Thermometer data for all the medical wards showed that for the period November 2014 to November 2015 the wards scored between 86% and 96% for 'harm free' care which was variable.

Cleanliness, infection control and hygiene

- All the wards we visited were visibly clean. We observed support staff cleaning throughout the day and undertaking this in a methodical and unobtrusive way. Wards had daily cleaning schedules in place, which staff would tick to indicate when specific areas had been cleaned. We saw the daily cleaning schedules were not always completed and ward managers were not always signing off the checklist on a weekly basis.
- We observed green 'I am clean' labels were in use to indicate when equipment had been cleaned. One of the ward managers reported that staff were encouraged to clean equipment after use.
- The trust reported no incidents of Meticillin-resistant staphylococcus aureus (MRSA) and 14 incidents of Clostridium difficile (C Diff) for the period January 2015 to December 2015. We saw where incidents of C Diff had occurred, these had been followed up in the clinical governance meetings and post infection reviews had been completed with action points identified.
- Adequate hand washing facilities and hand gel were available for use at the entrance to the wards/clinical areas, within the wards at the entrance to bays and side rooms. There was prominent signage reminding people of the importance of hand washing at the entrances to wards and within the toilet and bathroom areas. We observed staff generally washed their hands in line with the World Health Organizations (WHO) guidance "Five moments of Hand Hygiene." Hand hygiene audits showed for the period April 2015 to September 2015 that the medical wards only met the trust target of 90% in August scoring 91.2%. The lowest score was in September 2015, where the medical wards scored 61.2%.
- Adequate supplies of personal protective equipment (PPE) were available and we saw staff using this appropriately when delivering care. We noted all staff adhered to the "bare below the elbows" guidance in the clinical areas.
- Side rooms were used to care for patients where a potential infection risk was identified. This was to protect other patients from the risk of infection. Signs were in place at the entrance to side rooms which were being used for isolating patients, giving clear information on the precautions to be taken when entering the room.
- We observed clinical and domestic waste was appropriately segregated and there were arrangements for the separation and handling of high risk used linen. We observed staff complied with these arrangements.
- We observed sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.
- Infection and Prevention Control training formed part of the mandatory training programme and was updated

Medical care (including older people's care)

yearly. The trusts target was 80% of staff having completed the training, within the medicine directorate 60% of medical staff, 97% of nursing staff and 100% of allied health professionals had completed the training.

Environment and equipment

- The trust score was similar to the England average in 2013- 2014 and 2015 for Patient Led Assessments of the Care Environment (PLACE) in the sections of cleanliness and facilities.
- We observed ward bays and corridors were generally kept clear of equipment, therefore avoiding trip hazards so people were kept safe. We found on two wards (Blyth & Keats) equipment was stored in the shower rooms.
- On two wards (Blyth, Keats) we found the dirty utility and the clean utility on the AAU was not locked and hazardous chemicals had not been locked away.
- On Keats Ward we found the fire door had been propped open near to the gym. We advised the ward manager who confirmed it should not have been open and promptly closed it.
- We found each clinical area had resuscitation equipment stored on resuscitation trolleys, readily available and located in a central position. The trust policy identified the systems to ensure this equipment was checked daily, fully stocked and ready for use. We found on Kennett Ward there were some omissions in the records.
- We saw that all Electrical Medical Equipment (EME) had a registration label affixed and was maintained and serviced in accordance with manufacturer's recommendations. We also saw safety check labels were attached to electrical systems showing they had been inspected and were safe to use. However, we found some blood pressure machines and suction pumps on resuscitation trolleys had not been safety checked within the last 12 months.
- Health and safety and fire safety training was part of the statutory training programme, which staff were required to attend. The trusts target was 80% of staff having completed the training. Within the medical directorate 60% of medical staff, 97% of nursing staff and 100% of allied health professionals had attended training for health and safety. 50% of medical staff, 45% of nursing staff and 83% of allied health professionals had attended training on fire safety.

Medicines

- Electronic medical administration records via the computerised records system, (CRS) were in use across the medical wards. Staff was required to be logged on to the system when administering medicines. The electronic records recorded the time when patients had their medicine administered, changes to patients prescriptions, and highlighted when a patient could be given further medicines as required (PRN) medication. The system flagged when blood tests were required, if a patient was diabetic or had allergies. Staff also documented on the system the reason for medicines being omitted or not administered. The ward pharmacist stated the drug record could not be saved and completed without filling in allergy information. This acted as a fail-safe mechanism to reduce errors.
- Omitted and or delayed doses were recorded by CRS and flagged for review. This prompted the reporting of medicines incidents.
- Treatment rooms were clean and tidy, with medicines stored securely. Medicines to take out (TTO) were stored securely and appropriately in the designated cupboard and patient's own drugs (POD) were stored securely in lockers next to the patient's bed. Keys to the drug cupboards and POD lockers were held by a registered nurse and door to the room housing medicines were locked. However, we found drug trolleys were not chained to walls or immobilised when not in use. The medicines inside trolleys were however, appropriately locked by an electronic keypad.
- There was a policy in place to support the use of PODs. PODs were to be stored in green bags, however no green bags were seen containing PODs as outlined in the medicines management policy. This indicated the policy for medicines management was not being followed.
- Wards had a dedicated pharmacist available between 8.45am to 4pm daily Monday to Friday and there was an out of hours (evenings and weekends) pharmacy service. Pharmacists were responsible for screening drug charts on CRS, medicines reconciliation, ordering of drugs from pharmacy, ordering the TTO medicines for patients and counselling certain patients on specific medicines usage such as immunosuppressants.
- We observed medicines were administered by appropriately trained staff following the Nursing and Midwifery Council's "Standards for Medicines Management". Nursing staff were aware of the policies on the administration of controlled drugs. Controlled

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drugs (CDs) were correctly stored in lockable wall units in the treatment room. Controlled Drugs were audited on a daily basis by two nurses, with a separate signing sheet seen. Controlled Drugs were correctly documented in the CD register.

- The emergency medicines cupboard was on AAU; access was restricted to it via keys held with security at reception. There was a signing sheet for those who wanted appropriate access to emergency medicines. Inside the cupboard, medicines were appropriate for use, in date and organised. There was a separate register for signing which drugs had been taken. The process for replacing them was delegated to a medicines management technician, who had to sign the sheet to confirm when medicines had been replaced.
- We saw where applicable, medicines were stored in dedicated medicines fridges. These were locked and fridge temperature were recorded. Stock medicines and a small quantity of bulk fluids were stored appropriately in the treatment room. The majority of bulk fluids were stored securely in a store room just outside the ward, with access restricted to appropriate personnel.
- Maximum and minimum fridge temperatures were not recorded on a daily basis on some wards (Kennet, Blyth). The process of recording fridge temperatures was delegated to the housekeeper. When asked what would happen if the normal temperature of 2-8 degrees went out of range, a ward manager stated the housekeeper would inform her and she would be responsible for taking the appropriate action.
- Medication room temperatures were not recorded on a daily basis.
- Staff understood and demonstrated how to report medicines safety incidents. This was then escalated and fed back for learning through various channels, such as medicines safety newsletters, memos and face-to-face meetings.

Records

- An electronic patient record (CRS) was in use and accessed by doctors, nurses and other healthcare professionals. All professionals involved in the care of the patient recorded information in chronological order in the clinical notes section. This section included the medical plan for the patient. The clinical notes provided a good description of the patient progress. Staff members had unique logins to ensure professional accountability. Temporary staff were allocated logins.

This meant that recording errors from illegible writing were virtually eliminated. Paper records were also maintained, for example patient fluid intake/output charts.

- The CRS was able to flag patients who were at risk of falls, had MRSA or CDiff. However, patients living with dementia or patients with a learning disability were not flagged on the system. We saw if patients had a learning disability, their relatives or carers would be asked to complete a learning disability health passport so staff would know more about them, for example patient's likes and dislikes.
- The CRS required password access to ensure security. Patients' previous medical notes (hard copies) were stored in trolleys on the wards and were not stored securely as the trolleys were open and unauthorised access was possible. On one ward (Kennet) we saw patient records were in several piles on shelving behind the nurses' station. We were advised by staff these records were waiting to be archived. This demonstrated that confidential patient records were not always kept securely.
- We looked at the monitoring records, which had been put in place for two patients who were wearing mittens to prevent them from removing nasal feeding tubes. We saw one patient had been wearing the mittens for about three weeks and the other patient for a week. We noted the regular observations to check the mittens were not restricting the patient's circulation were not being recorded. There was also no review date on the documentation. One patient's last entry was recorded on the two days prior to our visit. We raised this with ward manager and this was subsequently addressed.
- We looked at 10 sets of patient records and found detailed information had been recorded. Information recorded showed the patients had been seen on a post take ward round within 12 hours of admission, diagnosis and management plans were identified, nursing assessments and care plans had been completed. Risk assessments had been completed and reviewed. These included pressure ulcer risk assessments, Venous Thromboembolism (VTE), nutritional and falls risk assessments. We saw where patients had been identified as a falls risk they were issued with non-slip socks and had wrist bands so staff could identify patients as risk of falling when they left their bays.
- Information Governance was part of the staff mandatory training programme. The trusts target was 80% of staff

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having completed the training. Within the medicine directorate 71% of medical staff, 97% of nursing staff and 100% of allied health professionals had attended this training.

Safeguarding

- Staff had access to the trust's safeguarding policy via the trust intranet and knew how to access the safeguarding team to provide advice and guidance when required. Staff told us this team was very supportive in giving advice and assisting them when concerns were raised or information was required.
- Safeguarding information, including contact numbers of the trust lead were kept on the wards in folders and on staff notice boards, and staff were aware of how to access this. Safeguarding concerns were also discussed at handover, which ensured all staff were aware of ongoing concerns.
- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral. We were given examples of concerns they had identified and referrals made. Staff told us they occasionally received feedback on the outcome of referrals.
- Patients we spoke with told us they felt safe in the hospital.
- Safeguarding adults and children was part of the mandatory training programme for staff and different levels of training were provided according to the job role. The trusts target was 80% of staff having completed the training. Within the medicine directorate 71% of medical staff, 85% of nursing staff and 100% of allied health professionals had attended safeguarding vulnerable adults and children training.

Mandatory training

- Staff were aware of the mandatory training they were required to undertake.
- The mandatory and statutory training programme covered basic life support for adults and paediatric, conflict resolution, equality and diversity, fire, health and safety, infection control, information governance, manual handling, safeguarding children and safeguarding adults.
- Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed, or refreshed.

- The trusts target for staff having completed their mandatory and statutory training was 80%. At the time of our inspection, compliance with mandatory training for the medicine directorate was 73% for medical staff, 85% for nursing staff and 97% for allied health professionals.

Assessing and responding to patient risk

- Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating. The electronic system allowed early warning scores to be automatically calculated within the e-noting electronic record system. The system was accessible from any computer terminal in the trust. The system also had built in alerts if readings were outside expected ranges, enabling speedy response and re-assessment of care.
- There was a clinical protocol in place for managing and responding to acutely unwell patients. Staff told us if a patient had a NEWS score of four they would monitor the patient and use their clinical judgement about escalating. If the NEWS score was five or above the patient NEWS score would be recorded hourly and they would start a fluid balance chart if not in place. They would also call the medical team, on site practitioner's at night and out of hours and the outreach team.
- Patients were risk assessed in key safety areas using nationally validated tools. For example we saw the risk of falls was assessed and the risk of pressure damage was assessed using the waterlow score. We observed risk assessments were reviewed daily and where required, care plans had been updated with appropriate risk management actions. The wards participated in pressure ulcer management performance (PUMP) meetings on a monthly basis. Tissue viability nurses were viable on the wards supporting staff and providing training.
- Risks were also communicated to staff using symbols displayed on a whiteboard above each patient's bed, for example, a forget-me-not symbol was used to identify a patient who was living with dementia. Patients who were at risk of falls were identified by wearing red wrist bands and wore non-slip bed socks; this meant that

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patients who were at a risk of falls were quickly identifiable. This method of communicating patient needs appeared to be consistent across the medical wards.

- Adult Basic life support was part of the mandatory training programme for staff to attend. The trusts target was 80% of staff having completed the training. Within the medicine directorate 67% of medical staff, 62% of nursing staff and 100% of allied health professionals had completed the training.

Nursing staffing

- The vacancy rate across all the medical specialities as of 31st January 2016 for nursing staff was 13%. Wards we visited had differing levels of nursing vacancies, ward managers told us they had been involved in the recruitment of new staff and a number of their vacancies had been filled but they were still seeking to recruit. A number of the vacancies had been filled by overseas nursing staff and we saw they were working on the wards as health care assistants (HCA) whilst they were waiting to be registered with the Nurse and Midwifery Council (NMC). Ward managers told us the use of agency staff had reduced and when agency was used they tended to use the same agency nurses.
- Across medicine we found that the use of agency and bank nursing staff differed and was high across all the medical wards in January 2015 and varied between 20.5% (Kennet) and 41.6% (Keats).
- The numbers of staff planned and actually on duty were displayed at ward entrance in line with guidance contained in the Department of Health Document 'Hard Choices'. On the wards we visited we observed staffing levels were generally in line with planned staffing levels. Depending on the ward, nurses were attached to bays or allocated to specific patients. Staffing levels were determined using an acuity tool to determine safe staffing levels. Wards were staffed with a 1:8 nurse to patient ratios, covering a six bedded bay and two side rooms with assistance from an allocated HCA.
- Ward managers were supernumerary to the agreed staffing levels so that if required, they could support ward staff if patient acuity or occupancy increased. Staff that provided one to one support for patients (specials) were not counted in the staffing levels. Staff on the AAU

advised staffing levels had improved over the previous three months, especially at night. A patient on the AAU told us the staff seemed to know each other and worked as a team.

- Health care assistants were specifically trained as 'specials' to support patients who had complex needs. We saw the specials were utilised across the wards overnight and during the day. We observed specials sitting with patients to ensure they did not fall out of the bed. The number of specials was reviewed daily and patients' needs assessed for so the wards could safely manage the risk.
- Ward managers informed the site practitioner's if staff levels/ skills mix were not as planned. Ward managers reported staff would be moved to different wards within the medical specialties to ensure safe staffing levels were maintained or bank or agency staff would be utilised. On the AAU the matron told us the skills mix had been an issue with 20 new starters and the practice team provided a floating staff member to support the new staff.
- We observed three handovers from day to night staff and found them appropriate and robust. Staff had printed hand over notes, which they updated during the handover. All the patients were discussed, including the 'Big 4' risks such as falls, pressure sores, NEWS scores, and patients with one to one care (specials), and actions outstanding for patients were allocated. Staff were allocated to bays and the staff going off shift gave a more detailed hand over to the staff coming on duty.

Medical staffing

- The vacancy rate across all the medical specialities in January 2016 for medical staff was 20.3%. The care of the elderly service had the highest vacancy rate of 48.4%.
- Across medicine we found that the use of locums differed across the medical specialities in January 2016, the locum usage in endoscopy 52.3%, care of the elderly was 30.7%, AAU 26.8% and gastroenterology 20.3%.
- There was a medical specialties consultant cover from 8am to 8pm Monday to Friday and weekends. There was consultant presence eight hours on a Saturday and seven hours on a Sunday. At weekends medical consultants were based in the AAU and were available on call to the medical wards.
- At all times there was a medical consultant on call who was able to return to the hospital within 30 minutes.

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- All medical wards had a daily consultant ward rounds Monday to Friday with junior doctor ward teams working alongside the specialist teams.
- Doctors advised us the consultants managed the medical rotas, which they felt was better, as this allowed for flexibility when covering the rota.
- We observed two multidisciplinary team (MDT) board rounds and found they were carried out efficiently and effectively, with the appropriate staff present.

Major incident awareness and training

- Staff were aware of the trust's major incident procedure and how to access it via the trust intranet. Staff told us they had major incident training. Staff advised the major incident plan was tested six months prior to our inspection with a test scenario of the electronic patient record system not being available so staff had to implement paper records. Emergency packs of patient records were available for staff so that patient services could be maintained.
- Wards had major incident files, which included staff call out lists with staff contact telephone numbers. On some wards where we checked, we noted these had been recently been updated.

Are medical care services effective?

Requires improvement 

We rated medicines services at Kingston Hospital as 'requires improvement' to ensure people's care, treatment and support achieved good outcomes, promoted a good quality of life and was based on the best available evidence. This was because:

- Staff reported they had no specific training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training however the trust reported that staff received training on the Mental Capacity Act as part of their initial induction. Whilst staff were able to describe the requirements of the Mental Capacity Act, we found examples where the requirements of the Act had not been fully applied. We found examples where patients were unable to consent to a mechanical restraint, no mental capacity assessment had been undertaken and no best interest decisions had been recorded.

- Patient outcome measures including National Heart Failure Audit, Myocardial Ischemia National Audit Project (MINAP), National Diabetes Inpatient Audit (NaDIA) the trust scored below the England average.
- In care of the elderly and cardiology, which represented the majority of activity, the average length of stay was worse than the England average. In care of the elderly it was 15 days compared to the England average of 10 days and for cardiology it was 9 days compared to 5.6 days which was the England average.

However;

- The trust used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to guide the treatment they provided.
- The trust was one of 13 trusts awarded with an A rating in the Sentinel Stroke National Audit Programme (SSNAP) for their performance in January to March 2015.
- The hospital's endoscopy services were Joint Advisory Group (JAG) accredited.
- People's needs with regard to pain management and nutrition were addressed.
- Consultants covering medical specialities were available seven days per week.
- There was effective multidisciplinary approach to care and treatment with good communication between the teams.

Evidence-based care and treatment

- The trust used a combination of National Institute for Health and Care Excellence (NICE) and Royal College guidelines to guide the treatment they provided. For example the trust's policy for Adult Observations Recording and Escalation Policy for recognising and responding to acutely unwell patients. Staff reported the clinical policies and guidance were available on the trust intranet. There was also good range of locally produced evidence based guidelines on the guidance on the intranet, which were updated regularly.
- Staff understood appropriate NICE guidelines and stated these were referred to in discussions with staff about patients' care and treatment.
- There was a medicine audit programme for 2015/2016, across the five medical service lines which identified 26 audits; 10 of which were national audits. Of these three had been completed; national lung cancer audit,

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cardiac rhythm management audit, endoscopy staff, 14 were in progress and nine had not started. This showed the trust was properly engaged in the audit of effectiveness of care.

- The endoscopy department had recently been re-accredited by the Joint Advisory Group (JAG) for gastrointestinal endoscopy.

Pain relief

- Patients told us they received appropriate pain relief. We observed staff assessing patients' pain levels and taking appropriate actions to ensure pain relief was administered in a timely way. Staff told us there were various ways to assess pain levels; verbal using a pain score of one to 10, facial expressions, and pain surges.
- The electronic medication administration records indicated when patients could be given further PRN (medicine taken when necessary) medication, which ensured patients received their medicine at the appropriate intervals.
- Assessments of patients' pain were included in all routine sets of observations. As part of "intentional rounding" processes (where staff attend patients at set intervals to check a range of patient-centred issues) staff ensured patients were comfortable and recorded this in patient records
- We saw when required, patients were referred to the pain team. Referral was discussed during the multidisciplinary board rounds and noted on the board to be actioned by staff. The palliative care team also provided support and advice in the pain control of those who were terminally ill.

Nutrition and hydration

- We looked at the results of the patient led assessments of the care environment (PLACE). In 2015 the trust scored a 94% rating for quality of food, which was better than the national average of 88%.
- We observed patients were served a choice of foods. The menus had been designed to include a range of special diets, which included a finger food menu (for with patients living with dementia) high energy, soft, gluten free, high fibre, vegetarian and healthy eating options. Dietary supplements were given to people when prescribed.
- One patient we spoke with advised that they were eating mainly sandwiches as they had food allergies which included mushrooms, milk and instant potatoes which can cause anaphylaxis, we checked the patients

notes and found their food allergies had not been recorded, The ward manager agreed to investigate and have the patient assessed by speech and language therapists (SALT).

- Staff told us that patients who had specific dietary needs were assessed by a dietitian; we saw patients who require thickeners in their drinks were identified by signage on boards behind patient's beds. This ensured staff were aware of the patient's requirements.
- We spoke with catering staff on the wards who told us they were given daily lists of patients' dietary needs and any restrictions. We saw staff using these during food service. This meant staff responsible for serving patients food were informed about their needs.
- We observed patients were offered sufficient quantities of fluids with a variety of hot and cold drinks available throughout the day including early morning and last thing at night. Drinks were left within reach and patients were given assistance to drink if required.
- On Derwent Ward we saw the activities room was also used for dining, which meant patients could eat together in a non-ward environment.
- We saw there were adequate arrangements to ensure food safety. For example we found food service personnel wore suitable personal protective equipment (PPE), food and fridge temperatures were checked and the temperature of food was checked before service to ensure it had reached safe temperatures.

Patient outcomes

- The trust participated in the Sentinel Stroke National Audit Programme (SSNAP), which is an ongoing national audit that investigates and analyses the quality of care in stroke services. Hospitals are awarded a score A to E where A is the best. At Kingston Hospital the stroke services scored B for July to September 2014, October to December 2014 and April to June 2015 and A in January 2015 to March 2015. The trust was one of 13 trusts awarded with an A rating for this period, with 70% of trusts achieving a D rating. This indicated the hospital was achieving good outcomes for patients with strokes compared with the national average.
- The hospital participated in the 2013/2014 National Heart Failure Audit and scored below the England average in all four standards audited for clinical practice for in hospital care. The hospital also scored below the England average in clinical practice for discharge from

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the hospital in six of the seven standards audited. We saw that an action plan was in place with four actions identified; in December 2015 these were still being progressed.

- The hospital participated in the Myocardial Ischemia National Audit Project (MINAP), which is a national clinical audit of the management of heart attack. In 2012/13 and 2013/2014 the hospitals scored below the England average in all three standards audited for care of patients with non-ST-elevation infarction (nSTEMI).
- In the National Diabetes Inpatient Audit (NaDIA) September 2015 the trust's performance was monitored against 17 indicators, in five of the indicators the trust performed better than other trusts and in 10 indicators the trust was worse than other trusts. We saw that an action plan had been put in place following the trusts previous NaDIA audit in September 2013 and this was still being progressed with two of the seven actions identified completed.
- Performance in national audits was analysed and action plans to improve performance were identified. Action plans identified following three national audits for the Lung Cancer national audit December 2014, Chronic Obstructive Pulmonary Disease (COPD) February 2015 and MINAP December 2014 showed some actions were still outstanding.
- Kingston Hospital's endoscopy services were Joint Advisory Group (JAG) accredited. The Joint Advisory Group on GI Endoscopy ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practiced. Using the Endoscopy Global Ratings Scale (GRS) Kingston Hospital had participated in the quality improvement system for endoscopy services to achieve and maintain accreditation.
- There were six quality improvement projects registered for medicine in 2015. One had been completed, three were being progressed, and two needed follow up.
- Across medicine the average length of stay was about the same as the England average of 6.8 days. In care of the elderly and cardiology, which represented the majority of activity, the average length of stay was worse than the England average. In care of the elderly it was 15 days compared to the England average of 10 days and for cardiology it was nine days compared to 5.6 days which was the England average.

- Between June 2014 and May 2015 the standardised risk of re-admission for medicine and the medicine specialities was below the England average for both elective and non-elective admission. This means there were less observed readmissions than expected.

Competent staff

- Staff told us they participated in the appraisals process and we reviewed documentation on wards and found most wards had some staff appraisal outstanding. The trust reported 72% of nursing staff within the medical services had received an appraisal in the period April 2015 to October 2015. As appraisals were completed on annual basis it was anticipated that by March 2016 the trust target of 80% would be achieved.
- Staff competencies for prescribing, dispensing and administering medicines were assessed by dedicated training packages provided by the trust, through the intranet portal. However, it was not clear how often nurses received regular training updates on a formal basis.
- Staff had access to a virtual British National Formulary (BNF) through the trust intranet, as well as all policies/information relating to medicines management.
- On wards nursing staff had lead functions; for example a nurse was responsible for infection control and led on related initiatives to develop staff skills and knowledge. Advance nurse practitioner's also worked across the wards to support staff and develop their skills.
- Nurses told us there were opportunities for learning and development and they could access training online. Staff told us they had received no specific training in dementia; however drop in sessions were run on a regular basis which staff could attend.
- Throughout our inspection we observed staff were professional and competent in their interactions with colleagues, patients and their relatives/carers.
- We saw there was a range of specialist nurses to provide advice and guidance on the care of specific groups of patients, such as those with diabetes and tissue viability issues. There were also lead specialist nurse for safeguarding. We noted their presence on the wards and staff told us they valued their input on the wards.
- Junior doctors we spoke with reported they were inducted into the trust and the hospital provided good

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training opportunities and were given time for training; they also had good support from consultants. Junior doctors felt workloads were manageable and that they felt valued.

Multidisciplinary working

- Medical and nursing staff of all grades we spoke with all described excellent working relationships between healthcare professionals. The multidisciplinary CRS ensured there was good communication about the input of each profession in the care of individual patients and care was well co-ordinated for patients and their relatives. We observed the healthcare team worked well together to provide care to patients.
- We saw multidisciplinary (MDT) working was evident on medical wards; physiotherapists and occupational therapists were part of ward board rounds on a daily basis Monday to Friday. There was evidence of a MDT approach to discharge planning.
- Wards also had weekly MDT meetings to discuss patients. These included the consultant, ward doctors, ward managers, the discharge coordinator, physiotherapists and occupational therapists, speech and language therapists (SALT), dietitians and palliative care if needed.
- Ward and specialist medical teams had access to the full range of allied health professionals such as speech and language therapists, dietitians, tissue viability, and diabetic nurses. Where allied health professionals and specialist medical teams had been involved with patients they had recorded this in the CRS. Discharge co-ordinators were also based on the wards to facilitate social care packages for patients on discharge.
- There was good pharmacist support on the wards and they provided information to patients on their medications and medication usage.
- The wards had access to psychiatric liaison services from South West London St Georges Mental Health Trust, and patients would be referred to the psychiatric liaison services for assessment when staff had concerns.

Seven-day services

- Consultants provided an on call service out of hours and at night after 9pm covering all the medical wards (8). At weekends an on call consultant was available from 5pm to 8am Friday to Monday to cover the medical wards working from the acute assessment unit (AAU). An advance nurse practitioner (ANP) was also available 24/7 to provide additional cover across the wards.

- The medical wards at weekends were covered by a discharge registrar and two doctors and the AAU was covered by three doctors and the on call medical consultant.
- There was a 24/7 Endoscopy rota for gastro-intestinal bleeding, and the department was trialling Sunday morning lists for routine endoscopy.
- Ward sisters from the medical wards operated a weekend rota to cover the weekends; matrons also provided occasional cover at weekends as required.
- Staff reported there was seven day availability of all diagnostic services including imaging, and laboratory facilities. They told us they did not encounter any problems with diagnostic services out of normal working hours.
- Physiotherapists and occupational therapists were available on site and provided on call service to the medical wards at the weekends, however SALT provided a weekday only service.
- Pharmacy services provided on call out of hours and at weekends. Nursing staff stated they were happy with the service and commended the support and advice received by the on-call pharmacist, but stated they thought TTOs could be dispensed more quickly than actually received.

Access to information

- Patient boards on the wards had details of patient's surnames which identified which bay and bed patients were in with their estimated date of discharge. Patients with particular needs were highlighted using symbols to indicate the person was at risk of falls, a forget-me-not symbol to indicate of a person was living with dementia or their dietary needs and whether SALT were involved. The boards also included which London borough the patient was from and whether patients had access to a social worker. The boards were updated as part of the daily MDT board round on a Monday to Friday.
- Staff had access to computers on the wards; some nursing staff we spoke with advised that when the medical staff were on the wards they had to wait to be able to update patient records. Patient past medical records were stored in notes trolleys on the ward. We saw computers were also available in patient bays so the staff responsible for those patients were able to update records in real time.
- Clinical staff were able to access CRS from across the hospital using a log in, which meant they were able to

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access current medical records. Staff had their own unique logons to the CRS, agency staff also had their own logins, ward managers advised they only used staff that had experience of using the system as they did not want to have to train agency staff unnecessarily to use the system.

- Staff were able to access diagnostic results such as blood results and imaging to support them to care safely for patients via the CRS.
- There was access to guidance and information on the trust intranet.
- Staff names, roles and photos were on display on wards, there was also information on nurse's uniforms so that patients and visitors would be able to distinguish between different roles.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- On Hardy Ward we found two patients were subject to a mechanical restraint by wearing mittens to prevent them from removing nasal feeding tubes. We found no mental capacity assessment had been undertaken, and no best interest decisions had been recorded. Next of kin had given consent for the restraint; however, there was no record to indicate if they had power of attorney for the patients' health and wellbeing. The trust's restraint policy was clear; a mental capacity assessment should be completed if the patient was unable to consent to the restraint.
- Staff reported they had no specific training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training however the trust provided supplementary evidence following the inspection to demonstrate that staff were provided with training as part of their initial induction on the Mental Capacity Act. Staff we spoke with were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS), and told us they would refer patients to the safeguarding teams if patients required a MCA. All DoLS applications were also dealt with by the safeguarding team.
- Patients told us staff took their consent before care or treatment was given and medical staff explained their treatment and gave them options to consider about their treatment pathways. One patient told us "medical staff always explain everything to me; feel I am in the right hands".

Are medical care services caring?

Good



We rated caring as 'good' with respect to the staff providing medical services at Kingston Hospital. This was because:

- People were cared for by staff that were kind caring and compassionate in their approach.
- Patients and their relatives were positive about their experience of care and the kindness afforded them.
- We observed staff being friendly towards patients and treating them and visitors with understanding and patience.
- Treatment was provided in a respectful and dignified manner.
- Patients told us they were involved in decisions about their care and treatment and were given the right amount of information to support their decision making.
- Emotional support was provided by staff in their interactions with patients.
- Most patients were positive about their experience.

Compassionate care

- The trust used the Friends and Family test (FFT) to gather patients' views on whether they would recommend the service to family and friends. We looked at the latest FFT scores available for the period August 2014 to July 2015. The average response rate for individual wards ranged from 18% to 64%. Overall, these showed satisfaction with the service, with the medical wards ranging from 20%, which was low to 100% during the period. Kennet Ward had the most consistent feedback scoring 100% in 10 of the 12 months; however their response rate was low at 22%. Hamble Ward scored the lowest, 20% in September 2014 having scored 100% satisfaction in August 2014 and 85% in October 2014. Further improvements in the overall friends and family scores were noted for December 2015 and January 2016 as follows:
 - Hamble Ward - 67% response rate; 98.3% would recommend
 - Kennet ward - 38% response rate; 100% would recommend

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- We observed interactions between staff and patients were professional, kind and friendly. For example, we observed a doctor speaking reassuringly to a confused patient, taking time to listen to what the patient was saying; a member of staff and patient talking on their way for a CT scan. Staff asked patients if they wanted a hot drink and made sure they were comfortable.
- Several patients told us they thought the staff were good and caring. Some of the positive comments we received from patients were: "staff are amazing, courteous, friendly and professional", "cannot praise the staff enough", "staff are very friendly and talkative", and "they are kind and know what they are doing".
- Patients told us the nursing staff were respectful to them and every effort was taken to ensure their privacy was protected when personal care was being given. We observed curtains were closed when patients were receiving personal care.
- On one ward, we witnessed a member of nursing staff loudly reprimanding a patient for using the call bell too frequently.
- On wards across the medical specialities we saw notice boards had on display numerous cards from grateful patients and or relatives thanking staff for their help and support following their hospital admission.
- We looked at the results from the acute stroke unit's inpatient survey 2015; these showed that 86% of respondents rated their stay on the acute stroke unit as 'very good/ good'.
- We looked at the results of the patient led assessments of the care environment (PLACE). In 2015 the trust scored 91% for privacy, dignity and wellbeing which was better than a national average of 86%.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they were involved in their care and understood their treatment and care plans. Patients described conversations with the doctors and consultants, they had been able to ask questions and had been told how their illness or injury might improve or progress. Positive comments we received were; "treatment always explained to me and I am given options and can pick which one I want", " the medical staff always explain everything to me; I feel I am in the right hands", and "always explain and talk me through the treatment".

- Relatives we spoke to were happy with the care their relatives received and felt they had been kept involved with their loved ones' treatment. One relative told us there had been a family conference about the patient's discharge to a care home. Another relative told us their loved one was improving day by day and was happy.
- The wards had flexible visiting hours which meant relatives could visit their loved ones from 9am until 8pm, with protected meal times from 12pm to 2pm. This meant that relatives could assist at meals times and then leave the wards so that patients could rest.

Emotional support

- Patients and their relatives told us the clinical staff were approachable and they could talk to staff about their fears and anxieties.
- Support for carers and relatives was available through the Carers Network, which operated out of the Kennet Ward on a Monday and Tuesday.
- The hospital chaplaincy service was multi-faith and provided support 24 hours per day. It provided services to patients across the hospital. Staff were aware of how to contact spiritual advisors to meet the spiritual needs of patients and their families

Are medical care services responsive?

Good



We rated medical services at Kingston Hospital as 'good' for ensuring the services were organised to meet people's needs. This was because:

- Medical specialities planned their services to meet the needs of the local population.
- The trust was exceeding the standards for referral to treatment (RTT) performance.
- The service had responded to the needs of an ageing population and were developing services to improve the experience of patients living with dementia.
- A number of initiatives had been developed to ensure the service met people's individual needs and those of vulnerable groups.
- Across medical specialities complaints were discussed at monthly clinical governance meetings, these identified learning and action points

Medical care (including older people's care)

However;

- Staff had access to translation services for patients for whom English was not a first language. Staff we spoke with told us they knew the service was available but they tended to use staff from the hospital who could speak various languages or ask patients relatives to interpret. This is poor practice as staff could not be confident that the information that the patient was being told was what staff had wanted to convey to the patient.

Service planning and delivery to meet the needs of local people

- The care of elderly medical services were actively developing good working relationships with the clinical commissioning groups (CCGs). This was to help facilitate developing integrated services for patients, linking community and acute services to move patients through the hospital into community based provision.
- The hospital had restructured the AAU to provide a 40 bed admission ward, which incorporated ambulatory care and frailty models with the aim to reduce hospital admissions.
- Care of elderly wards were seeking to improve the ward environment to make them more dementia friendly and the trust was actively fund raising for this.
- A ward had been reopened for elderly patients to assist with winter pressures. Demand for medical beds frequently outstripped supply especially in the winter period.
- Visiting hours had been extended to accommodate the needs of patients and visitors with extra-ordinary circumstances or who were very sick. Wards had fold-up beds available so relatives could stay with patients overnight. Relatives were encouraged to visit elderly and frail patients during meal times to assist with eating.

Access and flow

- The majority of patients admitted to the medical wards were generally admitted via the AAU. The target time for patients to stay in the AAU was 72 hours, staff advised that due to the number of side room patients stayed longer. The AAU held MDT meeting daily with the community team, advance nurse practitioner (ANP), and consultants to identify patients who could be discharged.
- Discharge plans were commenced on admission and patients had estimated dates of discharge documented

in their records. On wards designated discharge nurses would oversee patients' discharge arrangements and discharge plans were discussed at multidisciplinary team (MDT) board rounds. Patients who were able to be discharged had their discharge plans discussed, and they were identified on a discharge board which confirmed discharge arrangements were in place, such as care packages, transport, and TTOs had been ordered. Plans were also discussed and put in place for patients to be discharged at the weekend. This meant that patients were not kept in hospital longer than necessary.

- On Blyth Ward we found that 11 of the 30 patients were ready to be discharged, however discharge had been delayed as they were waiting for packages of care to be confirmed.
- The hospital had a discharge lounge, which was staffed by nursing staff. When we visited we found three patients were waiting to be discharged, two had care packages in place and were waiting for transport. A patient was waiting for their take home medicines. Staff had facilities to make hot drinks and provide snacks.
- Discharge letters and summaries were sent to family doctors (GPs) electronically.
- Bed moves were coordinated through the site control room. During the period October 2014 to September 2015, 60.3% (7,538) of patients experienced no ward move, 35% (4,393) of patients were moved once, 3.5% (439) of patients were moved twice, 0.9% (18) patients were moved three times and 22 patients were moved four or more times.
- Staff we spoke with advised patients were transferred from the AAU when more capacity was needed and frequently between five to seven patients would be transferred across hospital at night between the hours of 10pm and 6am. For the period April 2015 to September 2015 the total number of bed moves across the medical wards at night was 736, with 88.58% (652) patients being moved from the AAU.
- During the period September 2014 to August 2015 the trust was exceeding the standards for referral to treatment (RTT) performance. Waiting times for patient starting consultant led treatment within 18 weeks of referral was above the England standard of 90%. Across the medical care services cardiology, gastroenterology and general medicine, between 97.5% and 100% of patients started consultant led treatment within 18 weeks of referral.

Medical care (including older people's care)

- At the time of our inspection a number of patients across the trust were outliers (patients who were under the care of a consultant but looked after on a different ward). These patients were seen daily by the medical teams looking after them.

Meeting people's individual needs

- We saw patients had their needs assessed. We reviewed 10 sets of patient records and saw their care plans included all identified care needs.
- On the wards patients who were at risk of falls were offered non-slip socks. In the AAU we saw patients who were at risk of falling were also had red wrist bands.
- On care of the elderly wards there was an activities room available for patients, which provided a range of activities such as music therapy, puzzles, reminiscence therapy and art.
- All the wards operated a protected meal time policy, however on Blyth Ward we observed that the doctors round continued whilst food was being served.
- We observed lunch time on three wards; we found they were well organised even though there was a variety of food being served. At lunch time a bell was rung and the staff started to serve lunch. Patients who needed no assistance were served first, followed by patients who needed to be observed or required assistance with their food. This ensured all the patients had hot food and did not have their food left sitting in front of them.
- On some wards we observed patients were being assisted to eat by volunteers and the volunteers and patients appeared to be at ease. On the care of the elderly wards relatives and carers were also invited to visit patients at meal times to assist with feeding. Staff told us this initiative had greatly assisted them during busy times. A ward manager we spoke with said they would like more volunteers to assist patients with evening meals.
- Patients who required assistance with their food were identified by using red trays. On one ward we visited we observed some patients who needed assistance did not have red trays. However, the staff working in the bay knew if patients needed assistance.
- On wards we saw volunteers were used to assist patients with their food. Ward managers we spoke with appreciated the benefits to patients and staff and were keen for more volunteers to be available especially when the evening meals were being served.
- Patients and relatives we spoke with were generally satisfied with the quality and range and choice of food that was offered. Patients we spoke with told us "I am surprised the food is so good; I get a choice" and "breakfast is very good with lots of choice; scrambled egg, cereal, toast and marmalade".
- Patients admitted over the age of 75 years were screened for dementia within 72 hours of admission for dementia. For the period July 2014 to September 2015, 70% of patients were being screen for dementia within 72 hours which was less than the trust target of 90%. The trust reported that for the month of December 2015, 81.9% of patients were screened for dementia within 72 hours and for January 2016, 83.9% of patients were being screened for dementia within 72 hours.
- The care of the elderly wards were not dementia friendly, the wards were not coloured coded to assist patients find their way to their bay or identify male and female facilities. However, there was signage to help patients identify male/female bathrooms, toilets and shower rooms.
- Patients living with dementia were not flagged on the CRS, however patients were identified with a 'forget me not' symbol on ward boards and on the wards they would be allocated a bed within eyesight of staff, for example near to the nurses station. Patient passports were in use for patients with a learning disability, which were completed by their relative or carer. The passports were used so patients could to outline their care needs, preferences and any other information the staff would find useful to assist with their care. Patients with a learning disability were not flagged on the CRS.
- We observed staff providing one to one care (specials) were utilised across the medical wards, on one of the wards we observed a special sitting with a patient who required monitoring. The patient told us he had a special all the time who accompanied him if he wanted to walk around the ward. This meant the patient was being monitored and kept safe from harm such as falls.
- All the medical wards were divided into bays which provided single sex accommodation with designated male and female facilities in the bays.
- We saw call bells were within reach of patients and observed staff generally answered the bells straight away. Patients we spoke with told us bells were generally answered quickly.
- Following feedback from "You Said We Did" patient surveys, wards had introduced different initiatives such

Medical care (including older people's care)

as offering patients ear plugs to help mitigate noise on the wards at night, ensured lights were switched off as soon as possible in the evenings, and held MDT meetings earlier to discuss patients who may be being discharged.

- Staff had access to translation services for patients for whom English was not a first language, which was available via the telephone and could also be provided to face to face. Staff we spoke with told us they knew the service was available but they tended to use staff from the hospital who could speak various languages or ask patients relatives to interpret. This is poor practice as staff could not be confident that the information that the patient was being told was what staff had wanted to convey to the patient.
- Wards had a range of information leaflets available. This included generic trust information on topics such as infection control, Patient Advice and Liaison Service (PALS), complaints and VTE, plus some relevant diagnosis/condition specific information such as chronic obstructive pulmonary disease (COPD).
- Patient information and advice leaflets were available in English, but were not available in any other language or format.

Learning from complaints and concerns

- Leaflets on how to make a complaint and about PALS were available on the wards. One of the patients we spoke with said they were aware of how to make a complaint.
- Staff told us they tried to resolve complaints and concerns at the time where ever possible. They told us they received feedback about complaints and the learning from them. Senior managers told us they would contact every complainant and meet with them if they requested it.
- Each of the medical specialities had performance score cards. We saw evidence of a report for each of the specialities that brought together information on their performance in relation to different indicators. These included the number of complaints received within a month, and time taken to respond. The number of complaints received for the period April 2015 to September 2015 was 44, and there was a variable performance against responding to complaints within 25 working days across all the specialities.

- We saw across specialities complaints were discussed at monthly clinical governance meetings, these identified learning and action points.

Are medical care services well-led?

Good



We rated medical care services at Kingston hospital as 'good' for being well-led. This was because:

- There was a clear vision to deliver good quality.
- There was good leadership and management within the medical specialities with clear strategies on how the services were to develop.
- Managers were visible and approachable.
- Staff were proud to work for the trust; they were enthusiastic in their work.
- There was an appropriate system of clinical governance in the medical specialities, which identified quality and risk issues. Trends could be readily identified and learning was disseminated to staff.
- We found staff and patients were engaged with the development of medical specialities, and saw examples of innovative practice.

Vision and strategy for this service

- Senior staff within the medical services had clear visions for each of the specialities on how the services were to develop and move forward, this included opportunities to share learning across the specialities.
- We saw examples of where staff had developed their own ward vision on the wards team building away day which was based on the name of the wards. For example Derwent stood for Dedication, Equality, Responsible, Working together, Enthusiastic, kNoledgeable, Trustworthy. A healthcare assistant told us how this had been a collaborative effort with all staff involved in developing the team vision.
- Senior staff were aware they needed to attract doctors and nurses who had particular interests in their speciality. The recruitment programme was specific to the specialities needs, with matrons and ward sisters involved in the recruitment of staff.

Medical care (including older people's care)

Governance, risk management and quality measurement

- Clinical governance structures were set up and used across the medical specialities and staff felt this was effective. Each speciality held monthly clinical governance meetings. We reviewed the minutes of nine meetings across the specialities and saw there was good attendance from the multidisciplinary teams. Adverse incidents, infection control, performance indicators and patient feedback and or complaints were reviewed. However, we noted feedback and clinical outcomes from mortality and morbidity meetings were not regularly discussed.
- Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its objectives.
- We saw ward managers were provided with regular reports on incidents that occurred in their areas, complaints, survey results and staffing data. This information was discussed with the matron for the area who monitored for themes and trends.
- We spoke with the ward managers across all medical services who demonstrated a good awareness of governance arrangements. They detailed the actions taken to monitor patient safety and risk. This included incident reporting, keeping a ward based risk register and undertaking audits.
- Each of the medical specialities had performance score cards. We saw evidence of a report for each of the specialities, which brought together information on their performance in relation to a range of indicators of quality and throughput. Wards also had patient experience boards on display, which included performance on patient feedback which included FFT and "You Said We Did".
- We looked at the risk registers for each of the medical specialities. Each risk had a red, amber or green (RAG) rating, a review date, and there was a named manager responsible for the risk. There were details of the action taken to mitigate the risks and progress was recorded, demonstrating active management of identified risks.
- Difficulties in recruiting appropriately qualified and experienced nurse staffing was acknowledged as a risk and was identified on the risk registers for care of the elderly and the AAU. On Hardy Ward the nursing vacancy

rate was 67.8% (12.95 WTE) in 31st January 2015, however the risk register for gastroenterology and endoscopy had not identified difficulties in recruiting nursing staff as a risk.

Leadership of service

- Clinical leads reported changes to the service line structure had been successful and they had more autonomy and accountability, which enabled them to find solutions rather than 'top down' decision making. Clinical leads felt they were listened to and staff engagement had improved.
- A good structure was in place to provide support to staff at ward level through ward managers and matrons. The clinical leads worked closely with the matrons and service managers.
- Staff said the director of nursing was visible on the wards and reported they had been helping medication on one of the care of elderly wards recently.
- Staff said managers were supportive and approachable, they also had opportunities for personal develop and when they raised concerns they were listen to and their concerns addressed.
- Staff on different wards reported they had recently attended a ward team building day, which they spoke positively about. We saw on wards they had a team member of the month, which recognised a member of staff who colleagues felt had gone the 'extra mile'.
- Staff felt respected and valued. We spoke with house keepers and domestic staff who told us they were very involved on the wards and they felt part of the team. They were proud of their role and felt valued by nursing staff and patients.
- Medical staff were also positive about the support they received from their senior colleagues and their peers.
- On some wards we saw there were 'In Charge Boards'. These detailed who was in charge of each bay on the ward, who was the nutritional coordinator for the day and who was in charge of Friends and family tests to ensure patient's feedback was being captured.

Culture within the service

- Staff were proud to work for the trust; they were enthusiastic about the care and services they provided for patients. They described the trust as a good place to work and some staff we spoke with had worked at the hospital for a number of years.

Medical care (including older people's care)

- Staff said there was an open and transparent culture where people were encouraged and felt comfortable about reporting incidents and where there was learning from mistakes.
- On the wards we saw multidisciplinary working which involved patients, relatives, therapists and nursing staff working together to achieve good outcomes for patients.
- Patients acknowledged a positive and caring ethos and were mostly happy with their care.

Public and staff engagement

- The trust had various means of engaging with patients which included surveys such as Friends and Family Tests and other inpatient surveys. 'Your experience' patient boards visible on the wards had details of the latest friends and family tests. The Boards included 'You Said We Did' feedback. On different wards this had resulted in a 'milky drink champion' to encourage patients to have milky drinks and quiet closing bins were provided so patients were not disturbed at night.

- Wards operated a staff recognition programme and during our inspection we saw different examples of staff being named as team member of the month.
- Staff had recently attended team building events for their wards and we saw from these events staff had developed ward visions, which we saw was on display across the wards.

Innovation, improvement and sustainability

- The care of elderly had a named physician of the day who was available to be contacted by the wards at any during the day.
- On care of elderly they were trialling the housekeepers assisting patients with the friends and family tests as patient felt comfortable speaking to them.
- An activities room for patients living with dementia meant patients could access a therapeutic programme of activities.
- Volunteers were used on wards to assist patients at meal times. This enabled staff and volunteers to spend more time with patients.

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

Information about the service

Kingston Hospital provides a range of day case, elective and emergency surgical services to a mostly local population of patients from Kingston, Surrey and South West London. 19,584 surgical procedures were carried out in 2014 – in the lower quartile of trust surgical activity nationally. Kingston Hospital is used mostly for day case and non-elective surgery, with 61% day case procedures, 25% emergency/non-elective procedures and 14% elective procedures in 2014/15.

There are 10 main operating theatres at Kingston Hospital covering trauma and orthopaedics, general surgery, colorectal, breast, urology and vascular surgery. They operate Monday to Friday, with additional availability for elective lists at weekends. One theatre is designated for emergencies and is available 24 hours per day seven days a week. There are five theatres in the day surgery unit. There are 80 inpatient surgical beds across four designated surgical wards.

Surgical activity is managed by all two divisions within the trust: Specialist Services and Clinical Support Services.

We inspected the perioperative care pathway from admissions, through operating theatres and recovery onto surgery wards. We looked at provision for both inpatient and day case patients. During our inspection we visited four surgery wards: Alexandra, Astor, Cambridge and Canbury. We inspected the surgical admissions area, day surgery unit, main operating theatres and the recovery area. We also visited the Albany unit outpatient and minor procedures suite, and the Coombe wing, which was an

independent outpatient and inpatient unit managed by an external provider. We spoke with 20 patients and their family members. We observed care and treatment and looked at 10 care records. We also spoke with more than 60 staff members, including allied healthcare professionals, nurses, doctors in training, consultants, ward managers and senior management staff. In addition, we reviewed national data and performance information about the trust.

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Summary of findings

We found that the surgery service at Kingston Hospital was safe, effective, caring, responsive to patients' needs and well-led.

- The surgery service at Kingston Hospital had a good overall safety performance and patients were protected from harm.
- There were low rates of serious incidents and no never events.
- We found good processes for reporting and escalation of incidents and good sharing of learning from incidents.
- Clinical areas were visibly clean and there was good compliance with hygiene processes.
- Staffing needs were based on acuity of patients.
- There was a good understanding of the trust's duty of candour and major incident policies amongst clinical staff.
- There were good patient outcomes across surgical specialties and care was delivered in line with relevant national guidelines.
- The trust performed well in national clinical audits.
- There were short length of stay and low readmission rates.
- Patients had effective and timely pain relief.
- Doctors in training and newly qualified nurses felt well supported with good supervision and good training opportunities.
- There was good multidisciplinary team (MDT) working between doctors, nurses and allied health professionals.
- Staff across the surgery service were friendly, caring and professional, and patients were treated with dignity.
- Friends and Family Test results were consistently very good across surgery wards with a good response rate.
- The trust provided a number of services to improve outcomes for local people.

- Patient flow from admissions, through theatres and onto to surgery wards was satisfactory and bed availability was managed effectively.
- There were very good systems and provision of care for patients with complex needs, such as those living with learning disabilities and dementia.
- We found a cohesive and supportive leadership team, with well-established members of staff.
- There was a clearly defined strategic plan for each of the surgery service lines.
- Matrons and ward managers were very visible on the wards and the consultant body within the service provided clear clinical direction.
- There were comprehensive and robust governance and risk management processes in place.
- The World Health Organization (WHO) Surgical Safety Checklist was well-embedded in theatres but we did not find evidence of end of list debriefings to complete the five steps.

However;

- There was insufficient availability of sterile equipment and mechanical faults on equipment in theatres.
- There were some challenges with low staff morale in theatres.
- There were some incidents of sub-optimal pre-assessment leading to cancellations on the day scheduled for the operation.
- Some patients felt the provision of information for elderly patients could be improved.

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Are surgery services safe?

Good



We rated the surgical services at Kingston Hospital as 'good'. This was because:

- There was good overall safety performance on wards and patients were protected from harm.
- There were low rates of serious incidents, no never events, and good safety thermometer indicators.
- We found good processes for reporting and escalation of incidents and good sharing of learning from incidents.
- All of the clinical areas we visited were visibly clean and there was good compliance with hygiene processes.
- Staffing needs were based on acuity of patients.
- There was a good understanding of the trust's duty of candour and major incident policies amongst clinical staff.
- We found good completion of mandatory training.
- Medication was stored and managed according to appropriate guidelines.

However;

- There were reported problems with insufficient availability of sterile equipment and mechanical faults on equipment in theatres.
- The World Health Organization (WHO) Surgical Safety Checklist was well-embedded in theatres but we did not find evidence of end of list debriefings to complete the five steps.

Incidents

- The surgery service reported eight serious incidents (SIs) in the year preceding our inspection. Five of these related to pressure ulcers and patient falls. Relatively low numbers of pressure ulcers, patient falls and catheter acquired urinary tract infection (C.UTI) were reported.
- Six pressure ulcers were recorded between September 2014 and September 2015. Zero pressure ulcers occurred for the majority of months, with exceptions in

January 2015 (2.5), March 2015 (2) and June 2015 (1). Four patients experienced falls with harm between September 2014 and September 2015. There were seven cases of C.UTIs in the same period. Highest levels were recorded in the winter months of December 2014 to February 2015 (2.5 per month).

- The surgery wards identified patients at high risk of falls and this information was highlighted on the patient information board (RAG board). High risk patients were also allocated a bed in sight of the nurses' station so they could be monitored. Patients at risk of falls were co-located in one bay for more effective management.
- The trust used an online incident reporting system. All surgery staff had individual user login details to access this system. Doctors, nurses, theatre staff and allied health professionals told us they felt able and comfortable to submit incidents to the system. Ward and theatre managers used dashboards to review the incidents reported in their respective areas of responsibility.
- In the trust's incident reporting log for surgery we found general themes of occurrence of pressure ulcers, staffing shortages and lack of equipment availability in theatres.
- There were effective processes for investigating serious incidents. SIs were investigated by a band 7 ward sister or theatre manager with support from a matron. Ward managers liaised with relevant members of staff and conducted root cause analysis investigations. There was a standard reporting template for all investigations. Matrons and ward managers received training in investigating incidents.
- Reports of investigations were presented to an SI panel which was chaired by another matron from another department to provide externality. A risk consultant also reviewed all SIs to identify themes and learning. The trust's quality and risk managers supported the process of investigation and production of reports. Reports were shared with all staff with action plans to address concerns.
- The surgery head of nursing and senior staff reviewed incidents and monitored progress of action plans on a monthly basis at clinical governance meetings. Incident information was also shared at weekly Matrons' meetings.
- We found evidence that learning from incidents was shared effectively. We saw learning was disseminated in staff memos and nurses told us it was discussed at handover and weekly ward and theatre meetings. The

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trust had introduced 'safety huddle' board rounds on wards and in theatres to discuss learning from incidents. The aim was to improve communication by providing a forum for everyone in the team to meet in a morning huddle.

- Learning from incidents included redevelopment of local guidelines to prevent incidents from happening again.
- The surgery service held monthly morbidity and mortality meetings where difficult surgical cases were discussed by consultants and doctors in training. All patient deaths and surgical complications were discussed at the morbidity and mortality meetings. We saw a sample of meeting minutes and presentations which were comprehensive, with action points and lessons learnt clearly identified.

Duty of Candour

- We found senior staff within the surgery service understood their responsibilities for duty of candour, and were able to describe giving feedback in an honest and timely way when things have gone wrong.
- Some junior staff were not aware of the term duty of candour, but when questioned were fully able to articulate how they would respond should a mistake happen. They appreciated the need for openness and honesty in the investigation of incidents.
- Senior staff told us the trust's incident reporting section incorporated a section on duty of candour responsibilities to confirm staff had shared information appropriately with patients and their relatives. Incidents could not be closed on the system until this information had been completed.
- The surgery service provided ward based learning and development days on duty of candour responsibilities in November 2015.
- Matrons told us they offered to meet with patients and families when incident investigations had completed. They provided investigation reports if requested.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheters and

associated urinary tract infections (UTIs). The surgery service collected Safety Thermometer data on a monthly basis and the results were made available to wards managers.

- There was good Safety Thermometer performance of 95-100% for harm free care across the surgery service for the two months prior to our inspection. In November and December 2015 there were no new serious grade 2-4 pressure ulcers, no falls with harm, no catheter-acquired UTIs and no instances of Meticillin-resistant staphylococcus aureus (MRSA), Meticillin sensitive Staphylococcus Aureus (MSSA) or Clostridium difficile (C Diff) infection on any of the surgery wards.
- Current Safety Thermometer results were not clearly displayed on the wards which meant this information was not available to patients and their families. Out of date Safety Thermometer data were displayed on the information board in Alexandra Ward, and no data was displayed on Astor Ward. Wards managers advised they feedback on ward performance to staff at handover meetings.

Cleanliness, infection control and hygiene

- All of the clinical areas we visited were visibly clean. The environment across the surgery wards and theatres was clean, tidy, well organised and clutter-free. All floors in corridors were clean. There was no evidence of dust. Infection prevention and control was generally well managed.
- The equipment we reviewed was visibly clean, but it was not labelled as clean and ready for use consistently across all clinical areas. On Canbury Ward, we saw that staff used green 'I am clean' stickers to indicate that equipment had been cleaned. We saw these stickers used on resuscitation trolleys, IV trolleys, ECG machines, hoists and weighing scales. The stickers were also used comprehensively in main theatres and the DSU, but we found sporadic use in other wards. For example, we did not find evidence of stickers on Alexandra Ward to indicate when equipment had been cleaned and by whom.
- There were low rates of surgical site infections at the trust. The surgery service undertook surgical site infection surveillance of selected procedures, which was coordinated by the Centre for Infections at Public Health England. The trust contributed data for repair of neck of femur, knee replacement and large bowel surgery site

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infection rates on a quarterly basis. For the period January to March 2015 the trust was performing comparable to the national average, with 1.1% of knee replacements and repair of neck of femur patients experiencing a surgical site infection compared to a national average of 1.6%, and 8.9% of large bowel surgery compared to 12.6% nationally. The surgery service had identified no trends or commonality in surgical site infections but recognised that some infections were the result of patients having comorbidities, which made them more susceptible. Surgeons involved dietician and tissue viability nurses in such cases.

- Housekeepers provided patients with hand wipes and ensured trays were disinfected before meal times. Patients were given hand wipes again when they finished meals.
- Infection prevention and control posters were prominently displayed throughout wards and in theatres. This included hand washing instructions.
- Cleaning rotas and duties were displayed clearly on ward information boards. We reviewed cleaning schedules on wards which were all up to date, fully completed and signed including who was responsible for cleaning different areas and equipment (HCAs and housekeepers). All cleaning recorded were complete for the two months prior to our inspection. There was a daily and weekly cleaning plan for the external cleaning contractors.
- There was easily accessible handwashing gel facilities located at the entrance to each ward, throughout wards, theatres and the day surgery unit.
- All staff were given hand washing instruction during their induction and orientation to the wards and theatres. Hand cleaning instructions were visible on wards and in theatres, with posters displaying information on the importance of hand washing. We observed clinicians, nurses and allied health professionals cleaning their hands and following hand hygiene procedures.
- Matrons conducted regular hygiene compliance walk rounds and assessment of the care environment reviews across all surgery clinical areas.
- The surgery service conducted monthly formal environmental hygiene audits and separately for hand hygiene compliance. Hygiene compliance across the hospital was reported in the trust's 'saving lives summary' dashboard. Between April and September

2015 the surgery service demonstrated variable compliance with hygiene processes and matrons were aware of 'hot spots' where performance needed to improve, particularly with hand hygiene. There was a hand hygiene action plan.

- There was easily accessible personal protective clothing such as latex gloves and plastic gowns and we saw staff using this appropriately when delivering care. We noted all staff adhered to bare below the elbows guidance in clinical areas.
- There were clearly documented checklists and algorithms in place for screening, management and post infection review of patient infections and outbreaks. The trust reported no incidents of Meticillin-resistant staphylococcus aureus (MRSA) and 14 incidents of Clostridium difficile (C Diff) for the period January 2015 to December 2015.
- Side rooms were used to care for patients where a potential infection risk was identified. This was to protect other patients from the risk of infection. Signs were in place at the entrance to side rooms which were being used for isolating patients, giving clear information on the precautions to be taken when entering the room. Cleaning staff did deep cleans of side rooms after patients in isolation bays were discharged. This involved top to bottom cleaning with disinfectant to ensure complete decontamination.
- We checked sluices on wards and in theatres and all were clean, tidy and well organised.
- The toilets and shower facilities we inspected were clean and tidy.

Environment and equipment

- All of the clinical areas such as theatres and wards we visited were calm, well organised and quiet. Wards were well laid out with adequate space to move and no clutter or trip hazards blocking walk ways. Patients on the wards looked comfortable. Theatre infrastructure across main theatres and the day surgery unit was well maintained. The DSU was purpose built and well laid out.
- We saw resuscitation equipment available in all clinical areas with security tabs present and intact on each. Systems were followed for checking resuscitation equipment. We saw checklists were completed daily and in full and audit and policy documents were

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present, signed and up to date for all resuscitation trolleys that we checked. All necessary trolley equipment was present and sealed as appropriate, and in working order.

- We examined log books for daily anaesthetic machine checks in four DSU theatres. Records were accurately completed and there were no gaps. We found several gaps in the log books of an anaesthetic machine in the emergency theatre in main theatres and we informed the matron of this.
- Theatre equipment was neatly stored in labelled in drawers. The theatre equipment storeroom was segregated and contained large pieces of equipment that were cleaned and stored away from theatres. Part of the room had racked shelving containing all disposable supplies. Theatre supplies were well managed using a 't-card' replenishment system.
- In theatres, red labels were affixed to broken equipment for action by the trust's electronics and medical engineering department.
- All of the staff we spoke with in theatres reported challenges with sterile equipment shortages. This included consultant surgeons, nurses, doctors in training and ODPs. All staff said equipment shortages and incorrect labelling of instruments were daily occurrences and this was the main problem in theatres. Nurses and ODPs told us there were insufficient surgical trays for listed procedures, such as hysteroscopy. Consultant surgeons told us they had insufficient consoles for drills for orthopaedics cases. They also reported incomplete sterile equipment sets from the trust's sterilisation service. We were told insufficient surgical equipment resulted in daily problems in effectively managing operating lists. Staff told us the problems were further compounded because shortages meant they had to open additional full sets to use one or two items missing from another set.
- Staff and senior sisters told us this had been a problem for many years and had been escalated multiple times as a concern to the theatre manager and associate director of sterilisation services. The trust's capital investment board was aware of this matter and we were told the trust had approved a business case for additional funding for surgical equipment. The sterile service team planned to implement 'track and trace' system and extend working hours.
- Theatre staff had identified risks of patients falling off patient trolleys in DSU with mechanical failures during

positioning for surgery, and staff injuries due to manual handling incidents. Risk registers highlighted all 30 trolleys in DSU were purchased more than 20 years ago. Due to wear and tear they had mechanical faults posing risks to patients and staff. The trolleys were due to be replaced in April 2015 from capital funding but the funds were diverted to other higher priority causes at the time. This meant the DSU was unable to operate on some high body mass index patients, resulting in delays and inefficiencies. As from January 2016, the trolleys will be out of contract and obsolete. This meant faulty trolleys would not be repaired and would to be taken out of circulation resulting in potential loss of activity and income.

- We saw patients were provided with zimmer frames, crutches, toilet frames and perching stools. In our presence, occupational therapists explained to patients how to use equipment and how to return items. They did this in a clear, patient and comprehensive way.

Medicines

- Evidence seen during our inspection showed medicines including controlled drugs (CDs) were stored and managed appropriately across the surgery service.
- The trust used an electronic prescribing system and nurses and pharmacists reported the system worked effectively and had improved the timely administration of patients' medication. Pharmacists told us the system enabled them to spend more time with patients on ward and reviewing drug charts.
- We observed three members of staff distributing medicines to patients. Nurses enquired about any allergies and confirmed the patient's name. One person dispensed medicines; another checked the computer workstation to ensure correct dosage. Nurses put patients own drugs back into the patients lockers. Nurses wore aprons with visible 'do not disturb, drugs round in progress' to ensure they could administer medications uninterrupted.
- In theatres, local anaesthetic drugs were stored in a separate trolley to medicines for general anaesthesia, in accordance with guidelines. Theatre staff had access to emergency drugs, which were stored securely on resuscitation trolleys.

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- We conducted a thorough review of medicines management on Astor and Canbury Wards during our inspection. Across both wards, treatment rooms were clean and tidy, with cupboards labelled detailing contents within.
- Keys to the drug cupboards and patient's own drugs (POD) lockers were held by registered nurses and the door to the room housing medicines were locked. The key to the controlled drugs cupboard was held by the nurse in charge.
- A small quantity of bulk fluids were stored appropriately in the treatment room. However, the majority of bulk fluids were stored securely in a store room just outside the ward, beside the treatment room with access restricted to appropriate personnel.
- Controlled drugs were audited on a daily basis by two nurses, with a separate signing sheet seen. Controlled drugs were correctly documented in the CD register. Although the CD register was stored outside the CD cabinet, access to it (within the treatment room) was restricted by an electronic keypad.
- Staff had access to a virtual British National Formulary (BNF) through the trust intranet, as well as all policies/information relating to medicines management.
- We saw drug trolleys were not chained to wall or immobilised when not in use. However, the medicines inside were appropriately locked by an electronic keypad.
- There was inconsistency in the recording of drug fridge temperatures. These were not recorded on Canbury Ward between 7- 10 January and again on 12 January. In operating theatre four of main theatres, there was no record of fridge temperature checks. Also the process of recording fridge temperatures was delegated to the housekeeper on Canbury Ward. When asked what would happen if the normal temperature of 2-8 Degrees went out of range, the senior sister stated the housekeeper would inform her and she would be responsible for taking the appropriate action to rectify the anomaly.
- Room temperatures were not recorded on a daily basis. The treatment room in Canbury was below 25 Degrees, but the treatment room on Astor was above 25 Degrees, which could be uncomfortable for staff and patients.
- There was a policy in place to support the use of patient's own drugs (PODs), however no green bags were seen containing PODs as outlined in the trust's medicines management policy.
- Both wards had a dedicated pharmacist available between 8:45am-4pm daily Monday to Friday. They were responsible for screening drug charts on CRS, medicines reconciliation, ordering of drugs from pharmacy, ordering discharge medication for patients and counselling certain patients on specific medicines usage such as inhalers.
- Nursing staff stated they were happy with the pharmacy service received out of hours (evenings and weekends). They commended the support and advice received by the on-call pharmacist.
- Staff competencies for prescribing, dispensing and administering medicines were assessed by dedicated induction processes provided by the trust, through the intranet portal. However, it was not clear how often nurses received regular training updates on a formal basis.
- Staff understood and demonstrated how to report medicines safety incidents. Incidents were escalated and fed back for learning through various channels, such as medicines safety newsletters, memos and face-to-face meetings.
- Allergies were recorded on the CRS drug charts. Ward pharmacists stated the drug record could not be saved and completed without filling in allergy information. This acted as a fail-safe mechanism to reduce errors.
- Omitted/delayed doses were recorded by CRS and flagged for review. This prompted reporting of medicines incidents.
- Nursing staff stated delays to discharge medication were impacting on timely discharge of patients. This was identified as a particular issue on weekends.

Records

- The surgery service used the trust's electronic patient record (CRS) to record and access patients' records. This was available to doctors, nurses and other healthcare professionals. All professionals in the care of a patient recorded information in chronological order in the clinical notes section. This meant recording errors from illegible writing were virtually eliminated. We observed nurses and allied health professional using the CRS and saw they were comfortable and adept at using the system.
- We accessed the electronic patient record system with the assistance of a ward nurse. We reviewed five patient

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records and found patient notes were completed in a logical and comprehensive way. The clinical notes provided a good description of care plans, observations and patient progress.

- Paper copies of patients' previous medical notes were stored in secure trolleys on the wards. Records were confidentially stored and not left open or on display. The CRS required password access to ensure security. Staff members had unique accounts to ensure professional accountability. Temporary staff were also allocated logins.
- Nursing assessments were completed, including vital observations and early warning scores, falls assessments, assessment for pressure areas (Waterlow score), venous thromboembolism (VTE) assessment and nutritional status (Malnutrition Universal Screening Tool - MUST), drug charts, and safeguarding status. Care plans included all identified care needs.
- The CRS flagged patients who were at risk of falls, those with MRSA or CDiff. The system also provided an alert for patients with learning disabilities or dementia so all staff were aware of a patient's specific needs.
- Ward managers conducted daily audits of patient records to ensure they were updated and complete. During our inspection two out of 25 care plans were not initiated within 24 hours.
- The electronic patient record ensured that patients cannot be prescribed medication if the VTE assessment is not completed by the admitting doctor.
- Staff were alerted to incomplete record sections by CRS system prompts.
- Information governance was part of the mandatory training programme staff were required to attend. The trust target was 80% of staff having completed the training. Across all surgery service lines, 86% of staff had completed training.

Safeguarding

- There was a trust wide policy for safeguarding vulnerable adults and children. The policy and protocol for safeguarding referrals was available for staff to access via the trust's intranet. The trust's Deprivation of Liberties Safeguards policy and process was also available for staff to access on the trust intranet.
- The staff we spoke to were able to explain their understanding of safeguarding and the principles of

safeguarding for children and adults. They were clear about the trust's safeguarding escalation process.

Doctors in training and nurses were confident to seek safeguarding advice from their line managers.

- Safeguarding information, including contact details for the trust's safeguarding lead was displayed on posters in wards. Ward staff told us the safeguarding lead was accessible and responsive. There was also a child protection and safeguarding medical lead within the trust.
- Safeguarding concerns were also discussed at RAG meetings and in handover which ensured all staff were aware of new and ongoing concerns. There was a monthly safeguarding forum held at the trust, which surgery matrons and band 7 nurses attended.
- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral. We were given examples of concerns they had identified and referrals made.
- Patients we spoke with told us they felt safe in the hospital.
- There was good completion of mandatory safeguarding training within the surgery service. Safeguarding awareness was included in corporate induction and additional safeguarding training was available to staff depending on their seniority and role. The trust's target was 80% of staff having completed mandatory safeguarding training. Across all surgery service lines, 86% of staff had completed safeguarding vulnerable adults training and 87% of staff had completed safeguarding children training.
- The trust did not have a policy or guidance on female genital mutilation (FGM) awareness and reporting. Clinicians told us FGM was not a concern within the local patient demographic, but doctors and nurses felt comfortable in managing and escalation concerns in this area.

Mandatory training

- The trust target for staff completion of mandatory and statutory training was 80%. At the time of our inspection, compliance with mandatory training for all surgery service lines was 80.8% across all staff groups, with general surgery and urology reporting the lowest level of compliance at 69%.

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- The mandatory and statutory training programme covered equality and diversity, health and safety, basic life support, infection control, information governance, adult and child safeguarding, fire safety, manual handling and conflict resolution.
- Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed, or refreshed.
- Newly appointed staff were required to complete a corporate induction and a subsequent ward or theatre based induction. The second part of induction included orientation to the clinical area, mental capacity awareness training, using medical devices, moving and handling and medications management. Newly qualified nurses and doctors in training told us some mandatory training was e-learning via an online portal, however they told us mandatory training and induction relied heavily on staff reading a training booklet. We were told there were no assessments at end of online training to test comprehension and understanding. They felt some of this training was repetitive and would value more practical learning opportunities. Staff told us they were encouraged to complete mandatory training at home in their own time.

Assessing and responding to patient risk

- Patients' clinical observations were recorded and monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) system was used to measure patients' vital signs and identify patients whose condition was at risk of deteriorating.
- We saw staff in surgical wards recorded the observations of patient safety parameters such as heart rate, respirations, blood pressure, temperature and pain. These were recorded in patients' notes on the CRS. Patients were assessed for actual and potential risks related to their health and well-being and we saw evidence of these in notes.
- Nurses assessed patients' fluid intake and output multiple times per day. Fluid balance charts were completed in patient records on CRS and the system automatically calculated a patient's daily input/output and total fluid balance.
- The trust's escalation protocol for unwell patients was clearly displayed in a poster on the wall by staff computer stations.

- Nursing staff told us they would call a doctor if they were concerned about a patient. Nurses reported a very prompt response to emergency calls by doctors and the trust outreach team. Doctors assessed patients and nurses took over once the patient was stabilised and a care plan was in place.

Use of the 'five steps to safer surgery' procedure

- The surgery service completed safety checks before, during and after surgery as required by the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organization (WHO) surgical safety checklist. We found evidence of good compliance with the surgical safety checklist, with good completion of the three compulsory elements: sign in, time out and sign out. A daily pre-briefing was held in theatres each morning before lists started, but we did not find evidence of end of list de-briefings to complete the five steps.
- A perioperative safety checklist codified the actions needed to be taken by theatre staff before the list started, before induction of anaesthesia, before skin incision and before the patient leaves the operating theatre. The completed checklist was filed in the patient's notes.
- We followed the patient pathway through a number of different surgical procedures in main theatres and the Day Surgery Unit. In all of the procedures we witnessed staff completed the checklist comprehensively. All staff present were attentive to the process.
- The surgery service audited WHO checklist compliance on a monthly basis, covering main theatres and DSU. The audit reviewed compliance in emergency, urology, general surgery, trauma and orthopaedics using an audit tool based on guidelines by the Association for Perioperative Practice (AfPP) to bench mark against standards.
- The audit found very good general compliance with completing the checklist across the service, for example, most specialities in theatres completed the team brief, sign in, time out and sign out appropriately. Between October 2014 and October 2015 the audit reported average monthly compliance of 95% in main theatres and 100% compliance in DSU. The consistently high results reported in audit meant there were no recommended action to improve compliance.

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Nursing staffing

- Nurse staffing requirements were based on acuity measures. Safe nurse staffing levels were updated using a safe care e-system. The acuity tool used was the Safer Nursing Care Tool, which measured the number of required nursing shifts based on acuity of patients and automatically risk rated the requirement. Matrons reviewed handover sheets twice daily from each wards to assess high risk patients and make decisions about staffing needs and bed management. Full nurse staffing requirement was measured annually using detailed patient acuity measure. These audits were completed by the ward manager or shift leader and validated by the matron and head of nursing.
- Matrons told us nurse staffing levels were adequate and the wards were nearly at full establish after a period of some flux and rota gaps. There were some isolated problems with retention of nursing staff on some surgery ward but this was being managed appropriately. The service was actively recruiting nurses from overseas to fill rota gaps.
- Trust data demonstrated high usage of temporary (bank and agency) nurses on surgery wards. Matrons told us bank and agency usage had been quite high because there were gaps in the rota. Newly recruited nurses from overseas worked as healthcare assistants (HCAs) while they were inducted and upskilled which meant wards did not have a full contingent of qualified nurses. Matrons told us surgery wards used on average four to five temporary nurse shifts each week.
- Ward managers told us internal bank nursing staff were used as a preference to cover shifts, but agency staff were employed when necessary. Staff told us the service tried to use known agency workers and there were a number of regular, long term agency nurses which provided some stability.
- There were effective nursing handover processes to ensure transfer of information between staff at the end of each shift. Two scheduled handovers took place every day in wards at 7.15am and 7.15pm. Ward managers informed us the Situation, Background, Assessment, Recommendation (SBAR) structured communication tool was used to transfer crucial patient information between nurses starting each shift. Nurses told us handover was concise and focused. Student nurses reported handover was robust and thorough and helped them to plan the day ahead.

- Nurses told us they were happy and felt supported in their work. They reported variable work intensity, which depended on the acuity of patients on the ward. Nursing shifts were 37.5 hours per week, over four days in one week, and then three longer days the next week.
- The trust used an online rota system that staff could access remotely. Staff said it was very helpful and each nurse had their own login. They could review who they were working with on different shifts. Nurses told us they could swap shifts on the system and could request annual leave and bank shifts.
- Ward clerks told us staffing cover was not available when nurses went on breaks. Ward clerks reported they regularly had to keep patients relatives waiting on the phone while they try to locate a nurse.

Surgical staffing

- Surgical treatment at Kingston Hospital was consultant led. There was a stable cohort of consultant surgeons and anaesthetists working in the surgery service and many doctors we spoke with had worked at the trust for many years.
- The surgery service had a comparable percentage of consultant surgeons compared to the England average, with 42% of medical staff at consultant level compared to a national average of 41%. There was also comparable numbers of higher tier doctors in training (ST1-6 grades) with 37% compared to 37% nationally. There were slightly more foundation doctors in surgery posts at the trust, with 16% compared to 12% nationally.
- Service leaders reported no problems with recruitment and retention of clinicians. Trust data highlighted low levels of temporary (locum) doctor usage, with some usage of long term locums to cover known gaps in the rota. There were lower tier doctor in training (SHO) post vacancies in some surgical specialties as a result of changes to the allocation of training posts by Health Education England. The service was actively recruiting clinicians from overseas to fill rota gaps and two doctors had started in post prior to our inspection.
- The surgery service was investigating innovative options for new models of working and building capacity within the medical rota, such as employing physician assistants to support routine surgical cases.
- Arrangements were in place to ensure adequate surgical out of hours and weekend cover. Consultant surgeons

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were on call out of hours, rather than resident within the hospital. There were resident trauma surgeons on site during weekends. Doctors in training were resident on weekend shifts, including foundation doctors.

- Doctors in training told us they felt well supported by consultants and reported good access to supervision, teaching and advice. Consultants reported positive feedback from doctors in training and locum doctors.

Major incident awareness and training

- There was a major incident plan and policy, along with a major incident information folder in the ward manager's office on each surgery ward. The folder contained a printed copy of the policy and protocol, staff contact details and action cards with instructions for different staff roles. There was a major incident and emergency planning manager for the trust.
- Matrons told us the first stage of the trust major incident protocol was the issue of a special bleep for major incidents. Matrons were expected to contact all staff to come in for emergency shifts. Nurses would review all patients on wards to identify those who could be discharged to free up beds.
- There were protocols for deferring elective activity to prioritise unscheduled emergency procedures. Elective surgery lists would cease in the event of a major incident.
- Nurses were aware of the major incident plan and where to access emergency information. They were aware Alexandra Ward was a designated emergency ward during a major incident.
- Matrons reported the trust conducted regular emergency communications exercises but had not done a full major incident exercise for over a year.

Are surgery services effective?

Good



We rated the surgery service at Kingston Hospital as effective. This was because:

- There were good patient outcomes across surgical specialties.
- Care was delivered in line with relevant national guidelines.
- The trust performed well in national clinical audits.

- There were short length of stay and low readmission rates.
- All of the patients we spoke said they had effective and timely pain relief.
- Doctors in training and newly qualified nurses felt well supported with good supervision and good training opportunities.
- There was good multidisciplinary team (MDT) working between doctors, nurses and allied health professionals.

Evidence-based care and treatment

- Staff accessed policies and corporate information on the trust's intranet. There were protocols, policies and guidance for clinical and other patient interventions and care on the intranet.
- We reviewed a sample of trust policies for surgery and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- The trust's policy for recognition of and response to acute illness in adults in surgery services was provided in line with NICE CG50 guidance (see assessing and responding to patient risk in safe section).
- The trust was amongst the first in the UK to be accredited by the Royal College of Anaesthetists Anaesthesia Clinical Services Accreditation scheme (ACSA).
- Surgical pathways were delivered in line with referenced national clinical guidance. Senior service leaders reviewed their service outcome data, such as Patient Reported Outcome Measures and National Joint Registry compliance.
- Implementation of new guidelines and regulations was managed by clinical leads, heads of nursing and service line managers. The trust's head of clinical audit and effectiveness disseminated new national policies guidelines to service leads, and each service line conducted a gap analysis of existing local protocols and policies to ensure full compliance. This was reported at risk meetings for each service line.
- There was a comprehensive clinical audit programme for 2015/16 document which highlighted the surgery service's involvement in local and national audits. The service was on track to complete all outstanding audits.

Pain relief

- There were effective processes in place to ensure patients' pain relief needs were met and pain was well managed in the surgery service.

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- Staff on wards did intentional rounding every two hours to ask patients about their comfort, including pain levels. This information was recorded. We witnessed nursing staff regularly asking patients whether their pain was being effectively managed and if they were comfortable. Patients told us nurses were responsive to pain relief needs. All of the patients we spoke with were aware they could use the call bell to request additional pain relief.
- For those patients unable to take medication by mouth, pain relief also included patient controlled analgesia (PCA) and epidural infusion. Service leaders reported sufficient pain management equipment including dedicated epidural pumps.
- Pain was assessed using a 10 point scale for measuring pain in adults. This included observing the patient and identifying any behaviour that indicated pain. There was a separate pain scale for children and young people: children observation and severity toolkit (COAST). Pain scores were record on the electronic records system and there were specific monitoring forms for patients with PCAs or epidurals.
- There was a dedicated acute pain team at the trust with four consultants, two chronic pain nurses and physiotherapy support. They provided a consulting service for chronic and acute pain across the hospital. Nurses told us the pain nurses were very accessible and helped to review patients on a daily basis. We were told they provided very good guidance and teaching, including whole ward updates on pain management.
- Nurses received training in pain management as part of mandatory training.
- Anaesthetists at the trust conducted an annual pain audit in the surgery service, including theatre recovery and wards. The audit outcomes had resulted in changes to pain management practice, for example, in theatres, patients were given oxycodone after their procedure, but anaesthetists found this wore off quickly so theatre processes were updated so patients could be additionally prescribed morphine for more effective pain relief.

Nutrition and hydration

- The trust used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk of malnutrition. The accredited screening tool also screened patients at risk of obesity. Where patients were identified as at medium or high risk of malnutrition,

food intake was to be recorded, and the patient was to be encouraged and given assistance with meals. The meal hostess was also alerted on the menu card. Patients identified as at risk of dehydration also had fluid balance charts to monitor fluid intake and output.

- There were regular protected meal times on surgical wards and we saw these were respected by staff and visitors. This meant all non-urgent activities on the ward would stop and patients would be positioned safely and comfortably for their meal and staff would assist patients with their meals as necessary.
- Dietary plans were included in patient care plans.
- Nurses monitored patients' intake of food and health care assistants were instructed to assist patients who required additional help. The hospital also had a number of volunteers who helped patients with eating.
- Patients told us nurses ensured they were kept well hydrated. Hot and cold drinks were provided throughout the day.

Patient outcomes

- The trust contributed to relevant national patient outcome audits and performance in national and local audit was presented at regular planned audit team meetings.
- The overall average length of stay for elective patients was shorter than the England average and marginally longer for non-elective patients. Length of stay (LOS) for patients having elective procedures was better than the England average for the top three specialties whereas it was in line with the national average for non-elective LOS.
- The standardised relative risk of readmission for both elective and non-elective admissions was lower than the England average.
- The trust's scores in the 2014 national hip fracture audit were better than the England average for eight of the nine measures recorded. In the one area where the Trust scored below the national average of 46.1%, (admission to orthopaedic care within four hours) they had improved considerably from the 2014 audit results of 14.1% to 35.6%.
- The trust was rated as green (80-100%) for final case ascertainment in the 2015 National Emergency Laparotomy Audit (NELA). Four out of Ten measures were rated as yellow (50-69%), four as green (70-100%).

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Two measures rated as red (0-49%) were consultant surgeon review in within 12 hours of emergency admission and assessment by a care of the elderly specialist in patients aged 70 or above.

- The trust was in line with England averages in the Lung cancer audit 2014.
- The trust's performance in the Patient Reported Outcome Measures (PROMs) worsened for the groin hernia measurement in 2015. PROMs measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.
- The trust performed better than the England average in the 2014 bowel cancer audit with a case ascertainment and data completeness rate of more than 80%. 100% of CT scans were reported better than the England average of 89.3%. However, patients discussed at MDT level and patients seen by a specialist nurse were worse than the England average.

Competent staff

- There was very good completion of annual staff performance appraisals in the surgery service. Information provided by the trust for all surgery service lines showed 94.4% of surgery staff had received an annual appraisal in 2015 (up to the time of our inspection). Staff told us appraisals were used to identify learning and development needs.
- Surgeons and anaesthetists in the hospital participated in the GMC revalidation initiative for all UK licensed doctors to demonstrate they were competent and fit to practice. At the time of our inspection 100% of eligible doctors had completed revalidation.
- The trust participated in the NMC nursing revalidation scheme for all UK registered nurses. Senior staff told us they were aware of the implementation date and conducting ongoing work to prepare for revalidation.
- Specialty doctors in training told us Kingston Hospital was a very good place to work with approachable and supportive consultants, good supervision and good access to teaching and learning opportunities.
- The trust provided funding for staff continued professional development, which could be used for external training courses.
- Newly qualified nursing staff reported a supportive learning environment on surgery wards. They were

allocated a mentor to help with orientation and competency development. Nurses told us there were opportunities to develop their careers at the trust and to specialise if they wished.

- Nurses told us they had in-house training study days on completion of records, assessment of pain, using medical equipment and wound dressing.
- There was training in risk management and incident investigation available for all staff within the trust.

Multidisciplinary working

- There was an effective multidisciplinary team (MDT) working environment within the surgery service at Kingston Hospital. We found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.
- Patient records demonstrated input from allied health professional including physiotherapy, dieticians, occupational therapists, pharmacists as well as the nursing and medical teams.
- Nurses reported good access to and effective support from physiotherapists, occupational therapists, the trust pharmacy team and the palliative care team.
- Physiotherapists provided advice on exercises to improve mobility before and after surgery. Occupational therapists gave advice on aids and strategies to maximise independence and liaised with social services on behalf of patients and provided advice on any support patients may be entitled to.
- Some patients said they would value more time with physiotherapists, but they reported good levels of support from physiotherapists and told us their input had helped with recovery after their procedure.
- We saw multidisciplinary working evident on surgery wards: physiotherapists and occupational therapists were part of daily ward board rounds on a weekday basis.
- Wards had weekly multidisciplinary team (MDT) meetings to discuss patients, with input from consultant, doctors in training, ward managers, the discharge coordinator, physiotherapists and occupational therapists, and other allied health professionals as required.
- Ward staff had access to the full range of allied health professionals such as speech and language therapists, dietitians, tissue viability, and specialist nurses. Where

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allied health professionals had been involved with patients this was recorded in the CRS. Discharge coordinators were also based on the wards to facilitate social care packages for patients on discharge.

- There was good pharmacist support on the wards and they provided information to patients on their medication usage.

Seven-day services

- The hospital delivered a full service on six days, with on call availability seven day per week. Operating theatres were used on Saturdays for elective and priority list patients.
- There was a reserved emergency operating theatre, as recommended by the NCEPOD report (1990). This theatre (theatre 7) was available 24 hours per day seven days a week for emergency and trauma cases.
- Arrangements were in place to ensure adequate out of hours cover on surgical wards. Consultant surgeons were on call, rather than resident within the hospital. There were resident trauma surgeons on site during weekends. Doctors in training were resident on weekend shifts, including foundation doctors. Nurses reported that doctors were responsive to attendance requests.
- Some patients were aware of the limited availability of doctors at weekends. In some cases they felt this had delayed decision making about their care and treatment.
- Staff reported there was seven day availability of all diagnostic services including imaging and laboratory facilities. They told us they did not encounter any problems with diagnostic services out of normal working hours. There was a 24/7 endoscopy rota and the department was trialling Sunday morning lists for routine endoscopy.
- Physiotherapists and occupational therapists were available on site during weekdays and provided on call service to the surgery wards at the weekends.
- Pharmacy services provided on call service out of hours and at weekends. Nursing staff did not report any problems accessing pharmacy support.

Access to information

- There were information posters on the walls by ward computer workstations for staff reference. These included the trust's unwell patient escalation protocol, daily review of patients checks, principles of care for

dying patients, dietetic referral process, chaplaincy access, MUST assessments guidance and sepsis identification guidance. This information was clearly displayed and easily accessible.

- Notice boards along the ward corridors were neatly organised with information for staff and patients, including visiting hours, protected meal times and senior nurse contact details.
- Staff with access to computer workstations were able to access test results electronically. Access to patients' diagnostic and screening results was good. Computer stations with intranet and internet access were available on the surgical wards for staff to use.
- There were adequate number of computers on wheels for staff to access patient information on wards and prevent clashes of need.
- In the main theatres recovery area there were four manuals of departmental guidelines for all staff to refer to. At the back of each file was a list of all staff that had signed and dated to indicate they had read the contents.
- The surgery service introduced a 'big four' communication tool, which was a large laminated poster displayed on wards and in theatres with four key messages updated each week. Junior nurses said they valued this weekly information update because it ensured they were kept up to date with key messages.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us staff explained treatment and care and sought consent before proceeding. All patients we spoke with said they had been given information about the benefits and risks of their surgery before they signed the consent form.
- There was a trust policy for Consent to Examination or Treatment. The trust audited service line compliance with the policy on an annual basis to ensure that when a patient has undertaken a procedure requiring written consent, the consent form was scribed in accordance with national standards and the local policy.
- The most recent audit found consent processes were working well, with appropriate staff taking consent, and required fields in consent documentation well filled out. The audit recommended improved provision of procedure specific leaflets for common surgical cases.

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- There was mandatory training for all staff in the Mental Capacity Act and Deprivation of Liberty Safeguards. It was included in the trust's mandatory training. Records showed 86.5% of surgery staff had received this training.
- Staff told us they knew who to contact for advice in cases where a patient may require safeguarding support. Staff we spoke with were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS), and told us they would refer patients to the trust safeguarding team if patients required a MCA referral. DoLS applications were also dealt with by the safeguarding team.
- Senior nurses told us they involved patients' family members and carers, social services, clinicians and the MDT in best interest meetings to help make collective agreed decisions regarding DoLS or MCA referrals.
- There were three learning disability specialist nurses within the trust who provided ward based training on MCA and DoLS principles, application and processes. Large posters were displayed on wards with the photo and contact details of the specialist nurses so that staff could access their support when needed.
- Doctors and nurses explained they treated a number of patients who had delirium. We were told the trust had promoted and raised awareness of MCA amongst staff to make it the norm within review processes. Ward staff used a 'forget –me-not' list which contained essential information about identifying and referring mental capacity support needs.
- Ward managers and nurses reviewed the MCA status and needs of all patients on the ward during RAG board meetings.

Are surgery services caring?

Good



Overall we rated the surgical services as good for caring. This was because:

- We found staff across the surgery service were friendly, caring and professional.
 - Patients told us nurses and doctors had a caring approach despite being very busy.
 - We saw staff communicating with patients in a polite and caring way.
- Patients were treated with dignity.
 - Friends and Family Test results were consistently very good across surgery wards with a good response rate.
- However;
- Some patients reported long wait times in nurses responding to call bells, particularly at weekends.
 - Some patients and family members felt nursing staff were sometimes patronising of elderly patients. They felt the provision of information for elderly patients could be improved.

Compassionate care

- The majority of patients we spoke with were very happy with the care and treatment they had received while in hospital. Direct comments from patients, which were representative of this feedback included: "staff are very caring – they check everything is ok", "staff are friendly and will chat with us. Everyone is respectful, "staff are very kind and give you their full attention", "I feel safe here, staff give you the attention you need within minutes". This was a common theme in all the feedback we received. Patients' relatives and carers also provided positive feedback on the quality of care.
- Friends and Family Test (FFT) results were consistently very good across surgery areas. For the period September 2014 – August 2015 the surgery service received an average response rate of 36.4% comparing similar to an England average of 35%. Astor ward received consistently the most responses by patients with a 80.3% response rate averaging 90% recommendations. Alexandra ward had a response rate of 40% and 93.5% recommendations. Canbury ward had a response rate of 80.3% and 92% recommendations. Cambridge ward had a response rate of 29% and 89.8% recommendations.
- The Albany unit received 100% recommendations for December 2015 from 20 responses.
- Patient experience information boards were displayed at the entrance of each ward. They displayed FFT results, staff award nominations, patient comments, and 'you said we did' feedback. The wards were transparent in displaying the concerns identified by patients, which included communication, staffing levels and waiting times.

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- Senior nurses and matrons were proud of the quality and compassion of the care delivered by their staff. We saw evidence of many thank you cards from patients displayed around the nurses' stations on wards.
- We heard the ward clerks speaking with visitors and telephone callers in clear, calm and polite way.
- We followed a number of patients in main theatres during their procedures. We observed all staff interact with patients in a professional and pleasant manner. At all stages of the procedure, the patient was treated with dignity and respect. We also followed a patient through the day surgery unit. Nurses, anaesthetic staff and surgeons were all courteous and polite to the patient and clearly explained different stages of the procedure before starting treatment.
- Patients told us nurses were responsive to their requests. Call bells answered promptly during weekdays, but we were told this was less so at weekends and at night because there were fewer staff and they were very busy. Nurses recognised this and said more nurses at night and weekends would allow them to be more responsive.
- Patients on Alexandra Ward told us they saw one male patient walking around the bay with no clothes on and disturbing other patients at night time by rattling their beds. Some of the patients found this unsettling. We were told that security staff came to sit with the patient, but other patients were concerned for their safety, and for the patient's mental health and dignity.
- Some patients and their relatives felt some nurses treated elderly patients in a childlike and patronising way. Some patients were concerned that if they did not have family to advocate for them they would not have received timely treatment or full information. Some of the elderly patients we spoke with felt they were not "fully kept in the picture" and information provision could be timelier, particularly regarding discharge arrangements and post-operative care.

Understanding and involvement of patients and those close to them

- Patients on surgery wards and in the day surgery unit told us pre-assessment by consultant surgeons fully explained the risks and benefits of the procedure and provided information about after care and home support.

- Information boards and posters for patients, family members and carers were located at points throughout each ward. These included a guide to staff uniforms, photographs of the responsible matron, ward manager and nurses, and contact details for ward staff.
- In theatres, relatives and carers of children, and patients with learning difficulties or specific needs were allowed into the admissions and recovery areas to keep them company and help them feel more secure.

Emotional support

- There were specialist nurses within the trust who supported patients with stomas. They provided emotional and practical support to help them prepare to go home after discharge. There were also colorectal cancer support nurses and urology oncology support nurses. The specialist nurses met many patients before their procedure to provide a friendly face for patients when they were cared for on a ward after their procedure.
- Ward staff attended weekly multidisciplinary team (MDT) meetings, which were used to identify patients' support needs, including emotional support.
- Senior nurses received training in communicating difficult messages in a sensitive way, as well as training in conflict resolution.
- Nurses told us they received good palliative care awareness training, which included consideration of the needs of patients and their family members at a very sensitive time.
- There were staff in the hospital that provided for patients' spiritual needs, including a priest, rabbi and an imam.
- All of the nursing staff we spoke with on surgery wards demonstrated a very compassionate approach and we observed nurses carefully listening to patients and providing reassurance.

Are surgery services responsive?

Good



We rated the surgery service at Kingston Hospital as good for their responsiveness to patients' needs. This was because:

Surgery

- The trust provided a number of services to improve outcomes for local people, including the Albany unit - a 'one-stop' assessment and investigation facility for a number of outpatient surgical procedures.
- Patient flow from admissions, through theatres and onto to surgery wards was satisfactory and bed availability was managed effectively.
- In the Day Surgery Unit (DSU) there were dedicated operating lists for 11 specialties.
- There were very good systems and provision of care for patients with complex needs, such as those with learning disabilities and dementia.

However;

- There were some incidents of sub-optimal pre-assessment leading to cancellations on the day scheduled for the operation.

Service planning and delivery to meet the needs of local people

- The trust was working to meet the needs of local service users and improve health outcomes for local people.
- The trust worked collaboratively with commissioners and other NHS trusts in Surrey and South West London to plan and meet the needs of the local population. Senior clinicians and service managers told us they had regular communications and constructive working relationships with commissioning bodies.
- The trust had very good links with local healthcare providers as part of the South West London clinical network. The trust worked collaboratively with local hospital trusts including the Royal Marsden NHS Foundation Trust for provision of pelvic cancer surgery, and St George's University Hospitals NHS Foundation Trust for otolaryngology services. The surgery service was working with partner trusts to repatriate some work back to Kingston Hospital such as bariatric services.
- The trust was part of the South West London cancer network, with close contact with regional centres at other hospitals.
- Surgeons at Kingston Hospital conducted orthopaedic surgery in partnership with surgeons from three other local trusts at the South West London Elective Orthopaedic Centre in Epsom.
- The trust had one stop imaging and endoscopy units to streamline services and improve provision for local patients.

- The trust's complex amputations service was a tertiary centre that provided services to patients from across south London and Surrey.
- The Albany unit provided a 'one-stop' consultation, investigation and minor procedures facility for a number of services including outpatient general vascular and urology clinics for adults and children. The unit also provided outpatient clinics for urogynaecology, urodynamics, prostate cancer, haematuria and flexible cystoscopies. Patients' appointment lasted an average of 90 minutes for consultation, imaging and procedure. Staff told us the unit had improved efficiency and had particularly helped elderly patients and young children as it allowed clinicians to do all assessments and communication in one appointment. The unit was consultant led. Staff told us there were plans to audit this provision and extend the single appointment outpatient model to other surgical services.
- The surgery service was seeking more engagement with its local clinical commissioning groups (CCGs). The CCGs had set certain challenges for the service, such as routine dental extractions which was impacting on the service's capacity to do other procedures. The trust had liaised with local commissioners to transfer some referrals to primary care and community providers.
- The service had identified unmet demand in dermatology and plastic surgery as a result of limited capacity and environmental constraints within the hospital. This was recorded as a risk on the service risk register.
- Independent, fee paying patients were able to access surgery services via the Coombe Wing, which was a dedicated 22 bed outpatient and inpatient unit run by an external provider in partnership with Kingston Hospital.

Access and flow

- The flow within the surgery system was well managed and we found effective patient pathways from admission, through theatres and on to the wards.
- Overall theatre utilisation, across all surgical specialties was at 73% for the period July – September 2015. Theatre leads told us both main theatres and the DSU were operating at above 80% utilisation in the month preceding our inspection, against a local target of 83%.

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- The trust utilised The Productive Operating Theatre tool to improve efficiencies. There was also a theatre user group and an enhanced theatre productivity group, with fortnightly meetings led by the trust medical director.
- We found theatre lists in the day surgery unit were not based by procedure type, for example, general surgery and orthopaedic procedures were mixed in the same session list. This could have potential risks for cross-contamination and infection prevention and control.
- Theatre staff prioritised different patient groups in day surgery unit operating lists, with priority given to elderly patients, children and young people, and patients with learning disabilities.
- In main theatres and DSU recovery, adults and children were cared for in same space. There was no separate space for children to recover, but we were told paediatric patients were transferred to the paediatric ward once they were extubated and had a safe airway. Paediatric patients in DSU were cared for by qualified paediatric nurses, but there were none in main theatres. However two nurses had paediatric life support training and a consultant paediatric anaesthetist remained with the patient until their airway was safe and the patient was awake.
- Referral to treatment within 18 weeks was below the national standard of 90% and mostly below the England average for the period April 2013 – June 2014. From July 2014 to February 2015 referral times improved and were mostly above standard and the England average.
- Referral to treatment per specialty for the period September 2014 – August 2015 met national standards, with the exception of plastic surgery.
- There were no instances of patients not treated within 28 days between April 2013 and April 2015. Between June 2014 and April 2015 fewer than 10 patients were not treated within 28 days.
- There were few cancelled operations. As a percentage of elective admissions, the trust performed better than the England average between April 2013 and April 2015.
- Consultants reported some challenges with pre-assessment of patients, which was causing problems with high number of patients not attending or attending at the wrong time. They were also concerned notes were not available for some patients and some patients were not correctly pre-assessed. These concerns were recorded on the corporate risk register for the service.
- Bed management within the surgery service was effective. Bed management meetings were held three times per day attended by nurses and managers. However, the nurses we spoke with told us engagement by doctors in bed management could be improved to improve consistency and patient flow.
- We were told beds in the main orthopaedics wards (Cambridge and Canbury) were notionally ring-fenced and were only used for non-surgical patients as a last resort.
- There were few medical outlier patients on surgery wards. Surgery nurses told us medical patients were occasionally allocated to surgery wards if there were bed shortages elsewhere in the hospital. Ward managers ensured only low risk and non-critical medical patients were allocated to surgical wards and required full patient information such as care plans and discharge arrangements and a named consultant physician for support.
- Although there were few medical patients allocated to surgery wards, nurses told us they frequently cared for surgical patients with comorbidities. They told us physicians provided adequate support and were accessible.
- Discharges from hospital were completed by the nurse in charge with support from a doctor. Nurses ensured all medication, transport arrangement and discharge letters were ready. Nurses told us there were some discharge delays due to wait for pharmacy drugs.
- In the Albany unit there were separate waiting areas for adults and children. The service also held paediatrics only clinics held on Monday mornings.

Meeting people's individual needs

- The surgery service proactively considered and responded to specific individual needs, including patients with complex needs and cultural and religious requirements.
- The trust provided comprehensive support for patients living with dementia. There was a dedicated dementia improvement lead within the hospital, which was a trust wide role to improve support for patients in the hospital environment. Nursing staff told us this was a very visible role that had resulted in a number of positive interventions, including a carer's support pack, therapeutic activities and a memory café to provide a communal space for patients to engage in group activities.

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- There was an open visiting hours policy and a free car park provided for carers and relatives of patients living with dementia. Family members and carers were offered beds to stay overnight if needed. Staff told us about the trust's engagement with 'John's campaign', which promoted the rights of people with dementia to be supported by their carers in hospital.
 - There was a finger food menu available for patients with dementia which provided a varied selection of easy to eat food for patients who were unable to use cutlery or unable to sit for a main meal.
 - The trust's dementia improvement group and environment group provided training and troubleshooting for clinical staff.
 - The trust had introduced new calming colour schemes on wards to improve the patient experience for patients with dementia.
 - A symbol of a blue flower was used above ward beds to indicate a patient living with dementia. Patients with dementia were usually placed in a bay near to the nurses' station to provide close supervision.
 - The trust's electronic patient records and information system provided an alert system for patients with learning disabilities or dementia so all staff were aware of a patient's specific needs.
 - The trust used a patient passport system to ensure specific needs and preferences were considered during all hospital attendances. Staff worked with patients' carers and families to find out more about individual patients and any concerns or issues.
 - There were three learning disability specialist nurses within the trust. A poster was displayed on the wards with the photo and contact details of the specialist nurses so staff could access support.
 - Staff had access to communication tools for patients with learning disabilities such as picture cards. They felt confident to use these tools.
 - The trust provided targeted support for patients with learning disabilities. The surgery service worked with the learning disability coordinator from Richmond and Kingston Learning Disability community team to improve care management for patients with behavioural issues. Morning briefings in theatres highlighted any patients with learning disabilities to ensure staff were prepared.
 - Dedicated clinics were set up for patients living with learning disabilities to provide a calm environment.
 - Translation services were available for clinical decision making and most staff were familiar with the process for booking an interpreter. Translation services were provided via a telephone interpreter and also by face-to-face interpreters. However, staff told us local patient demographics meant surgical wards did not frequently require interpreters. Some staff told us they would consult the ward manager to arrange translation provision.
 - We found nurses relied on family members to provide translation services. Nurses told us they often encouraged family members to translate on behalf of patients on wards.
 - Nurses told us there was a list of trust staff who speak different languages. Staff in surgical wards also used a printed document containing basic words in other languages to support communication needs for patients who did not speak English as a first language.
 - Patients told us nurses were observant of specific cultural and religious needs, for example, religious compliant dietary needs were addressed appropriately.
 - Equality and diversity awareness was part of mandatory training for all staff. This was provided as a booklet and staff were required to confirm they had read it. There were staff groups for different affinity groups, which reflected the diverse workforce at the trust.
 - A day room was available on the surgery wards. The rooms were bright and comfortable with chairs and tables, books and a radio/CD player.
 - There was provision for family members and carers to stay overnight, particularly for parents of children, and patients with complex needs. A limited number of beds were available for family members and nurses provided towels and wash bags to help them feel comfortable.
 - An extensive menu was available for patients and displayed on information boards on the ward corridors. The menu was coded with meals for different dietary requirements and specific needs. A selection of food choices was available for patients, including options for high protein, low fat and religious/cultural specific diet.
 - Patients gave us mixed feedback about the quality of food while in hospital. Some patients felt meals were good quality with adequate portion sizes. Other patients disliked the food.
- Learning from complaints and concerns**
- Trust data from July-September 2015 demonstrated that 66% of complaints were responded to within 25

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working days. Of six complaints received in that period none had been reopened or referred to the ombudsman. Matrons told us there were five complaints in the month preceding our inspection which had been investigated and closed.

- Matrons told us there were no particular themes within complaints and most complaints were about isolated concerns regarding appointments, waiting times, communication about procedures and care plans and discharge.
- Service leaders told us matrons would telephone patients who had submitted complaints and would set up meetings if requested.
- Matrons received training in complaints investigation and management.
- Band 5 nurses told us they did not know of any recent formal complaints. They raised formal and informal complaints with the ward sister. One nurse informed us staff were notified by email of complaint investigations and outcomes. The trust updated its complaints policy and procedures in February 2015
- There was evidence of learning from complaints. Patient experience boards on each ward displayed reported concerns and actions taken to address them. This included offering ear plugs to patients in response to noise at night, timelier call bell requests, and interventions to reduce discharge waiting times to two hours. However, during our inspection, the patients we interviewed told us they had not been offered ear plugs and some identified noise at night as an issue.
- The patient experience board recorded concerns that more staffing was required on wards. The trust response highlighted that more staff at weekends and an extra person at night were being recruited.

Are surgery services well-led?

Good 

We rated the surgery service at Kingston Hospital as good for well-led. This was because:

- We found a cohesive and supportive leadership team, with well-established members of staff.
- There was a clearly defined strategic plan for each of the surgery service lines.

- Matrons and ward managers were very visible on the wards and the consultant body within the service provided clear clinical direction.
- Staff in the day surgery unit valued the leadership within the unit.
- There were comprehensive and robust governance and risk management processes in place.

However;

- There were some concerns with management in main theatres. We heard reports of low morale and perceived bullying and harassment. Theatre leaders recognised staff morale was an area for improvement and had put in place a number of interventions.

Vision and strategy for this service

- Leaders of individual surgery service lines were clear on the direction for their service and were able to articulate a long term vision for developing their services. There were comprehensive five year strategy documents for each of the surgery service lines which included strategy assessments, identified internal and external challenges and risks, and implementation plans. The strategy documents focused on service sustainability and expansion, improved partnership working, repatriation of activity and improved productivity.
- The five year plans were well evidenced and thorough, however it was not clear if there was a collective vision and strategy for the whole of the surgery services across the multiple service lines. It was also not clear how each of the separate strategies aligned with the trust vision.

Governance, risk management and quality measurement

- Clinical governance structures were in place across the surgery service lines and staff felt they were effective. Each service line held monthly clinical governance meetings. We reviewed the minutes of meetings and saw there was good attendance from the multidisciplinary teams. Adverse incidents, infection control, performance indicators and patient feedback and or complaints were reviewed.
- Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its objectives.

Surgery

- Ward managers were provided with regular reports on incidents that occurred in their areas, complaints, survey results and staffing data. This information was discussed with the matron for the area who monitored for themes and trends.
- We spoke with ward managers across surgical wards and they demonstrated good awareness of governance arrangements. They detailed the actions taken to monitor patient safety and risk. This included incident reporting, keeping ward based risk registers and undertaking audits.
- Each of the surgical specialities had performance score cards. We saw evidence of a report for each of the specialities that brought together information on their performance against a range of indicators of quality and throughput.
- There were weekly and monthly meetings between matrons and ward managers. Meetings had set agendas of finance and nurse staffing matters (sickness rates, new starters, ratio of bands).
- There were bi-weekly meetings for service line managers to review corporate risk registers.
- We reviewed risk registers across a number of service lines. Risks were rated appropriately, with review dates and a named manager responsible for addressing the risk. There were details of actions taken to mitigate the risks and progress was recorded, which demonstrated active management of identified risks. Common themes within the risk registers included; insufficient and dated medical equipment in theatre, recruitment concerns across staff groups and reliance on temporary staff.
- Some service lines had implemented half-day clinical governance meetings for clinical staff, nurses and administrative staff to discuss learning from incidents, clinical audits and performance score cards.
- Within the surgery service lines there was good communication and sharing of performance and risk information between different surgery lines. We found evidence of good informal links for service leaders to meet and share information, but they recognised formal opportunities for sharing concerns and information could be improved.

Leadership of service

- There were stable and cohesive surgery service line leadership teams which comprised a Clinical Director,

Director of Operations and Head of Nursing triumvirate. The second tier of leadership included clinical leads for each of the specialties within the directorate, matrons and service managers.

- Nurses and clinicians told us senior staff on wards were visible and accessible and receptive to staff feedback and evaluation.
- Service leaders told us matrons provided clear leadership as a result of extensive clinical experience and operational competence. When we spoke with the matrons they clearly understood their operational performance, were able to articulate the challenges within the service and had identified solutions to address them.
- Ward managers were provided with training opportunities to improve their leadership skills and the trust had commissioned educational programmes from higher education institutions. Ward managers provided positive feedback about the training and support. They received good supervision and guidance from matrons and the heads of nursing. Matrons encouraged ward managers to take ownership of the wards and their preferred way of managing the ward. Nurses told us the ward managers were open, honest and supportive and encouraged them to develop.
- Some theatre staff reported concerns about lack of visibility and direction provided by the main theatres leadership. Staff were not clear about who they should go to for support. We were told a substantive theatre matron post was introduced to help provide further leadership and support. However, consultant surgeons told us theatre management remained ineffective and did not facilitate service improvement. Nurses and ODPs also told us theatre management would be improved by more constructive engagement with staff and collaboration to make improvements happen.

Culture within the service

- We found, for the most part, an inclusive and constructive working culture within the surgery service. Staff we spoke with felt that Kingston Hospital was a good place to work. Nurses and doctors reported approachable and supportive colleagues. Senior staff were proud of their teams and the support staff provided to each other across wards and theatres.
- There were many long standing and established staff members within the service who had developed their careers at the trust.

Surgery

- Consultant doctors across specialties told us the consultant body was a cohesive group. Service leaders told us the positive culture and ‘perceptions that we get things done’ made it easier to recruit good clinicians and nurses.
- In main theatres, consultant doctors, nurses and operating department practitioners (ODPs) reported concerns with recruitment and retention of staff in main theatres. We heard reports of low morale, and perceived bullying and harassment in main theatres. Some staff told us they felt unsupported and victimised. Consultant doctors and theatre staff told us a number of staff had resigned because they felt theatre leaders were not supportive of their concerns.
- Some staff in main theatres felt that black and ethnic minority staff were not successful in applying for promotion opportunities, despite many individuals applying repeatedly for promotions.
- Theatre leaders recognised staff morale in main theatres was an area for improvement and had put in place a number of interventions. This included the introduction of a staff forum for theatre staff to express their concerns with managers. The forum identified issues with pay banding, limited training and development opportunities, limited career development and promotion opportunities, and unprofessional behaviours by senior clinicians. We were told all theatre staff also had confidential individual meetings with representative from the trust’s human resources department. Senior leaders in theatres told us bullying concerns had been addressed and performance in the most recent NHS staff survey last year had improved. However, at the time of our inspection theatre staff had raised further concerns, which were being investigated by two trust executives in staff clinics.
- Theatre managers had introduced a pilot scheme to fast-track development and progression of Band 5 anaesthetic practitioners to improve staff retention because they had recently lost a number experienced anaesthetic practitioners because they did not feel they were progressing from band 5 status. The service planned to expand this scheme to scrub nurses and recovery nurses to ensure fairness.
- The concerns related to main theatres only and staff in the day surgery unit were very positive about their experience of working there. DSU staff valued the leadership within the unit. There were no reported problems with staffing in the DSU.
- Doctors in training told us they enjoyed working at the hospital. They reported supportive consultants and good learning opportunities.
- The surgery wards displayed nurse ‘star of the month’ posters. Patients were asked to nominate nurses for the award. Ward managers told us it was a means of recognising high performing nurses and sharing their success.

Public and staff engagement

- Senior staff in main theatres facilitated a team building day for all staff in theatre to help improve communication and morale.
- In addition to the Friends and Family Test, individual surgical specialties at the trust conducted patient experience surveys to measure patient satisfaction against indicators such as waiting times, consultation and procedure experience and communications.

Innovation, improvement and sustainability

- Volunteers were used on wards to assist patients at meal times. This enabled staff and volunteers to spend more time with patients.
- The surgery service provided enhanced peri-operative care for high risk patients (EPOCH project), which had significantly reduced the mortality rate for patients undergoing emergency laparotomy.
- Local anaesthetic cases in general surgery were carried out in the day surgery setting and the service had introduced a minor operations list in an outpatient setting to further reduce wait times.

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 Kingston NHS Foundation Trust is described by the trust as a high dependency /intensive care unit, which cares for patients requiring level two care (patients requiring more detailed observation or intervention, single organ failure or postoperative care) and level three care (patients requiring advanced respiratory support and support of another organ).

Patients are admitted to critical care after becoming unwell on the hospital wards, via the accident and emergency department or after surgery. A 24 hours a day, seven days a week critical care outreach service is provided to assess deteriorating patients in other areas of the hospital and to follow up patients who have recently been discharged from the critical care unit on to the wards.

Since April 2015, the critical care unit has been funded and staffed for 12 patients, consisting of six level three and six level two patients. The patient mix can be adjusted depending on demand. The total number of patients can be increased to up to 15 in emergency escalation situations. There are four side rooms, in addition to one negative pressure room and one isolation room (with both positive and negative pressure).

There were 792 admissions from April 2015 to December 2015. In October 2015 there had been a 35% increase in admission compared with the previous year. However, there had conversely been a reduction of income, due to an

increase in patients with lower acuity who required level two care only. Between April 2015 and June 2015 there had been 181 patient admissions, 42% of patients admitted were level 3 and 57% were level 2.

We visited the critical care unit over three days during our inspection and returned to the unit once at night unannounced. During the inspection, we spoke with 30 members of staff including nurses, doctors, physiotherapists, support staff, pharmacists, and dietitians. We spoke with four relatives and reviewed comments from relatives in the feedback book. We gathered feedback from four patients and looked at 12 patient records.

Critical care

Summary of findings

- The Critical Care Unit (CCU) was good in a number of areas; however, current facilities were inadequate and did not meet the standards required. The unit environment was no longer fit for purpose. The bed spaces did not comply with HBN0402 critical care environment requirements; the unit was cramped, with limited storage space for necessary equipment and supplies. There were very few windows and little natural daylight. There were no toilets or shower rooms for patients and staff, visitors and patients all use the same toilet facilities. The Trust accepted that there were environmental constraints given that the building was very old and there had been some recent improvements such as re-decoration. However, there were no current plans in place to improve the environment to meet the requirements.
- Staffing levels were reviewed continually using an established acuity tool and there were enough staff to provide care and treatment in accordance with guidelines. Nurse staffing levels had been managed well and improving the skill mix was a high priority with appropriate strategies in place to mitigate risk. We observed good multidisciplinary working to ensure high quality patient care and good patient outcomes.
- Infection prevention and control was considered by all staff to be a high priority and there were robust systems in place to ensure compliance. Audit outcomes and low infection rates demonstrated high standards.
- Staff at all levels demonstrated a culture in which patients and relatives were involved in aspects of their care when appropriate. Staff were caring and compassionate to patients, relatives and colleagues.
- Staff in the department told us they felt respected, valued and supported by the matron and clinical lead. The matron was seen to have a visible and active approach to supporting and developing staff in the unit. We observed a friendly, open and honest culture throughout critical care, where staff felt able to ask questions and seek support and guidance when needed.

Are critical care services safe?

Good



We rated the critical care services at Kingston Hospital as good for safety. This was because:

- Safety performance targets were established, monitored, and reacted to by staff. Safety thermometer results were positive in all areas for the 12 months before our inspection.
- Lessons were learned as a result of reviewing incidents of harm or risk of harm, improvements had been made when needed and lessons had been learnt and shared.
- Infection prevention and control was demonstrated to be a priority on the unit. The unit was clean and there were regular audits and monitoring to ensure compliance. Data reviewed demonstrated no concerns relating to hospital acquired infection, hand hygiene or cleanliness of the unit.
- People were kept safe and safeguarded from abuse. Openness and transparency regarding patient safety was encouraged in the unit. Staff fully understood their responsibilities to raise concerns and report incidents and senior staff fully supported them to do so.
- Risks to people who used the critical care unit had been assessed; and their safety was monitored and maintained.
- Potential risks to the service were anticipated and responsive actions had been planned.
- Staffing levels on the unit were good. There had been a recent increase in employment of junior band 5 nurses. The skill mix on each shift was planned and reviewed to ensure patient safety. Staff training had been made a priority, with an increase in the number of nurses accessing the intensive care course.

However;

- Medicine management was not always appropriate and did not meet best practice guidelines. The drugs fridge and main drugs cupboard were not locked this had been added to the risk register and was reviewed regularly.

Incidents

- There were no serious incidents requiring investigation reported for August 2014 to July 2015.

Critical care

- Incidents of harm or risk of harm were reported online. All staff were able to access the forms, including bank and agency staff. Between January 2015 and December 2015, there were 167 incidents reported in the unit. The largest number were reported in June 2015, where there were six incidents related to device and equipment failure and a further five incidents involving patients having pressure ulcers when admitted.
- Staff across the department were able to tell us how to report incidents and could identify situations requiring completion of an incident form. Staff told us there was a good reporting culture in the department and they were encouraged to report near miss situations as well as incidents that had occurred. Staff felt they had adequate time to complete incident forms when required and staff had good support from senior members of the team when incidents occurred and needed to be reported.
- We saw evidence of a detailed investigation into a Never Event involving a guidewire that had been retained post operatively in January 2014. The investigation, involved all relevant people throughout the process. It concluded with recommendations, an action plan and arrangements for dissemination of shared learning opportunities. Staff were aware of the Never Event and told us about the changed procedures put in place as a result of the investigation.
- Nursing staff received feedback about incidents. Relevant learning points were communicated via email, handovers, and information posters in the staff room and through professional development groups. There was a dedicated band 7 risk lead nurse who ensured incidents and learning were shared with staff appropriately.
- Staff across the department could identify and describe principles relating to Duty of Candour requirements. Staff described this process as apologising for any mistakes, being open and honest and involving patients and relatives in the investigation process that followed.
- Recent incident, trends and learning were discussed at monthly risk meetings. However, the minutes for July and August 2015 showed limited attendance at these meetings, junior nurses and other multi-disciplinary staff members told us they did not attend.
- There was a monthly risk newsletter circulated amongst the unit staff, which highlighted trends, incidents, and action plans. Nursing staff reported that this kept them up to date with incident themes and actions and we saw copies of this newsletter in the staff room.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections, falls with harm to patients and Venous Thromboembolism (VTE) incidence. Safety Thermometer data was available in the nurses staff room. However, no data was available at the entrance to the department for relatives and visitors to view. Safety thermometer data detailed below refers to the twelve month period, October 2014 to September 2015 and was the most recent data available at the time of inspection.
- There were two unit-acquired pressure ulcers reported. During our inspection, we saw patients' risk of developing a pressure ulcers was routinely assessed using a Waterlow Pressure Ulcer Prevention Score on the computerised record system (CRS). We observed nurses checking pressure areas and were told these checks were carried out every four hours in line with local policies and guidelines. Staff also told us about a recent change in equipment used to prevent pressure sores developing from prolonged use of endotracheal tubes. Nurses told us that pressure area care was a priority on the unit and that all pressure ulcers were reported as incidents.
- There were no falls resulting in harm to patients on the unit during the reporting period. We saw evidence that falls risk assessments were completed and physiotherapists regularly carried out mobility assessments where necessary.
- There were two urinary tract infections reported during this period. Care plans were completed on CRS for all patients with a catheter in situ.
- There was one venous thromboembolism (VTE) reported during this period. All patients were assessed on admission to the unit for risk of VTE by the admitting doctor. These assessments were reviewed within 24 hours of admission and then every seven days, or more often if their condition changed. The CRS system used for assessments, alerted doctors when review was required and did not allow for any prescriptions to be entered before this assessment was completed.

Cleanliness, infection control and hygiene

- Infection prevention control (IPC) training was mandatory. In December 2015, 97% of staff were

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up-to-date with this training. Unit specific training was also carried out by IPC link nurses and was included as part of the nurses professional development group training.

- Staff adhered to infection control precautions throughout our inspection, such as cleaning hands when entering and exiting the unit, side rooms and bed spaces and wore personal protective equipment (PPE) when caring for patients.
- Side rooms had signs to alert staff and visitors if there was a presence of infection and all doors were kept closed.
- Intensive Care National Audit and Research Centre (ICNARC) data for the unit showed no concerns in relation to hospital-acquired *Clostridium difficile* and performance in this area was in line with comparable units. The unit had a rate of 1.1% per hundred admissions of hospital acquired *meticillin resistant staphylococcus aureus* (MRSA) between January and March 2015 and ICNARC data demonstrated that this was in line with similar units.
- The department appeared clean in all areas we inspected including the sluice, stock cupboards, and relatives' room. We carried out a spot check on commodes and a range of equipment and found that these were all clean. There was a completed cleaning rota for the commodes and 'I am clean' green stickers were used to identify when the last clean had taken place.
- A regular member of domestic housekeeping staff was allocated to the unit every weekday and there was regular cover provided at weekends. The housekeeper was employed by an external domestic company yet commented how much she felt part of the team on the unit. She had regular training in infection control and hand hygiene. Weekly audits carried out by the matron assessed the quality of cleaning on the unit and the housekeeper was proud of their consistently high scores. Feedback was given after each audit was completed and any concerns were raised immediately to discuss how improvements would be made. The regular housekeeper on the unit had recently been awarded a trust 'star' award, which recognised commitment to their work.
- There were two IPC link nurses on the unit and they ensured policies and procedures were followed and up-to-date. Annual trust IPC study days for link nurses were held for training and sharing of changes in policy.

- Weekly hand hygiene audits were carried out within the unit. IPC leads from other departments within the hospital took the lead on these to avoid bias. Feedback was then given to the matron and shared with staff. Lack of availability of staff from other departments could sometimes cause delays or omissions in audit completion. In this case, the department would carry out their own internal audits to ensure compliance. During the previous 12 months, the poorest compliance was in November 2015 at 72% and 100% compliance rate had been achieved in the months of March, June, July, and December 2015.
- Most staff adhered to 'bare below the elbow' policy. However, we noted a doctor with a wristwatch from outside the unit assessing a patient. He was not challenged by the unit staff.
- Disposable curtains were used between bed spaces and were labelled with the date they were put up. Bedside curtains were clean and were all changed within the previous two months.
- All patients were swabbed for *meticillin-resistant staphylococcus aureus* (MRSA) on admission to the unit. We observed a patient who needed to be barrier nursed in line with trust policy due to a previous MRSA positive result with a negative MRSA result this admission. Staff followed hospital policy, obtaining advice from microbiology and clearly and sensitively discussing the outcome with the patients' relatives to minimise their anxiety.
- Data reviewed demonstrated a higher rate of patients who were MRSA positive on admission to the unit compared with other similar units. However, unit-acquired MRSA remained low, demonstrating good infection control practices.

Environment and equipment

- The department had a dedicated housekeeper who worked Monday to Friday who would assist with ensuring equipment was clean and available when needed. The housekeeper met with the health care assistant and matron at 9am every morning for handover. There was also a diary where staff could communicate any equipment shortages or concerns. The housekeeper told us they were able to order the equipment needed for the department without restriction and felt that quality was always considered over cost.

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- Within the unit there was one isolation room with positive and negative pressure, and facilities to put on and take off personal protective equipment such as gloves and aprons. Negative and positive air pressure rooms are to either prevent patients from catching infections when they are immunosuppressed or to stop a patient's own infection from spreading.
- Sharps bins were provided in appropriate places at patients' bed sides. All bins were labelled correctly. Sharps bins were available on wheels and provided a medication preparation area on top. All trolleys appeared clean.
- An arterial blood gas analyser machine was available within the unit. This was also used by other departments within the hospital.
- A resuscitation trolley was available within the unit. The trolley was secured with a plastic lock. Documentation demonstrated the equipment was checked daily and there were no gaps on the checking documentation for October, November, December 2015 and January 2016 to the date of inspection. All equipment checked within the resuscitation trolley was in date and stocked in line with the checklist. Weekly operational checks of the equipment were also complete with no omissions.
- A difficult airway trolley was located next to the resuscitation trolley, stocked with contents reflecting current guidance from the Association of Anaesthetists of Great Britain and Ireland (AAGBI). We were advised that all difficult airway trollies across theatre, A&E and critical care were identical to ensure easy access and location of the equipment inside. All equipment sampled within the trolley was in date.
- There were two transfer bags located within the unit to use for internal and external patient transfers. These were sealed with plastic locks and all equipment sampled within the bags was in date.
- A range of equipment sampled throughout the department had dated portable appliance testing (PAT) stickers and a date for the next service was identified on each item. This included monitors, syringe drivers, ECG machines, portable suction devices, and infusion pumps.
- Medical equipment training was carried out during staff induction to the unit. We observed induction handbooks with all equipment listed and space to sign

off when training had been completed. Nurses confirmed they had been trained on all equipment used and were updated when required or when new equipment was purchased.

- During our inspection, the unit was part-way through testing and purchasing new monitoring equipment. The department was testing monitoring equipment from different companies and staff were involved in the feedback process to help decide on the best equipment available to purchase.

Medicines

- Medicine storage was not compliant with trust guidelines. The main drugs fridge was not securely locked. When we asked the matron about this we were told that a risk assessment had been completed and it was left open due to emergency drugs located inside. The main medicine cupboard in the middle of the unit containing intravenous (IV) medications and some fluids was also not locked. Staff were free to access it without the need for keys. We discussed this with the chief pharmacist who told us this was on the risk register and reviewed regularly. The rationale provided was due to the nature of the critical care unit, as it would be detrimental to patient care if medicines could not be accessed immediately.
- Allergy statuses were clearly recorded on the top of the page of the computerised record system. We were told that no prescriptions could be entered onto the chart unless the allergy status of the patient had been completed in full.
- There was a dedicated pharmacist for the unit. They checked patients' prescription charts daily Monday through to Friday and ensured medicine stock levels were adequate.
- Oral medicines and nebulisers were located in a separate cupboard, which was locked. The majority of fluids were stored securely in a storeroom, beside the staff room with access restricted by keypad lock.
- Fridge temperatures were recorded daily with no omissions noted for the month of December 2015 and January 2016 up to the date of inspection.
- A selection of medicines checked from the fridge, IV cupboard and oral medicine cupboard were in date.
- Controlled drugs (CDs) were stored in two separate lockable cupboards and required two nurses to be present for these medicines to be administered to patients. During our inspection, we observed two nurses

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following the correct processes for administering CDs. Two nurses checked the contents of the CD cupboard on a daily basis and we saw the log of such checks had no omissions. A selection of CDs were checked against the CD log and all were logged and signed correctly.

- All nursing staff had received medicine management training as part of their induction. It was trust policy that agency staff did not prepare or administer IV medication. Due to the majority of medicines administration on the unit being given by IV route, a risk assessment had been completed to allow agency staff to administer IV medication to prevent delay in treatments. We saw comprehensive assessment procedures in place for agency staff to ensure competency.
- Antibiotic compliance audits for the unit demonstrated a high compliance for all aspects looked at. The department scored 100% in documenting the indication for the antibiotic and 100% for all antibiotics having less than 72 hours duration, which is in line with local guidelines.

Records

- A computerised record system (CRS) was used throughout the unit and had been in place for ten months prior to inspection. All documentation was completed on the CRS system including medical, nursing, and other multi-disciplinary team documentation. The only exception was patient monitoring information, which continued on paper. This was different to the other areas of the hospital where patient monitoring was also completed on the CRS system. To mitigate problems at handover when a patient was transferred, nursing staff would begin to complete patient monitoring on CRS, 24 hours before the patient was transferred.
- Staff who used the CRS system were generally positive about it and thought the system was easy to use and to locate information about patients when required. There had been some concerns surrounding the electronic prescription of medication due to the long list of medications CCU patients could require. Both nurses and doctors told us it was easy to duplicate a prescription of a medicine as you have to scroll down the list on a small computer screen. There had been

some prescription errors due to this, but no errors in administration of medication. We saw this had been discussed at local meetings and risks were being monitored closely.

- Information governance training was included in the trust mandatory training and 97% of staff who worked in the critical care unit had completed this training.
- Access to the CRS system was via key card and we observed all nurses using their own key card to access the system, in line with policy.
- The CRS system prompted nurses to complete daily care records and risk assessments, or weekly assessments, when these were due. Staff reported this flagging system improved document completion however, could sometimes delay aspects of patient care if the system was flagging a record to be completed.
- During our inspection we looked at twelve patient records and noted that they were complete including summary of the reason for admission, VTE assessment, evidence of twice-daily ward rounds, drug charts, care plans, assessment of fluid status and multidisciplinary team input.
- NICE guidance states there must be documentation demonstrating when the decision to admit patients to the unit was made. There was no clear place on the system to record this and the information was difficult to find in the records we looked at. We were unable to find this information in two of the patient notes we looked at and therefore difficult to assess whether this standard was being met.

Safeguarding

- A trust safeguarding policy was available for all critical care staff to view on the intranet. There was also a safeguarding folder with easy access to key information available to all staff. Staff were aware of the policy and knew where to find the information they needed. Staff were able to give examples of recent patient referrals made and were able to identify triggers which would make them consider a safeguarding referral.
- There was a dedicated band 7 safeguarding lead nurse on the unit and staff were aware of who to go to if they were unsure or required support with any safeguarding concerns.
- Safeguarding adults training and safeguarding children level 2 training had been completed by 97% of staff.

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- We saw appropriate examples of three randomised safeguarding referrals in which appropriate patients had been identified, and referrals made accordingly.

Mandatory training

- There was a temporary lead practice development nurse (PDN) in post due to staff sickness. The PDN was able to demonstrate and access up to date mandatory training records for all nursing staff who worked within the department. Records reviewed demonstrated a high level of compliance with all mandatory training requirements including requirements for all staff to be trained in intermediate life support. Where there were gaps in completion of training, there was good reason, which included long term sickness and maternity leave.
- Completion rates varied from 96% to 100% compliance for all mandatory training topics, with the exception of conflict resolution training, which had a compliance rate of 87%.
- Mandatory training for moving and handling and fire was delivered within the critical care department to ensure the training was relevant to the environment in which staff worked. The critical care unit had a band 7 nurse who was a trainer in moving and handling and arranged teaching sessions using critical care equipment. Once completed the PDN fed back to the trust education centre to ensure records were kept up to date.

Assessing and responding to patient risk

- A nurse led outreach service responded to deteriorating patients on the wards who had triggered a national early warning score (NEWS) of greater than five or three in one parameter or patients who had been a recent transfer out of the unit. The outreach team worked 24 hours a day and consisted of one band 7 nurse at night and two band 7 nurses during the day. We were told the team were required to respond to patients within one hour. However, the team told us there was very little delay and could usually respond to patients within ten minutes. There was no current data available on outreach response times to demonstrate this.
- All patients were currently referred to the outreach team by the ward nurses. There was currently no electronic track and trigger system in place to alert the outreach team of patients who were triggering on their NEWS score throughout the hospital.

- Staff told us patients risk of Venous Thromboembolism (VTE) was assessed on admission to the unit and then again after 24 hours. The CRS helped with compliance of this, as would alert staff when this was required.
- Faculty of Intensive Care Medicine Core Standards for Intensive Care Units state patients should be transferred to the unit within four hours of the decision to admit. Audit data demonstrated there had been seven delayed transfers to the unit in 2015, however there had been no delayed transfers since September 2015, when bed capacity had been increased.
- Due to the unit caring for both level 2 and level 3 patients we were told that if a patient was to deteriorate while being cared for as a level 2 patient, they could escalate the patient up to level 3 care without moving the patient out of the current bed space, as all bed spaces could be used for level 2 or level 3 care.

Nursing staffing

- The department used the Intensive Care Society guidelines for the provision of intensive care services. These core standards for staffing were used in conjunction with Critical Care Minimum Data Sets (CCMDS), where the nurse in charge inputs data relating to organ support for each patient on the unit.
- The department aimed for a 1:1 nursing ratio for level 3 patients and 1:2 for level 2 patients. Staff recognised that this may need to be increased to safely meet the needs of the confused, delirious or infected patients or those requiring complex therapies.
- Based on the bed complement of six level 3 beds and six level 2 beds, 11 nurses were planned on each shift. This comprised 10 for direct patient care and one nurse in charge. This number provided flexibility to respond to service needs such as infection and acuity of patients.
- Patient acuity and allocation was recorded locally on the ward watcher database. During the three days of our inspection, there were 12 nurses on each day and 12 each night. During our unannounced inspection at night there were 13 nurses on duty. Details of staffing numbers were visible at the entrance to the unit along with details of the nurse in charge for that shift
- The budgeted nursing whole time equivalent (WTE) establishment for the department was 81. In December 2015, there were 73 WTE nurses in post with a vacancy factor of 8 WTE. Due to this vacancy factor, there was some use of bank and agency nurses.

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- The trust reported bank and agency usage for the unit as consistently higher than the trust-wide average from April 2014 through to March 2015. The unit reported an average of 19.58% for this period, compared with 12.96% for the trust as a whole. Bank and agency usage was highest in January 2015 (26.1%), and lowest in September 2014 (14.4%).
 - We were told that it had been difficult to recruit nurses to band 6 posts and this was a problem across the south London network. Due to this, there had been a recent over-recruitment to band 5 posts in the view of prioritising training and development. Senior staff were aware this recruitment would dilute the percentage of nurses with an intensive care accredited course; however, management plans for this had been discussed and were in place.
 - We were told how three nurses had recently been recruited through an overseas recruitment process. These nurses were currently awaiting their nursing and midwifery council (NMC) pin number and were currently working supernumerary at band 3 level.
 - Staff we spoke with told us staffing levels on the unit were good and there was adequate nursing cover to take breaks, to assist with patient care when needed, and to support junior staff.
 - The sickness rate on the unit for nursing staff had been 8% in October 2015, 4% in November 2015, and 5% in December 2015. This was above the trust average within the same period and we were told that there had been some long term staff sickness.
 - Handover took place twice daily in the morning and in the evening. Staff coming on shift would first have a brief overview of all patients in the department from the nurse in charge and then a more detailed handover from the nurse whom was looking after the patient they were allocated at the patient bedside. Handover was structured and nurses took due time to go through different aspects of patient care following guidance to ensure all aspects were covered.
- in intensive care medicine must be immediately available 24/7, be able to attend within 30 minutes and must undertake twice-daily ward rounds. We saw evidence in patients' notes of twice-daily ward rounds.
 - Nurses we spoke with told us they were happy with the level of medical cover provided with one nurse telling us the team of doctors were supportive, and the doctor on call would always attend quickly if needed within 30 minutes. The nurses we spoke with felt confident to phone the consultant if they felt there was a clinical need.
 - Weekly consultant cover was split between two consultants. The first consultant took over on Monday and led until Thursday afternoon. The second consultant took over on Thursday afternoon and led until Sunday. The two consultants worked together on Thursday from 2-5pm and used this time to carry out joint procedures. The on-call consultant took over responsibility of the unit at 8.30pm each evening. A daily "good night" phone call was always expected between the trainee and consultant. Staff told us this happened after the ward round.
 - There were two trainees allocated to the unit each day, as well as one foundation year doctor. One trainee worked the early day shift from 8am – 5pm and one trainee worked the late shift from 8am-8.30pm. The night trainee arrived at 8pm and finished at 8.30am.
 - The junior doctor rota was a full 24/7 resident rota (8am – 8.30pm and 8pm- 8.30am) with sole responsibility for the unit. There was always at least one other trainee on duty 8am to 5pm. We saw junior doctors working on the unit supported by consultants and more senior trainee doctors.
 - All admissions to the unit were discussed with consultants to ensure senior doctors made decisions regarding acceptance and refusal of patients.
 - Sickness rates for the medical team in the unit had been at 0% for the previous twelve months.
 - There was low reliance on locum doctors within the unit and doctors told us that if locum doctors were used they were familiar with the department and the CRS system.

Medical staffing

- There were eight consultant intensivists providing critical care cover to the unit. An extra consultant had been appointed from January 2016, making the unit compliant with London quality standards (LQS) in terms of long days and split weeks with twice daily ward rounds at weekends. Guidelines state that a consultant

Major incident awareness and training

- The major incident policy was up-to-date and had detailed action plans in the event of an emergency. An up-to-date policy was kept in the matron's office and all of the most recent staff phone numbers were kept within this folder.

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- All band 7 nurses were trained as fire marshals. There had been a recent drive within the department to ensure all staff were up-to-date with fire training which was facilitated locally within the department to ensure relevance. Records showed that 97% of all staff had received appropriate fire training.

Are critical care services effective?

Good



We rated the critical care service at Kingston Hospital as 'good' for effectiveness. This was because:

- Nursing staff had the skills, knowledge and experience required to deliver effective care and treatment. Nursing staff who did not have the intensive care qualification were either currently working towards this or were planning to do so. Nurses worked in professional development groups to review training needs, facilitate further training and discuss audit or improvement projects.
- Patients had comprehensive assessments of their needs, including assessments for clinical, rehabilitation, and nutrition and hydration needs. Patients care and treatment was regularly reviewed and updated through good multidisciplinary working. Staff, teams and services worked together to deliver effective care and treatment in order to meet patients complex needs.
- There is participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services and benchmarking. Accurate and up-to-date information about effectiveness is shared internally and externally and is understood by staff.
- People's consent to care and treatment was always sought, in line with legislation and guidance. Staff had a good understanding with regard to the Mental Capacity Act (MCA) Code of Practice and were able to give examples where this was applied in practice to critical care unit patients.

Evidence-based care and treatment

- Policies and procedures were available on the intranet, ensuring the most up-to-date versions were available.

Some of the main protocols used in the unit, such as the out-of-hours enteral feeding policy, were stored in a folder at each bedside for easy access. These protocols were dated and included dates for the next review.

- We saw care bundles in place for central venous line (CVP) insertion and on-going care. CVP bundle documentation had been fully completed in patients' records we reviewed. Audit data showed that between October 2014 and September 2015 between 95% and 99% of these bundles had been fully completed.
- Faculty of Intensive Care Medicine Core Standards for Intensive Care Units state that a consultant should review all patients within 12 hours of admission. Patient notes we reviewed reflected this standard and evidenced twice-daily consultant ward rounds.
- Audit data provided after the inspection demonstrated that, at times, patients were not seen within twelve hours of admission. Throughout January 2016, 51 patients' notes were looked at and ten were found to have been seen by a consultant more than twelve hours after admission. It was suggested that this was due to a delay in the recording of the review and not a delay in the review taking place. These results were to be fed back to the consultants and re reviewed in eight weeks' time.
- Ventilator-associated pneumonia (VAP) care bundles were used on the unit in line with current best practice to reduce the risk of infection associated with intubation. We observed VAP care bundles were part of the daily documentation requirements on the CRS system. However, there was currently no data collection for compliance with these bundles.
- The visual infusion phlebitis (VIP) score was used throughout the unit to monitor patient intravenous (IV) lines in line with best practice. We saw this documented on the CRS system in patients' records we looked at.

Pain relief

- Patients we spoke with told us their pain was managed appropriately and they received pain medication when needed. One patient we spoke with told us they had a lot of pain post operatively and told us the doctors and nurses on the unit had managed this quickly and effectively.
- Patients received analgesia via oral, IV medicines including patient controlled analgesia (PCA) and epidural, which could be managed in the department by the nurses.

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- Records and observation charts for patients did not have anywhere to record pain scoring for patients unless they had an epidural or PCA in place. We observed staff assessing patients' pain using a score of 1-10 and staff told us they would add a column onto the observation chart if it was necessary.
- There was no tool in place to ascertain if patients were in pain while they were sedated; however, staff told us they would monitor patient's pain according to their response to stimuli, such as being turned, heart rate and facial expressions. However, there was again nowhere to record this on the patient observation chart.

Nutrition and hydration

- A 0.3 whole time equivalent (WTE) dietitian was available on the unit Monday through to Friday and on-call cover on bank holidays. There was currently no weekend dietitian cover. There was good evidence of dietitian review in all patient notes we looked at. The dietitian would receive a list of all patients currently on the unit at handover and would prioritise any new patients who they had not yet seen.
- Up-to-date guidelines were in place for both enteral and out of hours parental feeding to ensure feeding could be started by the doctors and nurses during the weekend. These guidelines provided step-by-step information in relation to who to feed, what to feed them and how much to feed each patient.
- Although it was recognised there was a need for audit activity relating to nutrition provision, there were currently no active audits on-going. We were told this was largely due to the limited working time of the dietitian. This time was solely used to see and assess patient needs.
- Assessment of nutrition status was included in all patient notes we viewed and evidence of assessment of fluid state was also present.
- Patients who were able to eat could choose three meals each day from a menu. Jugs of water were left at the patients' bedsides. We saw nurses offering patients additional snacks and hot drinks when appropriate to do so.

Patient outcomes

- The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland. This meant patient outcomes could be benchmarked against

similar units nationally. The following data discussed was provided from ICNARC report dated 01 April 2015 to 30 June 2015 which had been published in December 2015.

- The unit had an audit programme in place for 2015/2016, which included audits that had been completed, on-going audits, and planned audits within the department. We saw a mixture of audits taking place, led by both doctors and nurses from the department.
- The Intensive Care National Audit and Research Centre (ICNARC) data reviewed showed that between July 2014 and June 2015 the mortality ratio for the unit had been increasing. In the most recent data published, the ratio had become higher than expected and was an outlier compared to nationally similar units. However, the mortality rate in the unit for the twelve months between July 2014 and June 2015 remained below 20% and had neither increased or decreased throughout this period. At the time of inspection the department were reviewing notes and in discussion with ICNARC to determine the reason for a mortality ratio increase without an increase in the rate.
- Ventilated admissions to the unit had a similar mortality outcome rate from July 2014 – June 2015 and an average length of stay compared to similar units.
- The mortality rate for patient admissions with trauma, perforation or rupture had fluctuated within the previous twelve month period demonstrating a reduced mortality rate compared to similar units up until January 2015 with an increase in mortality rate thereafter.
- Elective surgical admissions had a reduced mortality rate and around the same length of stay when compared with other similar units.
- Emergency surgical admissions had a lower mortality rate and a decreased length of stay in comparison with similar units.
- Admissions with severe sepsis had a rise in mortality rate since October 2014 compared to similar units for this period. Work was on-going within the department to ensure sepsis guidelines were followed to ensure early treatment and identification of sepsis.
- There was a rise in mortality of patients admitted with pneumonia during the first six months of 2015; this was expected during the winter months, however was above the rate of similar units.

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- The number of patients readmitted to the unit within 48 hours of discharge was less than other similar units from January – June 2015 and therefore indicated a better performance.
- From April to June 2015 the rate of early deaths was consistently below 1% of admission, which was better than the national average for similar units. In the same period, the number of patients who were discharged from critical care and subsequently died was about the same as other units.
- An audit report published in October 2015 demonstrated the use of physiotherapy led rehabilitation had helped to reduce CCU length of stay by an average of eight days. It had also reduced hospital length of stay from an average of 48 days to under 20 days.
- NICE guidelines recommend using rehabilitation to assess and treat physical morbidity in critical care patients as early as possible. The core standards for intensive care units support early rehabilitation and recommend patients receive 45 minutes rehabilitation, five days a week. Audit data received demonstrated 73% of patients received 20 minutes of rehabilitation every five days. Physiotherapy staffing levels were the main limiting factor why the unit was not meeting these core standards.

Competent staff

- New nurses in critical care department underwent a period of supernumerary practice, during which basic competencies were signed off before the staff member was able to work independently and counted within the nursing numbers for that shift. Staff were complimentary about their induction process and told us they had between two to three weeks supernumerary working. We saw a comprehensive induction booklet, which staff would work through to ensure skills and competencies had been demonstrated and met.
- Appraisal rates for staff were 94% in December 2015. The practice development nurse was able to highlight any gaps in this and demonstrated good reason for the incompletions, for example, maternity leave or sickness.
- Competency documents that were adapted from the national competency framework for adult critical care were used to develop nursing skills. Staff told us their skills and knowledge were assessed and measured against these documents and there was on-going progression for both band 5 and band 6 nurses using these framework documents.
- The Faculty of Intensive Care Medicine core standards state a minimum of 50% of critical care nursing staff should hold a post-graduate qualification in intensive care. The unit was working towards the London quality standards which suggest a minimum of 70% nursing staff hold the qualification. In December 2015, 61% of nurses held a post-registration qualification. Nurses we spoke with and training documentation we looked at demonstrated there were nurses currently working towards this qualification.
- We were told a number of new staff had been recruited at band 5 level due to a network shortage of suitable band 6 applicants. This had decreased the percentage of nurses with a current recognised intensive care qualification. Consideration was given when arranging the rota each month to ensure the skill mix of nurses was sufficient to ensure patient safety. During our inspection, we saw the matron and supernumerary senior staff helping on the shift to support nurses training and development. There had been a recent drive to increase the number of nurses with the qualification and further funding had been prioritised to increase the number of nurses on the course at one time. At the time of our inspection there were 11 nurses at various stages of course completion.
- There was access to development opportunities within the department. This included leadership, management and finance courses for band 6 nurses, as well as opportunities for nurses to pass an assessment to enable them to lead the department.
- Nurses worked in professional development groups. Each group would have three study days a year dedicated to topics such as, learning disability, safeguarding and fire. These groups were also used to discuss and develop audits and address other training needs within the department.
- All critical care consultants were trained in advanced life support (ALS) and trained in advanced airway skills. All registrars responsible for the unit overnight were also trained in advanced airway skills. Band 7 nurses were also encouraged to complete ALS training.
- Junior doctors provided positive feedback on the training and support received within the unit and

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commented on the positive learning environment. We were told there was an on-going programme of learning for junior doctors and they attended weekly journal clubs.

Multidisciplinary working

- There were weekly multidisciplinary team (MDT) meetings held for patients, which involved the medical team, senior nurses, outreach nurses, pharmacists, physiotherapists, microbiologists, dieticians and radiologist. Patient care was reviewed and staff had the opportunity to raise any questions or concerns. We observed a weekly MDT meeting and noted good communication and an overall team approach to patient care. The MDT supported each other in their work, this was demonstrated through a discussion in how best to support the staff involved in a difficult admission the previous day.
- We observed members of the MDT team liaising with the nursing staff to agree patient care plans. We observed good working relationships between the teams and nursing staff were flexible to ensure different members of the MDT had access to the patient and the patient's notes when required.
- We observed microbiologists conduct a ward round each day of our inspection. They worked alongside the consultants to ensure patients received the best treatment.
- Physiotherapists attended the nursing hand over each morning to understand daily departmental requirements. Physiotherapists would then work alongside the nursing team to provide rehabilitation and respiratory physiotherapy to patients.
- The critical care outreach service was available 24/7 to provide support to ward staff. The outreach team also facilitated teaching and training to ward staff, specifically in management of the deteriorating patient.
- Band 7 nurses had developed relationships with nurses working on other wards within the hospital. We were told each nurse had responsibility for a different ward and would provide training sessions and be a point of contact for them.

Seven-day services

- Some seven-day working was in place, with nursing levels staying the same throughout the week and a seven day outreach services available. However,

consultant and middle grade doctor cover was reduced at the weekend and there were no physiotherapy rehabilitation, pharmacy, microbiologist or dietitian services available at the weekend.

- Medical cover differed at weekends compared with during the week. At the weekend there was no twelve hour consultant cover and there was one registrar present (compared to two registrars during the week).
- The critical care outreach team was available 24/7 to provide support on wards caring for deteriorating patients. They routinely and followed up patients recently discharged from the unit.
- We were told at the time of inspection that on-going discussions with the physiotherapy department were taking place, with regard to increasing the level of service provided to the unit. Currently physiotherapy rehabilitation was only available Monday-Friday but provision was lacking at weekends. This meant the unit was not meeting core standard guidelines of assessing rehabilitation needs of all patients within 24 hours of admission at weekends and providing seven day rehabilitation.
- There was physiotherapy respiratory care available seven days a week. Nurses told us that at weekends they would continue patient rehabilitation as and when possible. Some of the nurses had been trained to use the rehabilitation equipment and there were plans in place to train others.
- There was a 0.3 WTE dietitian available to the unit Monday through to Friday only. The British Dietetic Association recommends there should be 0.05 – 0.1 WTE dietitians per 1 bed. Therefore the unit was not meeting these standards. We were told there were no dietitian services available at the weekend and if there was a three-day weekend due to a bank holiday an on-call dietitian would be available for the bank holiday only.
- Microbiologists performed ward rounds daily Monday through to Friday and provided an on-call service at the weekend.

Access to information

- Handovers would take place at the patients' bedsides. Nurses followed a bedside handover guide to ensure all required information was handed over.
- Nurses, doctors and other members of the multidisciplinary team recorded information about the patient on the trust computerised record system (CRS). Staff told us once you had learnt how to use the system

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all information was easily accessible and in one place. A junior doctor told us they, at first found the system difficult to use however, told us once you have learnt the basics you can quickly access the information you need.

- Patient observations were not recorded on the trust CRS system and were recorded on a large critical care unit chart. Nurses told us they would upload observations onto CRS 24 hours before discharge to the wards to ensure these were available for the ward nurses.
- Junior doctors told us it was their role to complete discharge summaries for a patients GP. One doctor told us this had recently been audited for completion rates and quality and had scored 100%.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff we spoke with were able to correctly explain how consent should be obtained from patients and also explained that best interest decisions were needed when the patient was unable to consent. Staff described how they would involve the family in decisions; however, they were aware that families could not give consent for patient's treatment.
- We did not see any evidence in the patient notes where a capacity assessment could be documented.
- There had been no deprivation of liberty safeguard (DoLS) applications completed within the department. On discussion with senior staff, we were advised there was ongoing discussion amongst the south London critical care network group as to whether patients under medicine sedation should have a DoLS application completed. It is current practice amongst most critical care units that under these circumstances a DoLS application would not be completed.

Are critical care services caring?

Good



We rated the critical care service as 'good' at Kingston Hospital for caring. This was because:

- Feedback from relatives of people who used the service was positive. Relatives told us staff would go the extra mile and the care they received exceeded their

expectations. Examples were given of how staff had gone out of their way to ensure relatives were cared for and we saw examples of relationships between relatives and staff were a priority.

- Completion of the Short Observational Framework for Inspection (SOFI) demonstrated positive interactions between staff and patients. We observed patients being involved in their care and staff responding compassionately when people needed help and support.

However;

- The collection of patient and relative feedback required some improvement. Friends and Family Test completion rates were low and there were no formal way in which the department collected or audited feedback information.

Compassionate care

- Staff across the critical care unit spoke kindly to patients and patients described staff as friendly, caring, and compassionate.
- We observed staff speaking to patients in a considerate and respectful way, addressing patients first before handover and enquiring how patients were feeling before discussing any treatment plans with a colleague. Observations of staff demonstrated kind and compassionate care; staff maintained patients' dignity by fully closing curtains and keeping discussions as private as possible.
- Staff interacted with unconscious patients; they introduced themselves and explained interventions to the patient prior beginning any treatments.
- Patients we spoke with described the care in the unit as "fantastic"; one patient commenting that he did not want to leave the unit to go to the ward because of the good and individualised care and treatment he had experienced. Patients described the nurses as kind and one said the staff had gone out of their way to ensure he was comfortable and felt safe.
- A relative of a patient we spoke with described the care as "world class" and told us he had never experienced such good care. He described the nurses as attentive and kind who treated patients with respect and as individuals. One nurse had laminated photos for him to put up around his relatives bed.
- We were told that Friends and Family Test (FFT) data was difficult to collect on the unit. There was no

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electronic device for relatives to record their experience and no feedback box available in the relative's room. Data provided showed a 100% positive feedback result for eight months of 2015 with no data collected for four months of the year.

- On discussion with the senior management team it was highlighted that there needed to be better more formalised processes put in place to collect both patients and relatives feedback about the care received within the unit.
- There was a patient and relative feedback book located in the relative's room. This book was filled with positive comments from patients and relatives who had thanked staff for the care.
- We observed staff referring to patients relatives by their names and asking them how their day had been. Staff made visitors feel welcome and ensured they had everything they needed.

Understanding and involvement of patients and those close to them.

- At the entrance to the department, a poster board displayed photographs of ward staff alongside their name and job titles to ensure relatives knew who staff on the ward were. In addition to this, the lead nurse for the shift was highlighted at the top of the board.
- Patient and relatives described how medical and nursing staff provided clear and thorough explanations about treatments and care plans. Relatives described how they felt listened to and felt they had time to ask questions or raise concerns.
- One relative we spoke with told us how the nurses always involved them in the care of his relative. They explained how he had been taught how to contribute to his relative's rehabilitation plan and was able to contribute to her care and treatment.
- We observed ward rounds which included discussions with patients and relatives where possible.

Emotional support

- Part of staff discussions at handover included the social circumstances of a patient, about their next of kin and any contact the nurse had with them or support provided. One nurse told us this was to ensure continuity of care to support the families as well as the patients.
- We observed nursing staff getting to know the relatives of patients, for example referring to them on a first name basis and asking about other family members.

- A chaplaincy service was available 24 hours a day seven days a week and available to patients and relatives if required. A recent audit demonstrated this service was not always offered and considered in all cases and therefore an action plan had been put in place to improve this.
- Relatives we spoke with were positive about the support they received from staff on the unit. One relative commented that he felt part of the "unit family" as staff took the time to look after him while he was visiting, ensuring he had a good night's sleep and had something to eat and drink when needed.

Are critical care services responsive?

Requires improvement 

We rated the critical care unit at Kingston Hospital as requiring improvement for responsiveness. This was because:

- The environment, facilities and premises being used, were not appropriate for the services provided, did not meet people's needs and action was not being taken by senior management to address this in the long term.
- There were some gaps noted in care provision to meet the specific needs of patients cared for in the critical care unit. There were no follow up services available for patients to reflect upon their stay or to address long term psychological concerns.

However

- Bed occupancy was consistently in line with The Royal College of Anaesthetists due to flexibility in the service to accept patients who require care when needed and elective operations were rarely cancelled due to bed availability. This flexibility within the unit also contributed to the minimal numbers of out of hour patient discharges.

Service planning and delivery to meet the needs of local people

- The unit served a combination of elective and emergency post-operative patients and medical patients requiring critical care. The admission policy

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supported the admission of patients with a reversible condition who required advanced medical interventions such as organ support and who would be at risk if they remained in the general ward area.

- There had been three cancelled elective operations due to the lack of critical care beds in the previous twelve months and four patients ventilated outside of the unit in the recovery area. Staff told us, generally the unit could meet the requirements of the hospital in providing level two and level 3 critical care beds to patients who needed this. Since September 2015 the bed availability had been increased, since then there had been no cancelled operations.
- Access to a critical care follow up clinic was not currently available. Follow up clinics are recommended to provide patients with an opportunity to discuss any ongoing medical problems, reflect upon their admission and also to re visit the unit if they wish. Senior staff recognised there was a need for such clinic to meet the needs of patients after discharge, however currently there were no staff or funding available to provide this service. The absence of this clinic also meant a lost opportunity to gain patient feedback about their admission.
- Staff told us visiting times could be flexible according to the needs of individual patients and their relatives. Visiting times were displayed at the entrance to the unit as between 2pm and 8pm, but also advised the nurse looking after the patient could arrange visiting outside of these times.

Facilities

- The department recognises the current unit environment was no longer fit for purpose and did not meet the needs of their patients. This was at the top of the departments risk register.
- The bed spaces did not comply with critical care environment requirements due to bed spaces being smaller than the recommended size. We observed a level 2 patient sat out in a chair for meal times having very little space and overlooking a level 3 patient in the bed opposite.
- The unit was cramped with not enough storage space for necessary equipment and supplies. During inspection we noticed equipment stored in empty bed spaces out on the open unit.
- There were very few windows and little natural daylight for both patients and staff. We were told there were plans to try and improve this by installing artificial windows, which could simulate day and night to try and improve patient experiences.
- There were no toilets or shower facilities for patients. Staff, visitors and patients all used the same toilet facilities. We observed one patient who required the bathroom having to walk from one end of the unit to the other to reach the one toilet.
- The staff room was small and there were no changing facilities within the unit. The office space was also small with little room on the unit for handover, teaching or MDT meetings.

Meeting people's individual needs

- Support for patients with psychiatric needs was available via the psychiatry liaison team while the patient was in the unit. There was currently no follow up clinic available to patients post discharge as recommended by faculty standards.
- There was a band 7 nurse in the department who was the lead for learning disability (LD) awareness and training. Staff were clear of the support available in regards to caring for patients with LD. Staff told us there were passports available, which they used to find out important information about their patients from their relatives and carers.
- Translation services were available and staff were clear of how to access this if required. We were told by nursing staff there were hospital staff in various departments who also worked as translators and could be used if available. We observed a ventilated patient who required a translator and this was being booked in advance of waking the patient and extubation of the breathing tube to ensure the needs of the patient were met and that staff were able to communicate.
- Information was available to relatives in the relatives' room regarding access to ICU steps. This is a charity organisation that supports patients and families through critical illness.
- Information was available to relatives about the chaplaincy service available and how this could be accessed if required.
- There was an end of life (EoL) lead nurse available within the department. Part of this role had included a recent audit on EoL care within the department. Results demonstrated that as a team the CCU were good at

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talking to relatives; however, needed to improve on the assessment of patient spiritual needs. There was one nurse from each professional development group who had recently attended an EoL focus group to discuss how improvements could be made and meet the needs of patients. EoL care plans had recently been introduced on the computerised record system to prompt appropriate care.

- Chaplaincy services were available 24/7 to meet the pastoral, spiritual and religious needs of patients, families and staff and could be accessed via switchboard. We saw a poster in the relatives room which advised of the chaplains available which included Church of England, Roman Catholic, Jewish and Muslim.

Access and flow

- Patients were admitted to the unit through three routes. These included elective post-operative admission booked in advance, emergency referrals from the medical or surgical teams and A&E and emergency referrals from the outreach team. All patients admitted to the unit were first discussed with the consultant on duty and there were no admissions to the unit without this agreement in place, to ensure appropriate patients were admitted only.
- The trust reported an increase of roughly 15% in admissions and discharges from critical care in the period April 2014 and March 2015, compared with the previous twelve months. Recent ICNARC report data demonstrated a steep increase in admissions between June 2014 and June 2015.
- The Royal College of Anaesthetists (RCOA) recommends a 70% bed occupancy rate, this allows for units to be able to admit patients should there be an emergency. If a unit is at a higher occupancy, it may be unable to respond to these emergency admissions. ICNARC data from April 2015 – June 2015 demonstrated a 70% occupancy rate or above, 50% of the time. However, this data was based on the availability of twelve beds and did not consider the three bed spaces that could be used when required during high occupancy and emergency. Senior staff told us they were currently able to provide care for all patients who required CCU admission.
- Faculty of Intensive Care Medicine Core Standards for Intensive Care units state that patients should be transferred to the critical care unit within four hours of the decision to admit. Outreach staff told us there was

little delay in transferring patients into the unit due to the extra bed capacity. Audit data reviewed demonstrated there were no delayed critical care admissions from September 2015 onwards.

- Faculty of Intensive care Medicine Core Standards for Intensive Care units advise a consultant should review all patients within twelve hours of admission to the unit. During Inspection we observed consultant review within this period and observed twice-daily consultant led ward rounds.
- Information from ICNARC indicated fewer patients experienced delayed discharges from the CCU than in other similar units from July 2014 – June 2015. Data provided within performance meeting minutes described a recent increase in delayed discharges of surgical patients. During our inspection, staff described how discharges for surgical patients could be difficult due to the availability of side rooms on the wards. It was trust policy that all surgical patients discharged from CCU were given a side room on the ward.
- Patient discharged from critical care ‘out of hours’ between 10pm and 6:59am are nationally associated with worse outcomes. Senior staff told us that due to extra bed capacity availability on the unit (up to fifteen); patients ready for discharge would be looked after overnight if the ward bed was not available before this time. ICNARC data demonstrated a lower proportion of out of hours discharges compared with similar units.
- Faculty of Intensive Care Medicine Core Standards suggest patients must not be transferred to other intensive care units for non-clinical reasons. Data provided from the trust stated there were no non-clinical discharges from April 2015 to December 2015.
- We were told patients referred from the ED were seen within 30 minutes of referral by a doctor, we were told if this was not possible the outreach team would see the patient.
- Guidelines suggest once a patient is discharged from the unit to another ward in the hospital, critical care review should be available at 24 hours and 48 hours after discharge. Critical care and outreach staff told us they would review all patients after discharge from the unit. ICNARC data from April 2015 – June 2015 demonstrated 75% of patients were followed up within twelve hours; however, we were advised this was due to the data being collected prior to the outreach team becoming a 24/7 service.

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Learning from complaints and concerns

- We were advised by staff that most complaints on the unit were minor and could be dealt with quickly and informally. Staff were aware of the processes by which patients could complain including through the Patient Advice and Liaison Service.
- Posters and information leaflets were available in the relatives' room advising relatives of how to raise concerns or make a complaint.
- We were told there had been three complaints in the previous twelve months, which the matron had dealt with by phoning the complainant within five days and fully responding to the complaint within 28 days as per trust protocol. There were currently no outstanding complaints.
- The trust provided data, which demonstrated three complaints within the last year regarding CCU. All complaints were investigated and responded to within the 25 day time scale required.
- During our visit, we spoke with a relative who told us he had complained about a minor incident that had happened over night. He told us his complaint was dealt with and resolved quickly in a sensitive and professional manner. Nurses we spoke with were aware of the complaint, outcome and learning from the complaint as this had been discussed at handover.

Are critical care services well-led?

Good



We rated the CCU services at Kingston Hospital as 'good' for well-led. This was because:

- There was a clear vision and strategy in place within the critical care unit and staff were aware and able to discuss the main points of the five year strategy framework currently in place.
- Leaders within the department demonstrated that safe, high quality, compassionate care was a priority within the department and we observed supportive relationships amongst all staff levels. Staff in the department told us they felt respected, valued and supported and all staff we spoke with commented on the effective team working within the department.

- Staff ensured it was a priority to engage with patients and relatives who used the service. Relatives told us they were encouraged to engage in plans for the care of their relatives.
- There was a strong focus on continuous learning and improvement through the nursing professional development groups. These groups ensured all staff at all levels were involved in driving improvement within the department and also a place to discuss and challenge poor practice.

Vision and strategy for this service

- The department provided details of their five-year strategy framework 2013/14-2018/19 prior to inspection. The main vision was to be the best unit in the region for patients, families and staff. The unit recognised and listed six ways in which this could be achieved. These included: Working with the fundraising and estates teams to provide the best environment possible. Develop the rehabilitation service to a seven day service. Increase the consultant base to meet requirements. Introduce a 24/7 outreach service. Provide level 2 and level 3 beds for all requested elective surgical patients and emergency laparotomy patients, and to develop family friendly policies to facilitate staff returning to work after maternity leave.
- During our inspection, we observed and were told there had been some progress on achieving this strategy. The consultant base had been improved in January 2016 which meant they were working towards achieving the requirements and the unit had achieved, through staff development a 24/7 outreach team.
- During inspection we observed there was a clear vision and strategy for the department, which most staff were somewhat aware of and able to discuss. During discussions with staff we found the main vision was to improve the environment and physical building, few staff discussed improving services for patients directly.
- There was no current plan progressing to improve the environment. We were told there had been other priorities throughout the hospital and the poor environment remained on the risk register.
- We were told recruiting CCU trained nurses had been a challenge for both the department and the network as a whole. Within the unit band 6 recruitment had been a particular problem and therefore there had been an over recruitment of band 5 nurses. There was a clear strategy in place to improve staffing levels including

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overseas recruitment and developing training and development opportunities. The department had increased the number of nurses enrolled on the intensive care course and had prioritised time and funding for this.

Governance, risk management and quality measurement

- The CCU at Kingston was managed under the director of clinical support services.
- Critical care risk meetings took place monthly; however they included minimal staff. We saw minutes from July and August 2015 that showed two attendees in July and three attendees in August, we saw no minutes, which indicated the inclusion of allied health professionals or other MDT members at these meetings. During these meetings, they highlighted current risks of concern, incident trends and reviewed the risk register.
- We reviewed monthly performance minutes where finance, performance and workforce issues were discussed with the divisional director. Each meeting produced an action plan to ensure progress on items discussed.
- Critical Care Unit business meetings took place monthly where outcomes, targets, and changes within the department were discussed. We saw documented evidence of when performance had improved and had been fed back to the group of staff involved.
- Areas identified as risks were included on the risk register. The risk register was updated regularly and largely reflected our inspection findings. The environment was identified as the top risk, which included poor lighting, ventilation, inadequate space around beds and clinical areas being used equipment storage resulting in a poor experience for patients and a poor and unsafe working environment for staff.
- There were regular audits, which took place throughout the unit by various different staff members. Audit results were fed back at business meetings, at handovers and through professional development groups and were displayed on the staff notice board. Nursing staff told us themes for audits were discussed within their professional development groups. Nursing staff had recently completed an audit on mouth care we saw results displayed around the department. Training for carrying out audits was provided at trust level by the trust audit lead.

- There were no regular, formalised mortality and morbidity meetings held within the unit. Critical care mortality and morbidity meetings were held alongside the surgical and medical meetings. Minutes of the meetings provided, demonstrated that these meetings were sporadic and senior staff told us that surgical mortality and morbidity meetings were more frequent than meetings with the medical team and that mortality and morbidity meetings with the medical team could be difficult to arrange.

Leadership of service

- Although there had been changes within the junior nursing team and the consultant team the clinical leadership team had remained constant for some time. The department had a long-standing clinical director who had been in post for six years and a long-standing matron leading the unit.
- Each shift had an identified band 7 or band 6 shift lead nurse who were supernumerary. During our inspection we observed the shift lead nurse supporting other members of the team when required.
- Nursing staff were aware of the leadership structure across the department and knew who to speak to about their concerns. They told us they felt comfortable approaching their leadership team with any issues however, told us they would first go to the band 7 lead of their professional development group. Staff told us they felt well supported and valued within their teams. .

Culture within the service

- We observed a friendly and open culture throughout critical care, where staff felt able to ask questions and seek support and guidance when needed. Staff told us there was an open and transparent culture in which they felt confident to challenge colleagues to benefit patients.
- During our Inspection we spoke with new nurses who told us they enjoyed working within the department because of the high level of support and team working. They told us they felt valued.

Public engagement and staff engagement

- Staff told us they had daily briefings during handover, which included any information regarding changes in practice, audit feedback or incident learning as well as any specific notices. A Handover we observed discussed changes to the surgical patient admission process and informed all staff in detail of these changes.

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- At the time of our inspection staff were involved in the process of choosing new monitoring equipment for the department. Staff were asked to fill in feedback forms about the equipment being tested.
- Nurses had opportunities within the professional development groups to discuss areas for improvement and identify areas for development within the service.
- Notice boards in the staff room showed current performance against targets, recent policy updates, and mandatory training compliance information.
- Relatives were encouraged to engage with patients care plans and recovery when appropriate. One relative we spoke with commented that he had been very much involved in his wife's rehabilitation and care when he was able.
- Senior staff were aware they needed to engage further in patient and public feedback. Due to the discontinuation of the critical care follow up clinics there had been no formal strategy to do this. Trust data provided

demonstrated a low Friends and Family Test response rate with the highest rate being 30% in August 2015. There had been no data collection for six months out of the nine months provided

Innovation, improvement and sustainability

- The department had responded to the NICE guidelines (Rehabilitation after critical illness) and core standards from the Intensive Care Society by purchasing a passive exercise machine (Motomed) from charitable funds. This helped to address the need to respond to the early implementation of rehabilitation of patients and reduce the length of stay.
- At the Patient First Conference in November 2015 the physiotherapy team presented a poster demonstrating the reduced length of stay for patients within the department as a result of the program and equipment. Due to this the companies involved in the equipment donated a stretcher card and upper body machine to the department, which will further enhance rehabilitation and patient's experience.

Maternity and gynaecology

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

Information about the service

From April 2014 to March 2015, there were 5,744 deliveries at Kingston Hospital NHS Foundation Trust. The maternity service is planning to deliver approximately 5,800 babies in 2015/16. This is close to the unit's current estimated capacity of 6000 per year. There were 492 births in August 2015 and 503 in September 2015.

The unit consists of an obstetric consultant-led labour ward with a midwifery-led unit alongside. The midwifery-led unit is for women whose pregnancies have been assessed as 'low risk'. The service is delivered from one site with some ante-natal clinics delivered in the local community.

In the maternity unit, obstetric-led births outnumber midwife-led births by almost four to one. Women with low risk pregnancies can also choose to have a home birth. Approximately 2% of births in 2014/15 were home births.

There are four teams of community midwives who offer antenatal clinics in local GP surgeries and children centres. There is a home birth community team and a team for more vulnerable women. Community midwives visit women immediately after they return home with their babies.

There is a fetal screening service for women between 11 and 13 weeks of pregnancy.

The labour ward has ten delivery rooms, all with en-suite facilities and one of the delivery rooms has a birthing pool. There are two dedicated obstetric theatres and a two bedded recovery area.

Maternity triage operates via a telephone line that is available 24 hours a day, seven days a week. Women telephone for an assessment, advice and reassurance and there is a two bedded assessment area for those who are asked to come into the unit for examination or monitoring. There are also a couple of individual rooms that can be used flexibly as additional antenatal or postnatal rooms.

There is a small maternity day assessment unit for women with abdominal pain, raised blood pressure or reduced fetal movements for example. The unit offers fetal monitoring in three curtained bays.

The midwifery-led unit has four delivery rooms, all with en-suite facilities and two have birthing pools. There are approximately 100 deliveries a month on the midwifery-led unit and these accounts for approximately 20% of all births delivered by the trust.

The unit provides inpatient antenatal and postnatal facilities on a dedicated ward. These beds are for antenatal women whose pregnancies have been assessed as high risk and for women and babies requiring additional support in the form of transitional care before going home. There is also a 21 bedded postnatal ward named Worcester. This ward is for lower risk postnatal women and their babies. Worcester has individual rooms with en-suite facilities.

The maternity unit is supported by a level two neonatal unit (NNU). There is a level 3 unit at St Georges Tooting, for babies requiring more intensive care.

There is an early pregnancy and acute gynaecology unit known as Jasmine, for women with acute gynaecological issues and women in early pregnancy, up to 17 weeks and

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six days. This is a day unit and is open 8am to 6pm Monday to Friday. It consists of four treatment rooms including a room for scanning. There are both emergency and planned gynaecology services with outpatient and inpatient care. There is general gynaecology, fertility, urogynaecology, gynaecological cancer, colposcopy, assisted conception and outpatient hysteroscopy.

There is a 15 bedded ward called Isabella, for gynaecology in-patients and those women who have had a medical termination because of fetal anomaly. From April 2014 to March 2015 there were 40 medical abortions conducted in the maternity delivery suite or Isabella Ward. In addition there were eight surgical abortions conducted on Isabella Ward and seven on the hospital's Day Surgery Unit. Isabella Ward also cares for breast cancer patients and there is a six bedded bay area where the ward can accommodate some patients overflowing from medical wards.

There was also an assisted conception unit and the unit had an inspection by the Human Fertilisation and Embryology Authority. This is the regulator overseeing the use of gametes and embryos in fertility treatment and research.

We visited all areas of maternity and gynaecology services and spoke with more than 80 members of staff, some on an individual basis and others in joint meetings, handover sessions and focus groups. This included staff of all grades including midwives, doctors, consultant obstetricians, domestics, maternity care assistants, receptionists, ward managers and members of the senior management team. We spoke with 10 patients from both gynaecology and maternity and we looked in detail at 10 sets of patient notes. We made observations in respect to the provision of care, staff interactions, the availability of equipment and the environment. We reviewed written material such as policies, guidelines and safety protocols and we reviewed formal arrangements for audit and the management of risk in order to evaluate the governance arrangements.

Summary of findings

Overall we rated maternity and gynaecology services as good. This was because:

- We found the service provided safe and effective care in accordance with recommended practices.
- Women could give birth at home, in the midwife-led unit or in the consultant-led delivery suite.
- There was a separate gynaecology ward, which provided support for other female patients who could not be accommodated on one of the medical wards.
- Staff were confident about reporting incidents and dealing with emergencies, knowing these would be reviewed and any lessons learned would be shared with colleagues.
- Leadership was strong and well respected.
- There was a culture of learning and a desire to improve the service.
- The response of the service to the alert on perinatal mortality was thorough and it was grasped as an opportunity for additional learning and improvement.
- Staffing levels were appropriate on ward areas. Additional midwives had been recruited and their numbers could be increased if the unit became busy.
- Community midwife services were operating well but were nearing full capacity.
- The individual needs of women were taken into account and they were offered compassionate care and emotional support from staff.
- Equipment was sufficient to meet the needs of women and their babies.
- The new bereavement room and services had been welcomed by women and midwives. The written feedback from women and their families was positive.

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- Staff were positive about the hospital and the services they were able to offer women and their families. They were proud to be part of the team and committed to providing high standards of care.

However;

- There was some pressure on bed capacity and the service was unable to increase the number of births per year without additional space in which to expand the service.
- The service would also need additional medical staff to support a greater number of births and greater support in the community.

Are maternity and gynaecology services safe?

Good



We rated the maternity and gynaecology services at Kingston Hospital as 'good' for safety. This was because:

- The service had effective systems and processes for reporting, investigating and acting on incidents and serious adverse events.
- Information was collected and reviewed around standards of safety. Learning was shared with the staff and the users of the service.
- Medicines were stored and managed appropriately.
- The environment in which women received care was suitably safe and clean.
- Staff planned and provided care and treatment in a way that ensured women's safety and welfare.
- Staff followed safety guidance for infection prevention and control.
- Staff had completed their mandatory training, or were on target to complete it, in areas relevant to the safety of women and their babies such as safeguarding, infection control and prevention and emergency procedures.
- There were sufficient maternity and nursing staff, and there were plans to increase the number of medical staff to provide cover in maternity and gynaecology, particularly overnight.
- Records related to the care of each woman were completed accurately and safeguarding procedures were operating well.
- Women reported feeling safe and confident in the skills of midwives, nurses and doctors.
- Equipment had been safety checked and was clean and readily accessible.

However;

- There were occasions where staff reported lack of basic equipment items both on wards and in the community.

Maternity and gynaecology

Incidents

- In the 12 month period between August 2014 and July 2015 no never events were reported occurring in the maternity and gynaecology services. In the same period, seven serious incidents were reported to have occurred within the maternity and gynaecology unit. We looked at six of the seven serious incident investigation reports. The seventh was still being completed as it had recently been upgraded to a serious incident.
- Of the six completed reports, three involved stillbirths (the death of a baby before or during birth after 24 weeks of gestation), there were two unexpected admissions to the neonatal unit (NNU) with one leading to an neonatal death (that is, the death of a baby within the first 28 days of life) and there was an antenatal intrauterine death (the death of the baby in the womb). All were reported appropriately and fully investigated.
- All six reports indicated an independent multidisciplinary panel had collected evidence and a comprehensive investigation had taken place with a view to learn lessons from the incident rather than to apportion blame. For example, in each case there was a description of the incident, a detailed chronology of events and the panel considered if the actions taken at each stage were appropriate in the circumstances. There were learning points from each investigation, a set of recommendations and an action plan. In one case, for example, it was recommended that in all cases a medical review should be sought when the cardiotocography (CTG) record from continuous fetal monitoring worsens or is difficult to interpret, especially in the active second stage of labour.
- We saw the investigation reports included a section on the arrangements that should be taken for shared learning and feedback with colleagues. These arrangements included discussion at perinatal mortality and morbidity meetings, discussion at CTG meetings, and a copy of the report to be sent to all staff and a feature to be included in the maternity risk newsletter. A senior clinician told us: 'As a unit, we are self critical; keen to learn and improve our practice'. We saw evidence of this when we discussed the unit's projects on improving the unit's competence in fetal monitoring, reducing the number of babies admitted unexpectedly to the neonatal unit and reducing the number of perinatal stillbirths. The staff demonstrated an eagerness to learn and improve and to share that learning with colleagues.
- We spoke with three midwives involved in managing the processes following the report of an incident. They were able to demonstrate how they acted on the incident on the day it was reported and followed the process through until they had received evidence all the actions had been completed. They maintained an investigation tracker and actions from each investigation remained live on the tracker until, for example, they had received a copy of the minutes of the meeting where the issue had been discussed by the staff identified in the action plan. We saw the tracker with the evidence attached and this demonstrated learning was shared and all actions were monitored until completed.
- We read the notes of some of the risk meetings and saw medical staff were fully engaged in the analysis of incidents and identification of any trends. There was also a reminder circulated in September 2015 about the Importance of reporting incidents. This reminder was given following an audit of babies born before arrival at hospital where it was discovered that only 25% of these cases had been reported as incidents. The guidance and trigger list for incident reporting was also circulated.
- We saw an analysis of incidents which had occurred in gynaecology from February to April 2015. We were informed of one serious incident in gynaecology, which resulted in moderate harm. During this period 49 incidents were reported and the highest number, 10 in all, were for postponed or cancelled operations. We saw minutes of gynaecology departmental and performance review meetings attended by the divisional and clinical directors and matron for gynaecology.

Safety thermometer

- The NHS Maternity Safety Thermometer allows maternity teams to take a 'temperature check' on harm and records the proportion of mothers who have experienced harm free care, and also records the number of harm(s) associated with maternity care. It is intended for public display so they are informed about the level of harm free care they can expect. The Maternity Safety Thermometer measures harm from perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby, and

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psychological safety. It also records babies with an Apgar score of less than seven at five minutes and/or those who are admitted to a neonatal unit. The Apgar score is an evaluation of the condition of a new-born infant based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being an optimum score.

- The maternity and gynaecology services participated in the NHS Safety Thermometer for the trust. This is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheters and associated urinary tract infections (CUTIs). There were no new pressure ulcers or catheter-acquired urinary tract infections from November 2014 to November 2015 in gynaecology or maternity. There was one fall with harm in May 2015.
- The maternity service had been preparing to participate in the maternity safety thermometer, which would be a meaningful measure of safety for the service, but the Head of Midwifery reported they were experiencing some difficulties with managing the electronic data for this process.

Cleanliness, infection control and hygiene

- We observed all areas of the hospital providing maternity services and gynaecology including the obstetric theatres. We found the standard of cleanliness to be good and there was evidence of domestic staff following guidance in regard to the required cleaning standards, practices and frequency of cleaning. We found stickers on items of equipment indicating they were clean and ready for use.
- Women we spoke with said they were pleased with the level of cleanliness. One woman said: 'It is spotless everywhere I go'. We saw staff, patients and visitors were using the hand sanitises on the wards and in the corridors.
- We saw the 'patient-led assessments of the care environment' (PLACE), for the gynaecology (Isabella) and antenatal (Tameside) Wards. This was a system for assessing the quality of the patient environment which involves local patients in the assessment. The assessments we saw were conducted in May and August 2015. They concluded they were very confident the environment on both Thameside and Isabella Wards supported good care. Some of the areas for improvement on Isabella Ward were in the storage of linen and there was dust found on bed frames and equipment.
- We saw the weekly cleaning audits undertaken between October 2014 and September 2015 by the facilities management provider at the hospital. Scores for antenatal, postnatal and gynaecology wards were mostly between 99% and 100% for the period. This demonstrates a high level of cleanliness and hygiene.
- We saw the quarterly reports from the infection prevention and control team for July to September 2015. The peer review of compliance with hand hygiene procedures demonstrated 100% compliance on the Mid-wife led Malden Suite and almost 100% compliance on the Thameside antenatal ward. There was one area where compliance was 90% and this was hand hygiene after touching patient surroundings. In addition, in September 2015 the postnatal ward, Worcester, scored 50% for all the hand hygiene processes including cleaning hands before and after patient contact. The score on this ward was 75% for staff observing the requirement to be bare below the elbows on the wards. The report said a hand hygiene action plan had been developed in response to some of the low scores and was being implemented by the Head of Nursing. The audits were being continued on a monthly basis.
- In response to a positive case of invasive Group A Streptococcal (GAS) in the maternity unit, which occurred in April 2015, Public Health England requested information regarding the number of previous case in the previous six months; number of staff members dealing with the case identified experiencing skin or throat infections and the trust's rate of post-operative wound infections relating to GAS cases in maternity. The trust carried out surveillance for six weeks and looked at readmissions and reported that, of the 38 cases looked into, none had GAS. The trust was able to report there had been no previous cases in the past six months and no staff members were identified with skin or throat infections.
- We saw from the maternity risk management group minutes and from the risk register there had been recurrent 'splash' incidents involving staff working in the

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delivery environment and in theatre. Staff were provided with full face visors for use at a delivery and staff were reminded in the maternity risk newsletter to wear protective equipment such as gloves and aprons. This item remained on the risk register until October 2015 when it was reviewed. It was agreed that, if there were no further cases within the next six months it would be removed. There would be a further review in March 2016.

- There was a reminder in the October 2015 edition of the maternity risk newsletter for all staff to dispose of needles and sharp objects safely. This reminder was following an incident where a domestic member of staff had been pricked by a needle when picking up a bag of rubbish.
- Rates of infection such as Meticillin Resistant Staphylococcus Aureaus (MRSA) and Clostridium Difficile (C.diff) were generally below the average for hospitals in England. There had been no reported cases of MRSA at Kingston Hospital from August 2014 to August 2015.
- We spoke with a housekeeper on the gynaecology ward. She was clear about her role and had received mandatory training. This staff member had catering and cleaning responsibilities. When we saw her she was wearing protective equipment, gloves and an apron. She said she was aware of the infection control procedures and her equipment was colour coded. She also said she knew how to escalate if she saw a patient was unwell.

Environment and equipment

- The Head of Midwifery and the Clinical Director of the service informed us the maternity service had outgrown the space available and was at the limit of its capacity. When the maternity unit first opened in 1995 there were just over 3000 births. In 2005/6 the unit was anticipating 6000 births at Kingston.
- There was an item on the risk register requiring discussion with colleagues in estates about the impact of the lack of space, as the number of births a year continued to grow. (see responsive R1 for full discussion of premises).
- We saw quarterly reports from the infection prevention and control team for July to September 2015 included equipment spot checks for most of the clinical areas in

the trust. The scores for compliance with cleaning, house keeping and keeping the areas clutter free were low for gynaecology, maternity and postnatal wards in the first spot check in June 2015. The report indicated that, in areas of low compliance, cleaning equipment schedules were re-introduced and a re-audit three months later showed some improved scores. In the second spot check in September 2015 scores had improved with Worcester and Isabella Wards achieving 100% compliance.

- We saw from the maternity risk newsletter a recent audit on resuscitaires had shown the rates of checking had fallen to around 70% in August 2015. There was also an incident highlighted in the newsletter where a midwife went to use a resuscitaire in an emergency and found it had no tubing for the mask and no mask. In addition the laryngoscope had no batteries. The midwife called for a second resuscitaire and found that was also missing the mask and tubing and had no gases.
- We saw staff were required to check resuscitaires once a shift, that is twice in 24 hours, and this had been entered on the risk register in August 2015. This was supported by an action plan involving monthly audits of checks by the maternity risk manager and for the midwife in charge to review resuscitaires on a daily basis and check that they were fully stocked. We checked three resuscitaire on the delivery ward and found they had been checked and signed on every shift, for everyday in November, December 2015 and January 2016.
- There were blue disposable curtains and they had the date they were last changed marked on them. We saw there were daily cleaning and equipment checks in all the rooms.
- The birthing pools in the midwife led unit and on the labour ward were clean and there were stickers to say when they had been cleaned.
- The matron told us non slip flooring had been laid in the two obstetric theatres because the floor tended to become slippery when wet.
- We met with a six community midwives and maternity support workers and their receptionist. They told us they had experimented with using laptops in the community so they could input information without

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having to return to base. However, the network signal was not good enough. They said many of them had to return to the hospital to input data and there were not enough computers to go around.

- The community midwives told us about the difficulties they had with finding car parking when visiting women in the community. They said they often had to drive around looking for a space or park some distance from the home they were visiting. This all took additional time. They said they required additional parking permits.
- There was some concern expressed in the focus groups about the lack of basic equipment in maternity such as thermometers and drip stands. Community midwives said that they needed a Bilirubinometer, a machine for checking for deterioration for a baby with jaundice.

Medicines

- We checked the drugs cupboards on the labour ward. Drugs were in a locked cupboard and there was a locked cupboard within a cupboard to store the controlled drugs. The key was always with the named midwife in charge. We saw that the records for all drugs were checked regularly and were correct in relation to the stock.
- We saw the temperatures on the medicines fridge were checked daily. Medicines were stored appropriately and managed well. The pharmacy also checked the labour ward records daily.
- In February 2015 the service had introduced electronic prescribing (e-prescribing) systems to support the whole medicines use process, enabling medications to be managed electronically at every stage, from prescribing through to supply, administration and stock control. The risk midwife told us the new process had resulted in an increase in the number of medicine related incidents initially. This had been included on the risk register but the item was closed in October 2015 when no further errors were reported as the staff became more familiar with the process.

Records

- In July 2015 the trust completed an audit of continuous electronic fetal monitoring. The sample period for this audit was September – November 2014 and 47 sets of records were included in the audit. The trust met the target of 75% compliance in all but two areas. These

were for recording the mode of delivery and for fresh eyes being performed at each hourly review. The service demonstrated 100% for recording the women's hospital number, the date and time, the delivery date, baseline rate for cardiotocography (CTG) monitoring, fresh eyes and for action taken if bradycardia occurs in the baby for more than three minutes. The trust had agreed an action plan for the areas that were not 100% compliant and we saw evidence this was being implemented. For example, one of the actions was to improve the documentation of mode of delivery at the end of the labouring CTG and this was to be added to the October 2015 edition of the risk newsletter. We checked and found it had been included in this newsletter. This demonstrated the record keeping was accurate and complete and work was continuing to maintain and improve this level of record keeping,

- We looked at six sets of notes on the Thameside (high risk) postnatal ward and one set of notes on the postnatal Worster Ward. There were complete venous thromboembolism assessments (VTE) in hard copy for every admission antenatally and on admission to the labour and postnatal wards. These assessments had also been recorded on the electronic record system.
- We looked at two sets of notes on the gynaecology ward, (Isabella) both the paper and electronic versions. We found a good standard of documentation with all the essential documents present and complete such as a pre-assessment, consent form, surgical safety checklist and anaesthetic record. We also saw appropriate care plans, an assessment of additional needs and discharge summary.
- We reviewed four sets of notes on the labour ward where the babies had been delivered that day. We checked the notes against a list 13 separate entries and all were present including the antenatal screening, birth plan, symphysis-fundal height, partogram and drug chart.
- The service used the red books for babies, a set of paper hospital notes and the mother had a set of handheld notes. There was also an electronic set of hospital notes. The triage service used a paper based log that was scanned and stored electronically. There were plans to move to an electronic record in triage.

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- We were informed by the consultant midwife the service was moving towards on-line electronic hospital notes. Several midwives said the duplication of paper based and electronic systems was inefficient. The Head of the service informed us the underdevelopment of information technology across the trust was an obstacle to electronic communication and record keeping.
- Community midwives told us that, when they were holding clinics in venues where there was no link to the electronic record system, they had to travel back to the hospital to input data. The Head of the service said they were planning to see women only on sites where there was access to the electronic system.

Safeguarding

- We saw guidelines for safeguarding vulnerable women at risk in the antenatal, labour and postnatal period to support the service in reducing harm to the mother, the unborn/new-born baby and any other children in the family. The service had a dedicated team (the Bridge Team) of specialist community midwives to support vulnerable women and, where risk factors were identified, a referral would be made to this team. Referrals may be made from other points in the service such as triage or the early pregnancy unit.
- The specialist Bridge Team had a specialist midwife for mental health and a link midwife for learning disability, a safeguarding midwife and a link midwife for domestic violence. They also had a set of criteria for accepting a referral and a number of separate pathways had been developed in the service for more vulnerable women in pregnancy. There was a multi-agency working around children protection and specific pathways for teenage young parents supported by health visitors and colleagues from social services.
- Each of the community midwifery teams had a safeguarding midwife allocated. We spoke with them and they told us sometimes the referral from the GP would highlight an issue, but more often they were dealing with a 'blank sheet' at the first booking appointment. They also said they had a close working relationship with the Health Visitors who may have important background information and there may be alerts individual health notes or on the database.
- The community midwives said they referred any women for whom they had concerns to the Bridge Team. Where the referral did not meet the criteria for the specialist team they would conduct a risk assessment and manage the case with support from specialist colleagues, the safeguarding midwife, supervisor and team leader. They also referred women under 19 years old, any women with special learning needs, drug or alcohol misuse and domestic abuse. They said and there were routine questions undertaken and recorded at the first appointment but they were also aware some women would find it difficult to disclose.
- The community midwives told us they were vigilant where a woman booked late in her pregnancy or when she missed appointments or was reluctant to agree to an advised plan of care. One midwife said 'It is important not to make assumptions but make sure you can talk to a woman on her own and be aware of her social and emotional needs.'
- We asked the community midwives about female genital mutilation (FGM) and the responsibilities of individuals to report cases involving under 18s to the police and safeguarding. They said cases in the area were rare but they were aware of the issue and one midwife had some suspicions about a possible case. She said she spoke with her supervisor and the safeguarding midwife. Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it was mandatory to record this in the patient's health record; there was a clear process to facilitate this reporting requirement.
- We looked at the data for compliance with safeguarding training for both adults and children. There were several areas of 100% compliance including the assisted conception unit, obstetrics and gynaecology administration and gynaecology general. All other areas were over 80% compliant, which was the trust target, apart from Obstetric and Gynaecology medical staff where there was 75% compliance. We saw a link to the children's safeguarding policy was included in the July edition of the maternity risk newsletter.
- The trust informed us that 172 midwives received Level 3 Safeguarding training in the year Dec 2014-Dec 2015. This represents 89% of the midwifery workforce receiving training. For those who were outstanding they were booked to attend the training.
- We saw the minutes of the safeguarding children's committee meeting held in November 2015. We noted

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the named nurse for child protection and liaison health visitor were in attendance along with the named midwife for safeguarding. There was a quarterly report presented from the Bridge Team with details of the number of babies removed from the care of their mothers and the number of babies subject to child protection plans in the quarter. The committed discussed the possibility of breaking down the figures for each Borough in order to look at comparisons with other maternity units. This demonstrated careful reporting and monitoring was continuing in relation to safeguarding in the maternity service.

- We saw copies of the guidelines for specialist pathways for the management of teenage pregnancy, the management of new-borns of mothers who misuse substances and for maternal mental health.

Mandatory training

- As part of the quality strategy, the trust had set itself a quality goal for 2015/16 to: 'Keep all staff up to date with mandatory training'. We looked at the staff training compliance data for the following categories: ante natal outpatients, gynaecology general, speciality midwifery, obstetrics and gynaecology medical, maternity stores and Isabella Ward. The data demonstrated low levels of compliance, that is less than 50%, amongst administrative and clerical staff in ante natal outpatients and gynaecology general for fire training and for additional clinical services on Isabella Ward.
- Other areas of non-compliance with the trusts target of 80% were in gynaecology general for nursing and midwifery staff in manual handling, which was at 33% and basic resuscitation, conflict, fire and information governance which were all at 67%. However, more areas were compliant than non-compliant with maternity stores 100% compliant in all areas of mandatory training. Areas that were non-compliant were working towards completion by the end of the financial year.
- We looked at the data recorded overall on the maternity scorecard for mandatory training. This showed 77% compliance in August 2015 and 72% compliance in September 2015. Compliance levels for the year at the time of the inspection was 84% for maternity.
- One of the senior midwives said the practice development midwife would make sure midwives did their mandatory training. However, if staff levels were low the senior midwives 'would have no choice but to

pull them off the courses because the service was busy'. The senior midwife said there was an antenatal screening study day next week and four staff wanted to attend. The decision had been taken to cancel an antenatal clinic so they could attend because they were unable to find cover.

- We noted new areas of training were linked to the needs of the service. For example, annual mandatory CTG study days had been introduced for midwives and obstetricians because of the risk of misinterpretation of fetal heart monitoring.

Assessing and responding to patient risk

- We looked in detail at four sets of notes on the labour ward and all four included the Modified Early Obstetric Warning Score 'MEOWS' charts to provide graphic evidence of the health of a patient deteriorating. All had been completed appropriately. In addition, we looked at 10 sets of notes on the postnatal and gynaecology wards and we also found MEOWS charts and assessments of risk and completed surgical safety checklists.
- Following a review of serious incidents and legal claims, the service had begun a project with funding from the NHS England 'Sign up to Safety' campaign to reduce the misinterpretation of fetal monitoring. This was also added as an item on the maternity risk register and emerging findings from the project were discussed at clinical governance meetings, the birth forum and risk meetings. This demonstrated the service was constantly measuring and monitoring to assess safety and reduce avoidance risk.
- We received an audit of compliance with completion of the World Health Organization's safe surgery checklist that was completed in relation to maternity theatres in November 2015. This was a baseline audit to assess the level of compliance. This checklist is part of the Safe Surgery Saves Lives initiative to improve safety in surgery and to reduce incidents. A baseline audit looked at 17 checklists over one week and found that 8, or 47%, were completed fully. As a result of this audit an action plan was being developed and then the audit would be repeated. We saw white boards in the maternity theatres for recording the swabs used in surgery. A similar audit for surgery in gynaecology was conducted in September 2015. In this case 21 checklists were inspected and all 21 were fully completed.

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- Health records we reviewed revealed that risk assessments were conducted for all women in gynaecology and maternity units. Risk assessments were used to determine if a pregnancy and labour were likely to be low or high risk and whether a home birth or midwife-led birth was appropriate in all the circumstances. Risks considered included maternity history, multiple birth, previous caesarean section, weight, age, blood pressure and conditions such as diabetes.
 - We saw a risk assessment completed following changes to an electronic system which meant NHS numbers would not be issued automatically as part of the birth registration process. The risk was babies without NHS numbers may be overlooked for new-born screening programmes and this would impact on the early detection and treatment of anomalies. It was decided, therefore that, until the electronic system was upgraded in March 2016, NHS numbers would be generated manually. A standard operation procedure had been written to provide guidance for staff.
 - We also saw risk assessments for environmental hazards, which could impact on patient safety. For example, the emergency call bell in the midwife led unit could not always be heard from all the delivery rooms in the unit. As a result, it was agreed that, if the emergency bell was activated two midwives should attend and, if they are providing one to one care, the triage midwife would attend. The administrative staff on the maternity reception were also trained to inform the delivery suite co-ordinator that the emergency bell has been activated.
 - We attended the morning handover and multidisciplinary meeting on the delivery suite. There was a clear emphasis on risk and safety at this meeting and ensuring there were enough staff to deal with the number of women and the complexity of their needs.
- ## Midwifery staffing
- The ratio of midwifery staff to births within the service at the time of our visit was one midwife to every 31 births, this is worse than the London standard of one midwife to 30 births and the England average of one midwife to 28 births. We saw from the maternity risk register the service had been non-compliant with the safer child birth standards since March 2012.
 - When the Local Supervising Authority audit report was published in October 2014 the ratio had been 1:34. The risk register said the 'Maternity Unit continues to be non-compliant and is the only unit in the South West London maternity network with ratios not at 1:30 or better.
 - The maternity scorecard recorded 100% one to one care for women in labour and the risk register indicated: 'the annual staffing review ensures we are compliant. The staffing was reviewed daily at the 9am board round and measures were put in place to address shortfalls where possible'. We attended the board round and observed staffing levels were being closely monitored.
 - There was a vacancy rate of 3.8% for the period April to September 2015. Since then the rate had been reducing because the service has been recruiting. In June 2015 there were an additional 12 midwives recruited and a further 20 midwives were due to start from September 2015. Staff we spoke with said the staffing levels were improving but, after so much recruitment over a short period of time, they had some issues with the mix of skills as there were greater numbers of less experienced staff.
 - There were specialist midwife roles for screening, infant feeding, safeguarding, mental health, risk, bereavement and for education.
 - We were told diversity and skill mix in the nursing staff was also a 'challenge' in gynaecology as they wanted to offer a broader range of services including urogynaecology.
 - These high levels of recruitment were coupled with a relatively high rate of turnover. Turnover in maternity was running at almost 9% for the year to date. Sickness rates were at 3.5% year to date which is above the target for the service of 2.5%.
 - The trust supplied total vacancy numbers for gynaecology and maternity in 2015. They were 8.56 vacancies in June, 7.38 in July, 9.68 in August and 6 in September. We saw the Safer Staffing Ward and Shift breakdown for December 2015 and saw the daytime staffing rate for registered midwives was over 100% of the planned establishment but the night time rate was a

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little under 100%. Similarly, the day time rate for registered nurses on the gynaecology ward was above 100% but the night time rate for Health Care Assistants was 89% of the required establishment.

- The maternity service had not used any agency staff for three years, preferring instead to use their own staff to do additional shifts through a staffing bank. They were also able to use mobile communication, text and a closed Facebook Group, to alert the on-call midwives and to contact staff quickly to offer extra shifts. They also had a supervisor of midwives on call.
- The Head of Midwifery said that the service was doing additional work on staff capacity. She said we are 'taking a proactive approach by anticipatory planning, having a good escalation policy, developing staff and creating new roles for greater retention'. The Maternity Assistants were able to assist in theatre and with antenatal screening. The advanced maternity support workers in the community could undertake the home visit on day five, weigh the baby and undertake the new-born blood spot test.
- Some community midwives, who had been trained, could conduct the examination of the new-born. There were two consultant midwives; a new on-call home birth team launched in 2014, an infant feeding team and the Bridge Team had been established for more vulnerable women. Midwives were flexible about the areas they worked and community midwives were rostered to also work in the midwife led unit.
- The trust used the intrapartum 'Birthrate plus' acuity and review tool to ensure staffing levels were appropriate for the present and future. The Head of Midwifery said she was making a case for creating a 'case-loading community team'. This team would take on a smaller caseload and offer more time and continuity of care for vulnerable women.
- We saw senior staff were monitoring activity and staffing on the antenatal ward, delivery suite, maternity led unit and postnatal ward. They were also aware of caesarean sections taking place, any home births and women calling triage with the early signs labour. This enabled the ward manager and midwives to assess the workload arising from the numbers of women needing care, their condition on admission and throughout the processes of labour and delivery. This was monitored and assessed in relation to the staff on duty, the bed capacity and the ability of the service to respond to an emergency. On occasions it would be necessary to delay an induction of labour or elective caesarean if the delivery suite was very busy.
- We spoke with community midwives who told us they were a committed and well functioning team but at the same time they felt they were often working at full capacity, particularly in the winter months. This meant they had to cover more clinics and visits when sickness levels were high but, one midwife said: 'we roll up our sleeves and get on with it'. They said they could save time if the technology was better and they did not have to come back into the hospital to enter data into the computer. The community midwives had raised this with the Head of Midwifery and one said; 'The leadership is great. No one looks down on you or thinks less of you if you ask for help. This is a great place to work we want women to have the best'.
- We spoke with the Head of Midwifery about the limitations placed on the service by the information technology. She said, 'we are reconfiguring booking in the community so that all women are booked on sites where community midwives will have access to the electronic system'. She also said they were working to improve and extend the use of the technology to improve the efficiency.
- Another community midwife said; "the team survives on good will, we just get it done even if that means that we miss our breaks and work longer hours."
- The community midwives said the new role of Advanced Maternity Support Worker had been very positive. This role, requiring a foundation degree, was developed at the trust with the input of staff and the leadership of the Head of Midwifery. The Advanced Maternity Support Worker could attend visits independently and this allowed Midwives to concentrate on more complex visits, first bookings and supporting clinics. There was an on-call system involving the supervisors of midwives on the rota.
- We spoke with the senior sister on the gynaecology ward. She said there had been a problem with

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insufficient senior staff on the ward and high levels of turnover. However, the situation had improved in recent months, there had been new starters and it had become more stable. She said senior capacity was getting better.

Medical staffing

- There were 98 hours of consultant cover on the Delivery Suite per week with long, 12 hour, shifts from 8am to 10pm Monday to Sunday. There was a consultant on-call rota operating outside of these hours. There was an obstetric or gynaecology registrar and a middle grade doctor at night. There was a second consultant for elective caesarean section lists from 8am to 1pm three to four days a week.
- A case was made, and documented in the risk register, in April 2015, for three new consultant posts. At this time the risk register entry indicated the unit was not achieving the national standards for obstetric staffing as defined by safer childbirth, Royal College of Obstetricians and Gynaecologists (RCOG) in 2007. Two new locum posts were agreed. So, by July 2015 there were: 13 substantive consultants contributing to obstetric care, two locum consultants in post, one full time obstetric labour ward lead and two combined obstetric and gynaecology posts. There was a plan to increase consultant cover in the future to 138 hours a week and have a consultant resident overnight on a Thursday, the busiest night on the Delivery Suite.
- We were informed that elective caesareans were delayed occasionally if the delivery suite was busy and dealing with complex issues. We were also informed by staff in the Day Assessment Unit there was sometime a delay for women who needed to see a doctor. In addition, the service wanted to turn the long term locum posts into substantive posts and recruit to a third post.
- There were 12.83 whole time equivalent (WTE) consultants covering gynaecology and also breast services.
- The skill mix and profile of the medical staff in maternity and gynaecology services revealed the trust had a higher proportion of consultants and slightly fewer middle grade and junior doctors than the average across trusts in England. So the medical staff were more experienced than at other trusts in England.
- Staff at the focus groups said there were effective working relationships between midwives, nurses and

doctors and a strong leadership team. One midwife said, 'There is no them and us culture and we can challenge doctors'. We observed medical staff were visible on the wards, engaged in leading projects, attending to governance and engaged in the morning handover meetings.

- A senior member of staff on the gynaecology ward said that there was not much occupational therapy input on Isabella ward.

Major incident awareness and training

- We spoke to senior clinicians about preparations in the service for major incidents. They told us there was a business continuity plan and regular trust wide drills involving cascading lists of important phone contacts, discharging patients ready to go home and shifting on to an emergency only service. They said there was also an annual assurance visit from NHS England to check on the level of emergency preparedness for periods of disruption.
- Our visit followed the first day of industrial action by Junior Doctors and so the Clinical Director was able to take us through the preparations that had been made for this. They had checked who would be participating in the industrial action, organised more consultant cover and made arrangements to cancel any elective work or clinics that could not be covered. They also planned to review the first day and learn any lessons in advance of the next day of industrial action.

Are maternity and gynaecology services effective?

Good



We rated the maternity and gynaecology service at Kingston Hospital as 'good' for being effective. This was because:

- Staff working in maternity and gynaecology services had access to professional guidance to inform care and treatment.
- Midwives had been trained to perform effectively in their roles and mother's said they were both competent and professional.

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- The service was continually monitoring patient outcomes through the use of a rolling dashboard and audits.
- The service was seeking to make improvements in a number of areas including perinatal mortality, Post Partum Haemorrhage (PPH) and in the rates of normal birth.
- Multidisciplinary working were good both within the service and with agency partners.
- Pain management was available and the service was supporting the development of new approaches to woman's care.

Evidence-based care and treatment

- There was evidence available to demonstrate women using the services of the trust were receiving care in line with the National Institute for Health and Care Excellence (NICE). For example, routine antenatal care was delivered in accordance with NICE guideline 62 – Antenatal Care; Routine care for the healthy pregnant woman, March 2008. The antenatal screening tests for fetal anomalies were conducted according to the Fetal Anomaly Screening Programmes Standards and the trust was undertaking a pilot programme with the Wolfson Institute of Preventive Medicine, the current leader in the field of antenatal screening for Down's syndrome
- We saw an update circulated in October 2015 to staff in the maternity service with details of seven quality standards that had been updated by NICE. These included new guidance available from July 2015, QS98 Nutrition: Improving maternal and child nutrition. The note said this new guidance was being compared to the local trust guidance to see if it required updating. There were also quality standards issued by NICE on Induction of Labour QS60, Multiple pregnancy, QS46 and Hypertension in Pregnancy. The note indicated the local guidance was consistent with these standards.
- There was a regular group meeting in maternity to agree new or updated guidelines. The new guidelines were listed in the risk management group minutes. We saw that nine new guidelines had been ratified and were reported to the risk management group on 6 October 2015. Examples of the guidelines were HIV in pregnancy, intermittent auscultation and management of postpartum hypertension.
- Maternity services had a formalised audit tracker, which when viewed indicated the area of focus, person responsible and relevant times lines for completion. We saw prioritisation was stated and where audits had finished they were presented to various groups, with associated action plans agreed.
- Results and action plans from an Association of Anaesthetists of Great Britain and Ireland (AAGBI) audit completed on 31st March 2015 were reviewed by us. There were 1746 epidurals carried out in 2014, of which 94 (5.4%) waited more than an hour for the epidural to be sited. Successful regional blocks were achieved in 97.6% of the 1624 lower segment caesarean sections undertaken in 2014. We saw from the information there were actions required with relation to post operative pain relief.
- We saw an audit of continuous electronic fetal monitoring had been carried out between September and November 2014. This was conducted to ensure compliance with local and NICE guidelines, and compared results with those obtained in the audit of 2013. Results indicated improved compliance, such as the recoding of CTG start time from 13% to 89%, the recoding of intrapartum events, from 75% to 96%. Signed discontinuation of the CTG monitoring improved from 58% to 94%. Recommendations were identified from the audit and information had been shared at the clinical governance meeting.
- We reviewed a quality standards audit on intermittent auscultation, which was conducted according to the NICE guideline CG55 for intrapartum care. This demonstrated that the practice at Kingston was consistent with the NICE guidance.
- An audit of patients' consent to surgery in gynaecology had taken place between 1 January 2014 to 31 March 2014, and this was referenced to the 'Policy for Consent and Examination or Treatment, version 8, January 2013. This was a trust guideline. Results indicated 100% compliance with three main elements, including; documentation that consent had been taken for the procedure, documentation of risks of the procedure to the patient, and consent having been taken by the clinician competent to perform the procedure. Improvements were required in a number of the areas, and an action plan was viewed.

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- Following an alert in June 2015, the service had undertaken a detailed analysis of perinatal mortality using the perinatal death data collection from 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' (MBRRACE) and the Perinatal Mortality Report published by RCOG in 2011. The trust also circulated a summary of the key findings of the MBRRACE-UK Perinatal Mortality Surveillance Report for perinatal deaths for births from Jan to December 2013
- We saw a patient information leaflet produced by the trust on the website. There was also reference and a link on the website to the Royal College of Obstetricians and Gynaecologists guidance in 'Your Baby's Movement in Pregnancy'.
- The service was working to the London Quality Standards for maternity and engaging with the South West London network for benchmarking and peer review. The service was using the birthrate plus acuity tool and the safer staffing framework to provide guidance on staffing levels. The service was also participating in national programmes, such as, the NHS England campaign 'Sign up to Safety'.

Pain relief

- The midwives told us an anaesthetist was always available for epidurals on the delivery suite. One woman who said she began with 'gas and air' and when her pain got worse she asked for an epidural. She added that the anaesthetist arrived quickly.
- We reviewed an audit of obstetric anaesthetic activity for 2014. In that year 1746 epidurals were performed, and all but 95, or 5.4%, were inserted within an hour of being requested. The audit indicated delays were caused by the out of hour's workload and some delays had occurred when there was more than one anaesthetist attending to women on the delivery suite. The audit also noted the midwives and doctors working on delivery suite were aware of the escalation process if there were delays.
- Two of the complaints received in the maternity service in the first quarter of 2015 were about delays in providing pain relief. We saw one involved poor communication and in the other case there was a delay

in transferring the woman to the postnatal ward. Apologies were provided and colleagues were able to reflect on the circumstances and learn from the two cases.

- There was a pain relief for labour and birth leaflet on the website. The leaflet set out the choices and the benefits of different types of pain relief such as, water, entonox, pethidine and transcutaneous electrical nerve stimulation. There was information about alternative forms of pain relief and management in pregnancy and labour from the Wellbeing Centre. These included yoga for pregnancy, acupuncture and active birth workshops for couples. These alternative forms of pain relief were not offered by midwives but were supported.
- We spoke to a gynaecology patient on Isabella Ward who had a procedure with an epidural. She said it was 'painless' and the anaesthetist gave her all the information she wanted. She said the nursing care afterwards was brilliant. Another woman on the same ward said, the nurses were very attentive and brought her painkillers and fluids immediately after her surgery.
- There was a midwife led birth centre at Kingston. It was decorated in pastel colours and had gentle lighting. The overall effect was calming. There were two birthing pools and beds and couches to support active labour and provide relief from pain. The service was piloting a new bed for active labour and there were other birthing aids such as 'V' shaped pillow birth and birthing balls.
- We were informed the transfer rate from the midwifery led unit to the delivery suite was between 12 and 15%. The main reason for a transfer was for epidural pain relief which was only available on the delivery suite.

Nutrition and hydration

- We spoke with a woman on the postnatal ward who said the food was 'pretty good'. Another woman said there was a good choice and it was always nice and hot. A woman we spoke with on the gynaecology ward said, 'I've not been up to eating much but the nurses have made sure I am taking enough fluids'. The nurses told us they could cater for all special diets.
- The service had a specialist midwife for infant feeding and a maternity support worker. The infant feeding team had information on the trust's maternity website about bottle feeding and breast feeding. There were also links to the NHS choices website and UNICEF. There

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were other helpful leaflets on the website including the UNICEF/World Health Organisation leaflet 'Off to the best start' and a Kingston postnatal booklet called 'Going home with your baby' with a section on 'feeding your baby' and 'how to tell if feeding is going well'. There were also monthly infant feeding workshops, which the infant feeding team suggested mothers attend between 32 and 36 weeks of their pregnancy.

- We spoke with a woman on the postnatal ward who had just had her first baby. She said she had attended the workshop and it was 'very information and also quite fun'. She told us she was being well supported with breast feeding in the hospital and it was going well.
- The service had committed to achieving the UNICEF baby friendly stage one and this commitment was on the website.
- When we looked in detail at patient records on the postnatal ward and on the gynaecology ward we saw detailed care plans with fluid and nutrition charts, where appropriate.

Patient outcomes

- Information about the outcomes of patient's care and treatment were routinely collected and monitored by the service through the governance and risk management processes, the maternity and gynaecology scorecards and the monthly performance board. The Divisional Director, Clinical Director, Head of Midwifery, Consultant Midwives, Matrons and the Risk midwife all attended the Performance Board. In addition, any variations from the norm were reported through the bi-monthly clinical governance report and were considered by the trust board.
- Episiotomy rates during normal vaginal deliveries were monitored as part of the maternity dashboard. We saw the target of less than or equal to 9.4% was met for each month covering the period August to December 2015. The lowest rate of episiotomies performed was 4.1% in December.
- The maternity dashboard covering the period August to December 2015 indicated a target of less than 2.9% for 3rd/4th perineal degree tears occurring during vaginal delivery. It was noted the target was exceeded in November (4.4%) and December, (3.2%) respectively. For quarter two the overall figure was 2.3% and quarter three, 3.3%.
- Assisted delivery rates ranged from 13.1% in December 2015 up to 16.75 in August 2015. The information within the dashboard did not distinguish the type of assistance needed, such as forceps.
- Caesarean section rates were monitored through the maternity dashboard. We reviewed this for the period August to December 2015. The elective caesarean section target was less than or equal to 12.1%. The rate varied from 8.7% in August to the highest level of 14.5% in September 2015. overall rates for quarters two and three were 12.6% and 12.8% respectively.
- Emergency caesarean section rates were measured against a target of less than or equal to 13.1% of the deliveries. We noted for the period August-December 2015 this target was met on one occasion, in November, (13.1). All other months exceeded this with the highest figures at 18.7% in August and 15.5% for September.
- We referred to the intelligent monitoring data for 2014 and found the trust was not performing significantly differently to the main body of NHS trusts in relation to maternal and neonatal readmissions, caesareans and cases of puerperal sepsis and other puerperal infections. However, during 2015 the service began to perform less well than the England average and the trusts own targets.
- The first of these indicators, post partum haemorrhage (PPH) of greater than 2000 mls and 1500 mls, was reported to the board in June 2015 in the clinical quality report. Also in this month the number of births had risen to 536. There was a careful analysis of the issues, 28 new midwives were recruited and a dedicated labour ward lead consultant was appointed. The focus was placed on fast action and early senior involvement. The number of PPHs greater than 1500 ml fell to within target by the end of December but the PPHs greater than 2000 mls, having fallen to within target for September and October, rose above the threshold for November and December 2015. The service was continuing to monitor this closely and take appropriate action.
- Consultant midwife clinics have been provided as additional support for women requiring specialist care.

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Referrals for women to these clinics were based on having had a previous PHH, maternal age, previous cervical surgery, Female Genital Mutilation and a BMI greater than 40.

- There were 12 stillbirths across the period August to December 2015, which was within the expected range for the number of deliveries. Information indicated contributory factors were identified as part of the investigation into these.
- The service also noticed an increase in the caesarean section rate in December to 30.4% of all births. This was above the trust threshold of 26% and the England average. The decisions taken in relation to all caesarean sections were already reviewed as part of the 'Sign up to Safety' project and the trust had specialist clinics and workshops for women considering a vaginal birth after having had a previous caesarean, known as VBAC. The service said the 'rate will be monitored closely to ensure this change is due to monthly variation rather than trend'. However, the year to date figure was 29.3% and also above the trust threshold and England average. The trust had recruited a matron who had experience of increasing VBACs and she had started on an audit of caesarean sections using the Robson categories of pregnancy. The Robson classification is a system that classifies women into 10 groups based on their obstetric characteristics (parity, previous CS, gestational age, onset of labour, fetal presentation and the number of fetuses).
- In June 2015 the Care Quality Commission (CQC) wrote to the trust informing them that an analysis of prenatal mortality had indicated significantly high rates of perinatal mortality between April 2014 and January 2015 at the trust. However, the performance monitoring in the maternity service had already identified the increase and it had triggered an internal alert in 2014.
- The trust completed a detailed analysis in response to the alert and identified some risks factors including missed antenatal appointments, raised maternal BMI, and need for interpreters. There was also evidence of intrauterine growth restriction and, in seven of the cases the lack of symphysis fundal height measurement/documentation was highlighted. The trust was able to make some immediate improvements to practice and was implementing an action plan which we discussed with the labour ward lead consultant. This work was also part of the Sign up to Safety project to improve birth outcomes for babies born at Kingston Maternity Unit.
- The service has also been identified as having higher rates of sepsis and of postnatal readmission. We spoke with the risk managers about the sepsis rates and they informed us this was not a trend in maternity but a coding issue. This was because the form used in community midwifery had too few options. An audit was underway and the risk manager said from the emerging findings, it was likely to confirm this. We discussed this and the readmission figures with community midwives and a community team leader. They said the other factors were early discharge from hospital, limited access to the GPs and women not focussing on self-care. The consultant midwife said the findings of an audit of readmissions had confirmed the reasons were not sepsis. This was confirmed the matron was leading on the action on this and there were no indicators emerging from the national Commission for Quality and Innovation data collection for Sepsis arising from maternity.
- The service was performing above its own target for women attending their first appointment within 12 weeks and six days of pregnancy. The target was to achieve this in 90% of cases and it was being achieved in 96.9% of cases for the year to September 2015. More than 50% of women had already had their first booking appointment by nine weeks and six days of pregnancy.
- 99% of women had a venous thromboembolism (VTE) assessment, which was above the trust target of 95%. The service confirmed they were providing 1:1 care in labour for all women and we observed this being monitored at the handover meetings.
- In the National Neonatal Audit Programme in 2013 the service was below the standard for three of the five questions audited, Standards were met or exceeded for the remaining two questions audited.
- The maternity risk newsletter in December 2015 included an entry celebrating the results of the national maternity patient survey had rated Kingston maternity as the best in London.

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Competent staff

- When we visited the ratio of midwives to supervisors of midwives was 1:13, which was better than the recommended ratio of 1:15. There was also a full-time supervisor of midwives. Midwives said they were well supported by their supervisors particularly in relation to safety, assisting junior staff and in advising on issues arising from capacity issues.
- We spoke with the consultant obstetrician leading the maternity unit's 'Sign Up to Safety' project. This project began in June 2015 with the aim of improving birth outcomes by enhancing the competence in fetal monitoring of midwives and doctors. The approaches taken were for clinical to lead teaching sessions, weekly multidisciplinary reflective learning sessions and master classes on monitoring the fetal heart in labour provided by an external expert in intrapartum fetal monitoring. We saw posters for these master classes on notice boards in all areas of the service.
- Following substantial recruitment in September 2015, additional resource was allocated to the Practice Development Midwives to allow them to be available across the week supporting new qualified midwives and those new to the trusts. There was on-going training for staff in support of their development, for example, mentorship training, modules towards Master's degrees, secondment opportunities and progression for maternity support workers.
- Three perinatal mental health conference study days were organised for maternity staff to increase mental health knowledge and awareness, develop clinical skills and discuss current issues. Multidisciplinary staff across Kingston's Hospital were also invited to attend.
- There was training for Maternity Assistants to assist in theatre and investment in the development of new roles to introduce new skills and capacity into the workforce. Support was also offered for newly qualified midwives and those advancing through preceptorship. One new qualified midwife said 'I have had great support and I now felt bad for asking questions.' Another said she had just had her first experience of providing care and treatment for a woman having twins. The new qualified midwife said; 'The midwife in charge supported me and helped me to build my confidence to give the best to the woman. I can now rotate between more areas so I am very happy to have had this experience'.

- Another midwife said that she 'highly supported' to go for promotion and had recently undertaken: a UNICEF baby friendly study day, an annual management appraisal and appraisal with her supervisor.' She said it was easy to access mandatory and other training.
- The November edition of the maternity risk newsletter included a report back from a Mbrace study day looking into term interpartum stillbirths and listed the three factors felt to have the biggest impact. They were gestational diabetes, measuring small for dates and reduced fetal movements. Advice was provided to midwives about action to take in relation to each of the factors.
- We looked at the rates for completed appraisals for midwifery staff at Kingston and saw that 93% of staff had appraisals in September. This was above the trust target of 90%. However, the rate for quarter two was 86% completed.

Multidisciplinary working

- We attended a morning multidisciplinary handover meeting on the delivery suite at Kingston Hospital. It was a well attended meeting with the labour ward consult lead, an anaesthetist, other medical staff, matrons, and a consultant midwife and ward managers. The board showed the women on delivery suite, in the Birthing Centre, on the antenatal ward, women whose labour was due to be induced and those who were having an elective caesarean. It also listed the home births.
- We saw how the team worked together to stagger the inductions and fit in the elective caesarean sections. A woman had arrived as an emergency morning and so some staff were attending to her. There were 17 women on the postnatal ward and 15 of them were due to be discharged. There was a review of the number of staff available and it was confirmed that all shifts were fully staffed for the next 24 hours. However, because it was particularly busy a 'whats app' request went out for additional staff.
- We were told by managers and staff that multi-team working was very good at the trust. We observed several meetings where staff from different disciplines were sharing information and expertise for the benefit of the patient.

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- We were also informed that staff from different disciplines trained together. For example they attended Practical Obstetric Multi-Professional Training (PROMPT) which is an evidence based multi-professional training package for obstetric emergencies. This training has been associated with improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working.
- We saw notes of meetings where staff from other areas of work attended. This included perinatal meetings where midwives met with colleagues from paediatrics. In addition maternity worked closely with gynaecology and with colleagues from the special care baby unit.
- We spoke with domestic staff and receptionists who said they felt included and part of the ward and unit team.
- We also spoke with community midwives who attended meetings with each other, with hospital based midwives and specialist midwives, colleagues from social services, health visitors and consultants and GPs. At the midwives focus group the student midwives said they were impressed with the multidisciplinary team meetings and how they felt valued within the team.
- We were informed by a consultant gynaecologist that there were regular multidisciplinary team meetings to discuss complex cases. All grades of staff attended but no minutes were taken.

Seven-day services

- The delivery suite, midwife-led birthing unit and the wards were open 24 hours a day seven days a week. Consultants and anaesthetists' were available out of hours either in the hospital or on-call.
- The Day Assessment Unit was open from 8am to 6pm Monday to Friday, 9am to 4pm on Saturday and 9am to 2pm on Sunday. Fetal monitoring and ultra sound scanning was available in this unit.
- The early pregnancy and gynaecology emergency unit was not open at weekends and so women would attend through the emergency department.
- The maternity triage service was operating 24 hours a day, seven days a week. There were on-call community midwives at the evening and weekends.

Access to information

- We found that professional guidance and policies were freely available to staff on the trust intranet.
- Information was communicated to staff via specific meetings, patient handovers and newsletters.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to a trust-wide policy for guidance on consent. This included specific details and guidance related to consent in children, based on Gillick competencies.
- We spoke with the antenatal and new-born screening midwife and she told us about the importance of obtaining informed consent in screening. She said they sent out a leaflet in the post and, at the first appointment they asked, 'Have you read the booklet and what did you understand?' She said the midwife could assess whether the woman has understood. She also said some women decide they do not want any screening or scans and their informed choice is respected.
- We saw the findings of an audit of consent for 2014. The objective of this audit was to ensure the process for recording consent from patients undergoing gynaecology procedures was being undertaken in accordance with the trust's policy for consent to examination or treatment. The findings from this audit of 40 cases was that a signed consent form was found in 100% of the patients notes.
- We saw completed consent forms in the patient notes.
- We spoke with staff about the Mental Capacity Act (MCA) and found they were well informed. Staff had also been directed to an e-learning site for a full session on the MCA.

Are maternity and gynaecology services caring?

Good



We rated the maternity and gynaecology service at Kingston Hospital as 'good' for caring. This was because:

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- Women using the service reported positively on their experiences, indicating staff were kind and caring.
 - We received feedback through the friends and family survey that women and their families had a good experience in the maternity and gynaecology services.
 - We witnessed behaviours from staff, which indicated they were using a caring and compassionate approach towards their patients.
 - Staff took time to ensure they protected the dignity and privacy of women in all areas of the service.
 - Partners were made to feel welcome and involved in the pregnancy, labour and birth.
- Compassionate care**
- We saw patient comments collected by Health Watch from, May 2014 to November 2015. One gynaecology patient said: 'I couldn't have been treated with more kindness. They couldn't do more to make me comfortable. They couldn't be more helpful if they tried. Even the volunteers are helpful'.
 - One of the midwives at the focus group said the person centred care model was adopted fully in the maternity service.
 - The 'Friends and Family Test' (FFT) patient survey positive scores for August 2015 were 92.5% for antenatal, 96.8% for the delivery suite, 100% for the postnatal ward and 98.2% for postnatal in the community.
 - We looked at some of the FFT feedback for the gynaecology ward for the first quarter of 2015/16. The comments were mostly positive including; 'amazing care and rapid treatment', 'excellent nursing care by everyone on the ward'.
 - Improvement themes had emerged for the gynaecology ward of several quarters around nursing care, communication, housekeeping and facilities. These themes had been incorporated into an action plan about 'the basics'. That action plan was being implemented.
 - The one negative comment: 'The first day no one talked to me or introduced themselves. The nurse said that my catheter wasn't in, was rushed and made me cry and said 'it doesn't hurt anyone else'.
 - The small day assessment unit had two bays with curtains and a separate room, also with a curtain. We asked about the privacy and dignity of women having physical examinations. The midwives said women had not said it was a problem.
 - We observed midwives, nurses and doctors protecting the privacy of women by knocking before they entered rooms and not opening doors and curtains any wider than necessary. When we asked to speak to women the ward sister sought the consent of women first.
 - The labour ward consultant lead told us they were making the environment on the delivery suite as welcoming as that on the midwife led unit. Butterflies on the walls in the midwife-led unit were also on the ceiling in the two obstetric theatres.
 - Most of the wards and units had single rooms with en-suite facilities for the privacy and comfort of women and their families. One woman we spoke with said, 'I did not expect to have my own room and it has been a wonderful surprise have such privacy'.
 - It was noted there was a separate ward for gynaecology patients including those woman who had a pregnancy loss. However, it was usual to have other types of female medical patients on the ward including those requiring elderly care. When we visited there were six medical patients in a separate bay. The nurses we spoke with said that 'this is not ideal for those experiencing loss of a pregnancy'.
 - In the reception areas of the gynaecology outpatient's clinic there was a notice saying 'In the interests of patients confidentiality please wait to be called to the desk'. We saw patients were observing this request.
 - A patient on the gynaecology ward told us the care treatment had been 'really, really good from the nurses, consultant and anaesthetist'. She said the nursing care was 'brilliant – kind and respectful'. She said 'personally I couldn't fault them, even the porters'.
 - The antenatal screening sister told us they telephoned women with results when their screening indicated a high risk of fetal abnormality because they wanted them to have the information as soon as possible. The sister said that we tell them in advance that we will do this in these circumstances and we offer a counselling appointment.

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- Patient feedback was also received through the trusts maternity website. One woman wrote about the midwife led unit: 'The incredible midwives there were warm and encouraging. When I arrived in labour, feeling fearful and overwhelmed, the first thing I was given was a hug before being checked that both the baby and I were in good health. I felt respected and totally safe and looked after all the way through the birth and aftermath'.

Understanding and involvement of patients and those close to them

- We spoke with a woman and her partner on the postnatal ward who were ready to go with their baby. They said that they had a very good experience. 'Midwives' and doctors were attentive and had explained everything during labour'. The partner said they could stay as long as they wanted and they were made to feel welcome, helpful and involved.
- We saw graffiti boards where couples were encouraged to offer feedback on their experiences. All the comments we read were constructive and positive. We read the board on the postnatal ward which said 'Baby said thank you for looking after me and my mummy and daddy'.
- We saw the CQC patient survey for maternity services published in December 2015. Kingston performed about the same as other trusts on most of the indicators including being kind and understanding, being treated with respect and dignity and for having confident and trust in the staff caring for them during labour and birth. Kingston did better than other trusts for involving partners.

Emotional support

- The bereavement midwife said she helped the couples with emotional and practical support. The hospital did not have a counselling service but provided an information sheet with details of local sources of support such as Kingston Bereavement Support, Cruse and the Surrey Sands group. The bereavement midwife said that sometimes she helped with the first appointment.

- The bereavement midwife was also able to help with the practicalities such as the paperwork and dealings with the coroner. She kept in close contact with the couple whilst they were awaiting the results of the post mortem.
- The service was planning to begin a pre-term loss clinic for women who had a mid trimester loss. At this clinic they would be able to discuss the loss with their consultant.
- We were told by the antenatal screening sister there was counselling for women who had received news of a high risk of fetal abnormalities following antenatal screening. This counselling was from the specialist screening midwives and was to enable couples to consider their options and make a decision of how to proceed.

Are maternity and gynaecology services responsive?

Good



We rated the maternity and gynaecology services at Kingston Hospital as 'good' for responsive. This was because:

- The individual needs of women and their families from different communities was addressed.
- Specialist support was available for young pregnant women, those with alcohol and drug addictions and women with mental health issues.
- Improvement plans were linked directly to feedback from women.
- People could raise concerns and complaints and be confident this would be investigated and responded to appropriately.
- There was evidence the trust used complaints to improve the services.
- The lack of capacity with the service was beginning to affect smooth flow within the service.
- Careful service planning was improving responsiveness through enhanced recovery programmes, outpatient induction and maximising the use of the midwife-led unit and opportunities for home birth.

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However;

- There were some delays in the induction of labour and elective caesarean sections when the unit became overly busy.
- Senior staff were managing the situation by closely monitoring activity, staffing and bed capacity.

Service planning and delivery to meet the needs of local people

- The service had a number of improvement projects directly related to the needs of local people. The tongue tie clinic, a specialist clinic for new-borns with congenital tongue tie, was initiated in response to patient's requests due to the limited NHS services providing this specialist care for new-borns. There was also a slot utilisation project to utilise effectively midwifery lead appointments at all off site Kingston Maternity locations to increase workforce efficiency and improve access for women.
- The service has specialist midwives to meet the needs of local women such as midwives for mental health and learning disabilities. There was also a midwife lead for new-born health and infant feeding.
- Following a risk investigation and a review of complaints, the service was planning to open a high triage service for 'high risk' women in pregnancy. This new service was in response to instances where women calling the unit were encouraged to remain at home longer than may have been appropriate. The new service was in progress and due to open in the February 2016.
- There was an interpreter service and a language line for women whose first language was not English. Leaflets, translated into the LAN gangues spoken by the minority groups living locally, were available on the website. There was also a Polish speaking midwife running antenatal classes that midwives at the focus group said were receiving 'great feedback'.

Access and flow

- Staff at all levels, both midwives and doctors, spoke to us about the issues around capacity and the limitations placed on expansion by the hospital 'footprint'. Bed occupancy rates in maternity were much higher than the England average and were 100% for the fourth quarter of 2013/15 and the second quarter of 2014/15.

- The Head of Midwifery and the Divisional Director said it would not be possible to extend the service beyond 6000 births a year without additional space and staffing. As the service was almost supporting this number of births already, the Head of Midwifery said that they were working to make the best use of the existing capacity available by maximising the number of home births, currently at just over 2% of all births, and by increasing the number of midwife-led births, currently at about 20% of all births.
- Women were able to access the service in a timely way when booking for their first appointment. The trust was performing better than the services on target on this and so women were able to access antenatal screening and scanning in good time.
- The gynaecology service was not meeting the national target of 18 weeks to start treatment over the summer in 2015. The reasons for this identified by the service were high levels of leave during August and September and a high number of theatre lists closed. An action plan had been agreed and consultants had been covering additional lists during September and October 2015.
- Midwives at the focus group said maternity triage worked well and this helped to give women in early labour continuity as the same person is answering the phone, and there was a good tracking system for calls. The service was also important in prioritising women according to clinical need and complexity prior to arrival. The day assessment unit and triage were in constant communication and worked well together particularly when the service was busy. The planned high risk triage service would assist with more complex cases and reduce the number of incidents and babies being born before arrival at the hospital. The high risk triage service would also enable more efficient flow and reduce delays.
- We were informed by the Head of Midwifery they continually monitored and reviewed waiting times. If waiting times were increasing the team would identify problems and propose solutions including the provision of additional staffing on the shift.
- We observed a lack of antenatal beds and the need to use beds on the postnatal ward for the overflow. The postnatal ward was not ideal as it was distance from the delivery suite. The midwife led unit was adjacent to the

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delivery suite which made for easy escalation and the doctors on the delivery suite were able to attend a woman on the midwife-led unit if the need arose. There was no unhelpful demarcation. The rate of transfer from midwife led unit to the delivery suite was between 12% and 15% and the obstetric theatres were on the delivery suite.

- Community midwives told us the dedicated home birth team had improved the service and may result in a higher take-up of home births.
- The service was also achieving an average two day length of stay for normal deliveries and 3.5 days for caesarean section. Some women were discharged home directly from the midwife led unit and there was an enhanced recovery process for caesarean section. They were operating with outpatient induction of labour and examination of the new-born was available to women after they had been discharged from hospital. This helped to maintain access and flow. In addition, there was always a 24 hour following up in the community to support the quicker discharge process.
- The service had experienced an increase in postnatal readmissions and had conducted an audit to better understand the causes for readmission. As 50 of the 77 readmissions analysed in the audit were stays of less than 24hours, the service was looking to increase support in the community. The introduction of the new role of Advanced Maternity Support Worker had helped with this.

Meeting people's individual needs

- We spoke with the senior maternity team about the choices available to women deciding where to have their baby. We noted, if assessed as low risk, women could choose to have a home birth or attend the Birthing Centre at Kingston Hospital. Women assessed as likely to have a higher risk birth, with medical or obstetric complications, would be advised to have a consultant lead hospital birth. We saw the website set out these options.
- Antenatal clinics for booking were held in children's centres so midwives did not need to travel and visit women in their homes, except in areas where there were no children's centres.

- Vulnerable women were referred to the specialist midwives in the Bridge Team who could provide greater expertise and had more time to spend with individual women.
- The service was also providing a consultant midwife clinics for women requiring specialist case, VBAC clinics, and a wellbeing centre to improve the wellbeing of women and for women who wanted to access yoga classes and hypnotherapy, for example.
- Women whose were having their labour inducted and their pregnancies had been assessed as low risk, were able to return home to allow the medication to take affect. The midwife we spoke to about this said that if women could be at home they were more relaxed and inducted was more successful.
- We saw there were reclining seats and sofa beds for partners and they were able to visit with siblings.
- We spoke with the bereavement midwife in the dedicated bereavement room, the Daisy room. This room had been opened in November 2015 and the bereavement midwife said it had already received 'fantastic feedback'. We saw it was sensitively decorated, soundproofed and it had a double bed, sofa bed, small kitchen area and TV.

Learning from complaints and concerns

- We saw the complaints policy and we saw details about how to make a complaint were displayed on notice boards. Leaflets were available in clinics and on the wards. We also saw details of the how to contact the patient liaison services (PALS).
- From April to November 2015 there were 19 complaints received in maternity services. That was just over two complaints a month. The number of complaints received were recorded monthly on the maternity scorecard.
- The risk midwives received and managed the complaints and sent them out to the appropriate colleagues for a draft response. The complaints were discussed at the risk management group and, at the meeting on 20 October 2015; a presentation was circulated on the themes of the nine complaints received between April and July 2015. All the nine of the complaints were responded to within the time specified in the policy of 25 days.

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- The main themes identified from the complaints were multi-factorial and most of them had elements relating to poor communication. The maternity risk newsletter had a section about lessons learned from incidents, claims and complaints. Lessons included care and service delivery problems relating to an abnormal CTG, when to escalate and a reminder that, in the event of delays transferring to theatre, observations should be performed regularly.
- One of the complaints in 2015 led to service changes. The first was about communication with triage and resulted in the plan to set up a triage service for high risk pregnancy and another led to a request for funding for the tongue tie service.
- We looked at six complaints and the responses from the trust, including one from gynaecology. The complaint to gynaecology was used by that service to highlight to Junior Doctors the importance of reading all post-operative notes and discussing complex cases with a consultant. All the complaints contained a written apology and in some cases there was also a meeting with the complainant.

Are maternity and gynaecology services well-led?

Good 

We rated the maternity and gynaecology service at Kingston Hospital as 'good' for well-led. This was because:

- Staff were overwhelmingly positive about working in the trust and being part of a team who understood and shared the trust's vision.
- Staff were proud of the services they were able to deliver to women and their families.
- There were good arrangements for assessing and monitoring the quality of the service.
- Information was shared in an open and honest way with staff and with stakeholders.
- Staff and service users were involved in shaping the future developments and improvements in the service.

Vision and strategy for this service

- We spoke with a range of staff all of whom were aware of the trust's vision and strategy. The vision and values were clearly displayed throughout the trust. When we asked staff in maternity services about the strategy for maternity they were clear that they wanted 'to be the maternity unit of choice in South West London' and that they were aiming to increase their market share by attracting women from outside the immediate catchment area. In the focus group the midwives were able to talk with pride about providing person centred care.
- Staff in maternity were also aware of the tension between the vision and the lack of capacity to expand in the current unit. One midwife said, 'we are a victim of our own success'. The divisional Director told us about a plan that had been proposed in 2010 for a new building but it had been rejected because of the risk of destabilising other trusts in the area. The Head of Midwifery said the service wanted to be in a position to withstand threats from the local competition and be ready to expand should the opportunity arise.
- The gynaecology strategy was similar. The Clinical Director set out four areas for development namely; to provide a more diverse suite of services and support, diversify skill mix, 'fix the basics' and grow the reputation of the service. The Clinical Director was clear the 18 week pathway was currently the greatest challenge for the service.
- Both maternity and gynaecology were participating in the South West London networking group and contributing to the development of London Quality Standards.

Governance, risk management and quality measurement

- We spoke with the midwives leading on patient risk, incidents, complaints and the development of guidelines. We found there were reliable risk management processes in place including systems for learning from incidents, sharing the learning and implementing change across the service. The team were looking to identify themes and recommend areas for concern and improvement. The risk management newsletter was informative and constructive. We

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reviewed examples of notes of governance meetings, which demonstrated an open and risk management approach to matters related to quality, safety and performance.

- We saw action plans were developed and implementation of the recommendations was tracked at service level. The risk midwives did not close an action point until they had seen the evidence of implementation. Wider service trends and alerts were also tracked at board level including the raised level of PPHs, perinatal mortality and caesarean sections,
- We saw the maternity and gynaecology services had a comprehensive register of risks and these risks were graded and mitigation put in place where possible. The risks were dated and reviewed regularly until they were resolved and removed from the register. Highly graded risks would be escalated to the trust wide risk register.
- We found there was an effective governance process involving good levels of incident reporting and thorough investigation and learning from serious incidents. Clinical outcomes were being monitored and there was a rolling programme of audit and review. Complaints were used as an opportunity for learning and service improvement.

Leadership of service

- We observed a strong and effective leadership team. Senior staff accepted their responsibilities, were keen to improve the service and invited feedback from staff and patients. We saw the midwives, nurses and medical staff respected each others roles and worked collaboratively. Staff said the senior staff and the supervisors of midwives were approachable and would act on concerns raised by staff. One newly qualified midwife told us, “I feel supported and I know that if I need help it is always there.”
- A community midwife we spoke with said “The leadership is great. No-one looks down on you or thinks less of you if you ask for help. This is a great place to work – we want women to have the best.” Another midwife said, “Leadership is accessible and open – they are also pretty savvy.”
- The Head of Midwifery said, “we have a committed team, I am proud of our service. I could not do what I do without the wonderful people I work with.”

- Staff in the focus groups were generally positive about the local leadership of maternity and gynaecology services. One member of staff said ‘The Head of Midwifery is open to trying new things within reason; she takes suggestions and is very approachable. She always comes to the 9am meeting on the Delivery Suite’.

Culture within the service

- Staff told us there was an open, honest and collaborative culture. Staff in maternity and gynaecology were proud to work at the trust and were striving to offer a good experience for patients.
- We noticed that there was no inflexible separation between the consultant and midwife led services and the approach was to work co-operatively in the best interests of women and their babies.

Public engagement

- There was a joint Kingston and Richmond maternity services liaison committee. We saw the notes of the meetings from April and June 2015; both were well attended by senior midwives, clinicians and users of the services. The April meeting discussed the themes and action plans arising from the ‘whose shoes’ workshops held in the summer of 2014.
- These workshops were part of the South West London Maternity Network process of engagement with service user to help develop and improve services and deliver the priorities identified in the Health and Social Care Act. The participants at the workshop were mixed together into groups to ‘play a game’ which acted as a catalyst, using real scenarios to build relations and connections. The themes that emerged included finding ways to reduce the high levels of anxiety of women and resulted in using mindfulness and other relaxation strategies. We saw the results of this work in the service with a mindfulness-based stress reduction programme available through the wellbeing centre.
- There was also engagement with the public via the dedicated maternity website, the hospital patient opinion website, social media and the patient surveys including the Friends and Family Test and the national maternity survey. Individual women and their families could attend a one-to-one meeting to give their feedback on their experiences or could provide comments informally on the graffiti boards.

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Staff engagement

- The staff survey feedback for 2014 indicated that 63% of staff in maternity felt supported in their role, 68% felt part of a team and 55% said they could raise concerns without fear. Areas for particular concern were that just 31% felt colleagues were treated fairly and equally at all times, and 35% felt there were equal and fair opportunities for all.
- As a result, the service held an open forum in March 2015 to discuss the results and agree some action to take about the areas of concern. The action included a review of how rosters were created and the inclusion of an member external to maternity on interview panels. These actions demonstrate that the service listens to staff and responds to their concerns.
- All the staff in the focus group said that they felt 'involved in open and honest discussion with doctors and senior staff'.
- Staff told us they were involved in a number of special improvement projects such as 'sign up to safety, and birth after caesarean section. The midwives said that they could also move into specialist areas such as the Bridge Team, infant feeding or maternal age.
- Staff in the focus groups said they felt engaged in decision making. There was also a staff suggestion box and midwives had been involved in developing the new role of Advanced Maternity Support Worker. One new starter said, 'It does not feel like there is a hierarchy in the department in a detrimental way. It feels that your ideas and suggestions are valued.'

Innovation, improvement and sustainability

- We saw a number of innovations and continual improvement was a constant theme in the service. The Advanced Maternity Support Worker, for example, was a role unique as it was developed within the service. Other recent innovations included the tongue tie service, the home birth team, the wellbeing service and the high risk triage service.
- The Sign up to Safety project was designed to enhance effectiveness in fetal monitoring and we observed that the service was doing this advanced training and by challenging assumptions.
- The service was working with the Wolfson Institute of Preventive Medicine, the leader in antenatal screening services, to provide women at Kingston Hospital with the in-house antenatal reflex DNA screening service. This was the new combined test for Down's syndrome, trisomy 18 (Edwards syndrome) or trisomy 13 (Patau syndrome) conducted by analysing cell free DNA from a sample of maternal blood. If that test indicates a risk of having an affected pregnancy, that is a risk equal to or greater than 1 in 800, they can have a further test. The further test involves analysing cell free DNA from the sample of maternal blood that has already been taken. This screening method detects about 9 in 10 affected pregnancies and has a low false-positive rate of less than 1 in 1,000. A positive screening result leads to an offer of a diagnostic test (a chorionic villus sampling or an amniocentesis).

Services for children and young people

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

Information about the service

There were 4372 children and young people's spells in Kingston hospital between July 2015 and June 2015. 86% of these were emergency admissions.

Children's services at Kingston Hospital were consultant-led. The children and young people's Sunshine ward had a total of 24 inpatient cots, with the ability to accept infants, children and teenagers. Sunshine ward had two rooms set aside for high-dependency care.

The paediatric assessment unit (PAU) at Kingston Hospital provides ease of access to senior paediatrician review for acute paediatric referrals from primary care. Such referrals will be seen directly in the PAU avoiding the need to come via accident and emergency (A&E).

Dolphin ward is an 'ambulatory care' area providing observation, investigations and treatment for children who do not require inpatient admission.

Children and young people were admitted for a range of medical and surgical conditions, including oncology, general surgery, plastic surgery, ear, nose and throat (ENT), orthopaedics, urology and oral surgery.

The medical team lead additional specialist services for children with diabetes, cancer, feeding problems, epilepsy, cystic fibrosis, weight problems and those who have graduated from neonatal intensive care. The consultants also host regular joint clinics with visiting specialists from central London hospitals for children with cardiac, growth and hormone problems, neurological and renal disorders.

The Neonatal unit has a total of 20 cots, six cots for intensive and high dependency care and 14 cots for Special Care babies. The unit is designated as a Level 2 NNU within the South London Neonatal Network. The Neonatal unit (NNU) had three levels of care that a baby may require: Intensive care for critically ill babies, high dependency care for babies who require continuous observation and support and special care for babies who required some support and observation or help with feeding. The level of care provided within this unit allowed for all categories of neonatal admissions, with the exception of babies who required complex or long-term intensive care.

There was a dedicated children's outpatients department (OPD) which took place within the children's department. There was a clinical matron for children's outpatients and specialist nurses.

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 14-17 April 2015.

During the visit we spoke with over 30 staff on the wards including consultants, doctors, nursing staff and support staff.

We also talked with three children and young people who use services and six visiting parents. We observed how patients were being cared for and talked with carers and/or family members. We met with children and young people who use services and their carers, who shared their views and experiences of their care and treatment. We reviewed 16 care or treatment records.

Services for children and young people

Summary of findings

We found children and young people's services were good overall.

- Children and young people who were at risk of deteriorating were monitored and systems were in place to ensure that a doctor or specialist nurse was called to provide the patient and ward staff with additional support.
- There was an open culture and staff were prepared to learn from clinical incidents.
- Across children and young people's services there were enough medical and nursing staff to keep patients safe. The trust found it difficult to recruit new nursing staff; but was able to effectively fill gaps by using bank and agency staff.
- Attendance at mandatory training was above the 90% trust target.
- We found care was provided in line with national and local best practice guidelines. Clinical audit was undertaken and there was good participation in national and local audit that demonstrated good outcomes for children and young people.
- We observed good clinical practice by clinicians during our inspection. There was a good knowledge of the issues around consent among staff.
- Children and young people received compassionate care and were treated with dignity and respect. All of the children, young people and relatives we spoke with said they felt involved in their care and were complimentary about the staff looking after them. The children and young people's division had good results in the children's survey.
- The division were effective at responding to the needs of its community. Children and young people's care pathways had been well designed to ensure that children and young people were assessed and supported with all their medical and social needs. The paediatric admissions unit (PAU) provided effective alternate pathways for GPs and other referrers.
- Children and young people's services were well led; divisional senior managers had a clear understanding of the key risks and issues in their area.

- The service had an effective meeting structure for managing the key clinical and non-clinical operational issues on a day to day basis.
- The service had a risk register which covered most of the key risks.
- Staff spoke positively about the high quality care and services they provided for patients. They described the hospital as a good place to work and as having an open culture.

Services for children and young people

Are services for children and young people safe?

Good



We rated the service as good for safety. This was because:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they were fully supported when they did so. Children and young people's safety performance showed a good track record and steady improvements. When something went wrong, there was an appropriate thorough review or investigation that involved all relevant staff and children, young people and their families. Lessons were learnt and communicated widely to support improvement in other areas as well as services that were directly affected.
- Safeguarding children and young people was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification.
- Staffing levels and skill mix were planned, implemented and reviewed to keep children and young people safe at all times. Any staff shortages were responded to quickly and adequately.
- There were effective handovers and shift changes, to ensure staff could manage risks to children and young people who used services.
- Risks to children and young people were assessed, monitored and managed on a day-to-day basis; and risk assessments were child-centred, proportionate and reviewed regularly. Risks to safety from anticipated changes in demand and disruption were assessed, planned for and managed effectively. Plans were in place to respond to emergencies and major situations.
- Equipment on the neonatal unit and paediatric wards did not have appropriate servicing schedules in place.

Incidents

- The service had systems to ensure incidents were reported and investigated appropriately. All the nursing and medical staff we spoke to stated they were encouraged to report incidents via the electronic incident data management system. There had been 166 incidents recorded on the trust's electronic incident reporting system electronically between October 2014 and September 2015. There had been no never events

or serious incidents requiring investigation reported between July 2014 to August 2015 to the strategic executive information system, (STEIS). Incidents were monitored by the neonatal and children's ward matrons for trends.

- As expected for children and young people's services there were no pressure ulcers, falls, or catheter related urinary tract infection recorded between September 2014 and September 2015.
- Incidents were standard agenda items at monthly 'service line' governance meetings. The meetings were attended by a medical and nursing representative from each service area. Where incidents had been reported a full investigation had been carried out and steps were taken to ensure lessons were learnt. Action plans were produced following investigations. These were monitored and tracked to completion at subsequent meetings.
- Staff told us learning from incidents was cascaded to ward staff at team meetings, as well as handovers. Handover records we viewed confirmed this.
- The lead nurse received safety alerts and was responsible for taking action to respond to relevant alerts. This included discussion of alerts at the children and young people's clinical governance meeting. Staff told us completed actions would be reported to the Department of Health's (DOH) central alerting system, (CAS).
- Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed they received feedback on incidents that took place in other areas of the service as well as their own. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly within children's and young people's services. Incidents were audited on the trust's electronic reporting system.
- The NNU and Sunshine Ward used the adults' safety thermometer to monitor harm free care. This is a nationally recognised tool, which monitors how a service performs in providing harm free care. The trust undertook the adult safety thermometer and applied it to children and young people's services. Staff

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recognised this had limitations with regards to children and young people, but used it to record relevant episodes of harm. The service reported that care had been 100% harm free in the previous 12 months.

Duty of candour

- There was a contractual duty imposed on all NHS providers of services to 'provide to the service user and any other relevant person all necessary support and all relevant information' in the event that a 'reportable patient safety incident' occurred. Staff and managers we spoke with were aware of and able to explain the 'duty of candour'.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities 2014) places a 'duty of candour' (DoC) on healthcare providers to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. Staff told us the DoC was included in the trust's safeguarding training, and said the DoC had a high profile at the trust. For example, a matron told us about an example of when the service had used the DoC in 2015. The matron added that the trust's electronic incident reporting system prompted staff when entering information to consider DoC requirements. This meant staff were encouraged to consider the DoC in the event of incidents involving patients.
- The service held monthly 'morbidity and mortality meetings'. The meetings included: case presentations, annual perinatal statistics, and reviews of perinatal mortality audits. We saw the findings from mortality and morbidity meetings had been reviewed by the consultant paediatrician in 2015. Learning from reviews was disseminated to staff in the form of a presentation.

Cleanliness, infection control and hygiene

- The hospital was found about the same as other trusts in question 26 of the children and young people survey 2014, "how clean do you think the hospital ward was."
- The ward areas provided a safe environment for children and families which were effectively cleaned and maintained. All the areas we visited were clean and free from clutter. We saw housekeeping staff cleaning on the wards and in the departments throughout our visit.
- The ward areas had an ample supply of appropriate toys that could be cleaned safely. Play specialist staff told us

the toys in the children's ward were cleaned by them as part of their role. The toy cleaning records we viewed on Sunshine Ward were up to date. Play specialists told us toys were cleaned prior to being taken to children in isolation and cleaned again when they came out of the child's isolation room.

- An established audit programme was in place for reviewing infection control and cleanliness in clinical areas. For the year to date children and young people's services were fully compliant with national institute for clinical excellence (NICE) standards for infection control, achieving the trust's minimum target of 80%. The NNU had regularly achieved 100% compliance, whilst Dolphin and Sunshine Wards had monthly audits where the compliance rate was between 99% and 100%.
- We viewed Sunshine Wards patient led assessments of the care environment (PLACE) audits. These were audits undertaken by patients on 7 May 2015. The ward received a pass rating for all domains including: ward cleanliness, condition and appearance, and equipment cleanliness. To the question "how confident are you that the environment in this ward supports good care", the patient assessors had responded, "very confident."
- We saw staff regularly washing their hands between treating patients. Hand washing facilities and hand sanitising gels were readily available. 'Bare below the elbow' policies were adhered to. The importance of all visitors cleaning their hands was publicised. However, we observed some parents and other visitors not using hand gels or washing their hands when entering Sunshine and Dolphin Ward.
- At the time of our visit, Sunshine and Dolphin Wards were regularly achieving the trust's compliance standards of 100% for hand hygiene. Gloves, aprons, and other personal protective equipment (PPE) were observed to be readily available to staff. We observed staff following the trust's policies on the removal and disposal of clinical waste. We spoke with a member of the housekeeping staff who explained the procedures for handling and disposal of clinical waste.
- There were no reported cases of meticillin-resistant Staphylococcus aureus, (MRSA), in children's and young people's services in the past 12 months. Babies on the NNU were screened on admission and re-screened on a weekly basis.

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Environment and equipment

- All staff reported shortage in access to equipment. Some staff we spoke with raised concerns about timely access to equipment maintenance. We reviewed a number of items of equipment on the Neonatal unit (NNU), which were in use and had not been serviced on their due dates. These included incubators and breast pumps. Staff told us they could not release equipment due to equipment shortages and the equipment being constantly in use. Whilst we did not find any equipment in use on Sunshine Ward and the paediatric assessment unit (PAU) where servicing was not up to date, we did find equipment in the equipment storage area where servicing was out of date.
- Staff told us the hospital did not have an effective system of alerting the NNU and paediatric wards when equipment required servicing. Following our inspection we carried out an unannounced inspection on the 26 January 2015 at the NNU and found the ward had all the equipment in use serviced since our initial inspection. However, staff told us there was still no system in place for the wards to be alerted when equipment needed servicing, and that spare equipment was needed to enable staff to release equipment for servicing when this was due. Staff were also unaware of where the asset register for NNU equipment was held.
- We visited the trust's maintenance division. The manager told us they recognised there was a problem with servicing in the children and young people's division. The manager showed us work in progress on a spreadsheet to monitor equipment on the wards. We noted a number of items on the register were out of date. The manager told us the wards had received requests to have the equipment sent for servicing, but staff were reluctant to release equipment as it was in use.
- The trust was found about the same as other trusts in question 25 of the children and young people survey 2014, "does the ward where your child stayed have appropriate adaptations or equipment."
- Entrances to all children's ward areas were secure, and entry was granted by a member of staff via an intercom for visitors during the day and at night. On Sunshine Ward and the NNU access was granted by a ward clerk at reception during the day and by ward staff at night.

CCTV was used to monitor entrances at all children's wards. However, we did not see any tailgating notices to alert visitors not to allow people they didn't know onto the wards.

- The service's risk register identified a risk from limited isolation facilities in the NNU. This identified a risk of reducing the NNU's cot capacity for new admissions and babies who were returning to the unit from other hospitals. The risk had been on the register since 16 November 2012. The unit had a plan in place to manage the risks on a case by case basis. However, there was no plan in place for a longer term solution, even though the situation was being regularly reviewed. Staff told us the size of the NNU had not been an issue in 2015 due to a reduction in NNU activity.
- The children and young people's equipment room had a policy, whereby clean equipment had an 'I am clean' sticker applied when it was cleaned. Staff told us they only used equipment from the storage area that had 'I am clean' stickers applied.
- Age-appropriate resuscitation and emergency equipment was available for staff across children's and young people's services. We saw that resuscitation trollies were checked daily and records were up to date.
- We visited the hospital's fracture clinic. We found the clinic did not have a children's waiting area. Staff told us the children's waiting area had been closed due to refurbishment of the main entrance. However, the children's waiting area was due to re-open in December 2015. Staff said the work on the main entrance had over run and they did not have a date for when the work would be completed. Staff said in the interim children were being prioritised to minimise waiting times for children.

Medicines

- The trust had a divisional pharmacist for children and young people's services who staff could liaise with and ask for advice. The pharmacist worked across all the ward and department areas; and attended the children's ward and NNU daily, reviewing prescriptions and making recommendations.
- We found medicines were stored safely, and room temperatures had been checked regularly and recorded. We viewed records, which showed medicines were being stored at the required temperatures. All the drug

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store cupboards were locked and controlled medicines were stored in separate locked cupboards. Where medicines required refrigeration, fridge temperatures were checked daily.

- Keys to the drug cupboards and medicine lockers were held by registered nurses. Doors to the rooms housing medicines were locked.
- Controlled Drugs (CD) were audited on a daily basis by two nurses. The signing sheet for safety checks was complete and up to date. Controlled Drugs were correctly documented in the CD register.
- Medicines reconciliation rounds occurred on children and young people's wards. Medicines were restocked through a 'top up' system, ensuring a continued supply. Out of hours, the hospital had an on-call pharmacist.
- Children's weight was clearly documented and prescriptions were appropriate for the child's weight. We viewed six children's medicine administration records (MAR). Children and young people's allergies were clearly recorded in their medical records.
- Children's and young people's medicines were audited regularly by the trust's pharmacy. The neonates and children's formulary was regularly updated by the children's pharmacist and consultant to ensure safe prescribing.
- Prescriptions were prescribed daily by the registrar and checked by the consultant.
- Nursing staff' training in medicines administration was up to date. Nursing staff were aware of policies on the administration of controlled drugs and the Nursing and Midwifery Council's Standards for Medicine Management.
- Staff had access to all policies relating to medicines management including the paediatric formulary via the trust intranet. However, staff on Sunshine Ward told us the British National Formulary (BNF) had been recalled from the wards, and staff were reliant on using their phones to access the current BNF.
- All medication errors were reported as incidents, recorded on the electronic system, investigated and reviewed at the monthly clinical governance meetings.

Staff were open and reported medication incidents. Where the incident was a prescribing error, senior medical staff were informed and the error was followed up with the doctor concerned.

- To take away (TTO) medicines were stored securely and appropriately in a designated cupboard.
- Emergency medicines were checked, age appropriate, in-date, tamperproof and available for immediate use.

Records

- Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept confidential on the wards in lockable trolleys in the reception area.
- We looked at 16 sets of notes on the wards and the NNU; we found them to be accurate and legible. Patient Information was easy to find. However, staff highlighted there was no universal children's paperwork in other departments. This meant staff in other departments might not be familiar with children and young people's documentation.
- Information governance was part of the trust's mandatory training. Staff told us they had received information governance training. The staff training spreadsheet recorded that most staff mandatory training, including information governance was up to date.
- Leaflets explaining patients' rights to access their medical records were available on the ward. The trust's website carried information on people's rights under the Freedom of Information Act 2000.

Safeguarding

- In the children and young people survey 2014, the trust was found about the same as other trusts in question 7, "do you feel that your child was safe on the hospital ward"; and question 8, "did you feel safe on the ward."
- Comprehensive safeguarding policies and procedures were in place. This included referral pathways for children's safeguarding.
- The trust employed one whole time equivalent (WTE) named safeguarding nurse; and one WTE named doctor. Safeguarding children's supervision was formally provided to the named safeguarding nurse and named

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safeguarding doctor on a regular basis. Formal safeguarding supervision was also provided to specialist children's staff. Staff told us safeguarding supervision was available upon request to all hospital staff.

- The Director of Nursing and Patient Experience was the executive lead for safeguarding children. The children and young people's safeguarding named nurses managed complex safeguarding cases and worked collaboratively with other health and social care organisations. The safeguarding named nurse also worked with wards and departments, raising awareness and offering advice and support where necessary. Staff we spoke with told us they would liaise with the safeguarding named nurse if they had concerns.
- We viewed the safeguarding training programme; this recorded that training sessions were provided to ensure staff across the service were trained to the appropriate level in safeguarding. Staff we spoke with understood their safeguarding responsibilities and knew what to do if they had concerns. 100% of qualified nursing staff had completed level three enhanced safeguarding training.
- The children and young people's report recorded all children and young people's staff received level 1 training on induction, and level 3 training annually. The compliance figures for levels for safeguarding training in 2014 to 2015 reached the hospitals recommended 80% for the financial year. Training figures were monitored by the Safeguarding Children Committee quarterly and fed back to the Executive Lead. This ensured the Trust has robust planning in place to ensure compliance with annual training requirements.
- Staff told us they could access the safeguarding team easily. Staff on Sunshine Ward and the NNU had access to the contact details of the local authority safeguarding team for out of hours safeguarding advice or to report concerns. The trust had information sharing protocols in place with the local authority.
- The trust had comprehensive guidelines for staff in regards to female genital mutilation (FGM). The trust had a policy of addressing FGM when booking women for maternity care.

Mandatory training

- The children and young people's service had a clinical practice facilitator. They showed us the children and young people's mandatory training records. This

showed there was a good level of compliance with mandatory training. Children and young people's services had 94% compliance with mandatory training in December 2015. Mandatory training included: fire safety awareness, safeguarding, basic life support, infection prevention and control, and information governance. However, some staff told us achieving compliance with mandatory training could be a challenge due to work commitments.

- Staff we spoke with confirmed they were up to date with training, or had dates to attend scheduled training. Staff had access to a comprehensive programme of training, including medicines training and training in the use of specialist equipment; most of the staffs' specialist training was up to date.

Assessing and responding to patient risk

- The children and young people's service used a paediatric early warning score (PEWS) system on the children's wards for monitoring the condition of children and young people. This was based on the NHS institute for innovation and improvement PEWS system. We spoke with staff, who were aware of the appropriate action to be taken if patients assessment scores were higher than expected.
- We reviewed 16 children and young people's notes and saw where higher scores had been recorded, action had been taken to escalate concerns, or the rationale for not escalating had been documented.
- In case of an emergency within the children and young people's inpatient area, the paediatric resuscitation team would attend. Staff told us staff paediatric life support skills were considered when organising the staffing roster, to ensure there were appropriately trained staff on every shift.

Nursing staffing

- We viewed the nursing 'establishment vs actual' spreadsheet dated June 2015 to September 2015. For example, in September 2015 the service had 82.06, whole time equivalent (WTE), these were the planned qualified nurses working hours for the month. The actual WTE number of nurses on shift in September 2015 was 68.79 WTE. This meant the children and young

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people's service would need to use either bank or agency staff to ensure there were enough nurses on duty to ensure children and young people received safe care.

- Staff told us that staffing levels in the NNU were safe. The matron told us flexible staffing meant that staffing levels were managed on the NNU. We viewed the NNU and paediatric 'planned versus actual' staff record. This indicated that actual staffing levels were generally in accordance with the planned numbers. Where staffing levels were not in accordance with the planned staffing levels the spreadsheet recorded this. We noted both the NNU and Sunshine Ward consistently had fewer WTE registered nursing staff recorded on the record. For example, the NNU had a registered nursing shortage of between 5.32 and 6.32 whole time equivalent per month between June and September 2015. Sunshine Ward had between 7.56 and 10.46 WTE nursing staff between June and September 2015. Staff told us the service had taken steps to mitigate risk; this included the use of bank staff and on-call cover.
- Staff told us there were sufficient nursing staff to ensure shifts were filled in line with their agreed staffing numbers. However, staff told us this was sometimes based on the use of agency staff.
- The safe staffing dashboard was displayed in the neonatal unit and children's wards. This showed details of the required levels of staffing, and actual levels present on each shift. Staffing levels were adequate, as was the required skill mix at the time of our visit. Staffing levels conformed to the Royal College of Nursing (RCN) guidance 'defining staffing levels for children and young people's services' 2013. There was a minimum of two registered children's nurses at all times in all children and young people's inpatient and day care areas.
- Staff had access to a band 7 nurse at all times in any 24 hour period. We viewed staffing rotas for the previous month that confirmed this. Staff had access to a lead nurse or ward matron for twenty four hours, seven days a week, via a joint on-call children and young people's and neonatal rota.
- During our inspection staff were very visible, particularly on the NNU. Staff and managers told us they met surges in activity by using bank staff who were familiar with the

ward areas. As a last resort, agency staff would be used. Procedures were in place to request agency staff. Staff told us if agency staff were required they would request agency nurses who were familiar to the service.

- Nursing staff on Sunshine Ward told us they had a twice daily hand over; staff were not to be disturbed during hand overs as this was classed as protected time. Nursing handovers occurred at each change of shift. On the paediatric wards the nurse in charge who had the overall co-ordinating role, received a detailed handover from their counterpart. We viewed a Sunshine Ward handover sheet and saw staffing for the shift was discussed, as well as any high risk patients or potential issues.
- Staff told us the paediatric and NNU were introducing a 'grow your own' policy to recruitment, due to the pressures of recruiting nursing staff in outer London. This would give HCA's the opportunity to train as qualified nurses and develop paediatric skills for nurses from non-paediatric backgrounds.

Medical staffing

- All children were seen by a consultant within 14 hours of admission to the ward.
- Staff told us the consultants had job plans in draft format, but these were under review as an aspect of the trust's workforce review.
- The medical skill mix showed there were fewer junior doctors and slightly fewer consultants when compared with the England average. This was made up of 31% consultants, compared to the England average of 35%; 3% middle career, compared to the England average of 7%; 63% registrars, compared to the England average of 51%; and 3% junior doctors, compared to the England average of 7%.
- There were consultants on call, one each for the paediatric wards and one for the NNU. The paediatric consultant hours were 8am to 6pm, Monday to Friday. From 6pm to 8am there was an on-call consultant for both the NNU and Sunshine Ward. At weekends and Bank Holidays there was one consultant on site from 8.00am to at least 2pm. There were three consultant led ward rounds in every 24 hour period Monday to Friday and two ward rounds at weekends. The PAU had consultant cover from 8am to 10pm.

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- The trust were meeting British Association of Perinatal Medicine (BAPM) 2014 guidelines for medical staffing on the NNU. A neonatal consultant was on-call at all times; none of the staff reported any difficulties or delays in receiving attention from a consultant. Nurses told us that when they were concerned about a patient, they were encouraged to call the consultant.
- The service had employed five new consultants following paediatric workforce review meetings, in order to meet the South London Quality Standards for medical staffing levels.
- Junior doctors across children and young people's services reported they had very good training and support from their senior consultants.
- Consultants undertook ward rounds daily, including at weekends. There were two handover sessions per day for the medical teams. A consultant was present at all handovers.

Are services for children and young people effective?

Good 

We rated the service as good for effective. This was because:

- Children and young people had good outcomes because they received effective care and treatment, which met their needs. Outcomes for children and young people who used services were positive, consistent and met expectations.
 - Children and young people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
 - There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services and service accreditation.
 - Accurate and up-to-date information about effectiveness was shared internally and externally. This was understood by staff and used to improve care and treatment, as well as children and young people's outcomes.
- Children were cared for by a multidisciplinary team of dedicated and skilled staff. Consultant support and presence was provided over seven days. Staff felt supported and had access to training.

Evidence-based care and treatment

- Children and young people's services had a band 7 nurse who was a practice development nurse responsible for ensuring that practice was based on national best practice guidance.
- Staff told us children and young people's services were working with other hospitals to standardise guidelines across South London.
- Children and young people's services regularly reviewed the effectiveness of care and treatment through a rolling programme of local and national audits. We viewed the paediatrics and neonatal annual clinical audit programme, 2015 to 2016. During this period children and young people's services had registered 27 new audits. These included: the 'epilepsy 12 audit' and 'neonatal sepsis audit'.
- We viewed the trust's results for the national 'epilepsy 12 audit', November 2014. 95% of those who answered the question indicated yes to: 'Overall, are you satisfied with the care you receive from the epilepsy service,' compared to an average of 88% across the UK. This meant there was a higher level of satisfaction with the epilepsy service at Kingston Hospital than there was across hospitals in the UK.
- The Neonatal Unit (NNU) was working towards level 2 UNICEF Baby Friendly accreditation. The Baby Friendly Initiative is based on a global accreditation programme from UNICEF and the World Health Organization. It is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.
- Policies, procedures and guidelines were available to all staff, including temporary staff, via the trust intranet. Staff we spoke with knew how to access them when necessary. A band 7 nurse demonstrated how staff could access policies and procedures on the trust's intranet.
- Children were treated according to national guidance, including guidance from the National Institute for Health and Care Excellence (NICE), and the Royal College of Paediatrics and Child Health (RCPCH). For

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example, we saw clinical guidelines were regularly reviewed at the children and young people's 'service line performance meetings'. We viewed minutes of the meeting dated 25 March 2015 and saw the meeting's attendees had reviewed the operational policy for paediatric assessments, as well as the GP referral form and the referral flow chart for the PAU.

- There were clinical guidelines for both neonatal and paediatric care available on the trust's intranet. The service had a departmental guidelines review process, that was led by a consultant. The consultant had a list of clinical guideline review dates. The trust also had a range of clinical guidelines and pathways that were shared with the services clinical networks, including the South West London cancer network.
- Children and young people's clinical guidelines were reviewed and updated in 2015, out of date guidelines were archived. The service was working with its networks to develop South London regional guidelines for common paediatric problems.
- The hospital took part in the National Paediatric Diabetes audit in 2014 to 2015. The 7.5% percentage of children tested with an HbA1c (glycated haemoglobin) was much better than the England average. This indicated there was better management of diabetes and therefore a lower risk of complications than the average in England.

Pain relief

- The trust was found about the same as other trusts in question 11 of the children and young people survey 2014, "do you think the hospital staff did everything they could to help your pain."
- Pain was assessed and managed appropriately. Sunshine Ward used a nationally recognised paediatric pain assessment tool. We saw age specific tools in use in the NNU and the appropriate national guidance being followed. Patients were given analgesia, as required, and staff monitored whether the analgesia had adequately relieved the child's pain. For example, we saw a child receiving analgesia on Sunshine Ward following a surgical procedure. We also saw staff asking the child "if it hurt."
- Appropriate equipment was available including equipment for patient controlled analgesia (PCA). The lead anaesthetist for children was involved with the children's pain strategy.
- The play specialist team were available in each ward and department, and provided distraction technique therapy for children undergoing a variety of procedures. Play specialists described to us the numerous distraction the therapies and techniques they used to help reduce children and young people's pain and distract them from painful procedures.
- Parents we asked confirmed staff ensured their children were not in pain.

Nutrition and hydration

- The trust was found about the same as other trusts in questions 24 of the Children and young people survey 2014, "did your child like the hospital food."
- We observed the children's and young people's ward areas had a protected mealtimes policy, which ensured children and young people could eat without being disturbed, with the exception of their parents and siblings. We saw this was observed by staff on the children's wards.
- Children's likes and dislikes regarding food were identified and recorded as part of their nursing assessment on admission. Children's and young people's wards used a nationally recognised screening tool for the assessment of malnutrition in paediatrics to determine if patients were at risk of malnutrition. We noted there were plans of care for any children at risk of being malnourished, with input from speciality teams as required.
- Children and babies were frequently weighed, and there were records relating to their fluid and nutritional intake and output. The records we reviewed during our inspection showed fluid or dietary intake was monitored and recorded where required.
- Children and young people were able to choose what they wanted to eat from a menu. Staff told us, if children didn't want what was on the menu they could have an alternative by request. Support was available from

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dietitians for specialist dietary advice, and support with special diets. Staff were also aware of how to order specialist menu choices, such as halal food or gluten-free meals.

- There were adequate facilities for the management of bottle-feeding.

Patient outcomes

- The service took part in all the national clinical audits that they were eligible for. For example, the trust took part in the national neonatal audit programme (NNAP) in 2014, published in 2015. The annual report showed for the period of January to June 2015, the service were achieving either the national average or better than the national average in the NNAP audit. For example, they achieved the standard that all (90%) of babies of less than 28 weeks gestation had their temperature taken within one hour of delivery:
- The trust took part in the national paediatric diabetes audit, published in 2014/15. The paediatric diabetes audit indicated the hospital had a lower percentage of children with 7.5% glycosylated haemoglobin (HbA1c), this was lower than the England average, and the median HbA1c was also lower than the England average.
- The emergency readmission rate for children and young people aged between one year and 17 years was higher than the England average. Emergency readmissions for non-elective children and young people aged between one and 17 years was worse than the England average. This indicated there was an increased risk of readmission following hospital discharge than the England average.
- The average length of stay between July 2014 and June 2015 for non-elective admissions was better than the England average for children under one year old. The average length of stay for children and young people aged between one and 17 years was the same as the England average.
- The hospital had processes in place to undertake mortality and morbidity case reviews should this be required as part of the children and young people's services governance arrangements. Staff told us the service had very few child deaths.
- The multiple readmission rate within 12 months were slightly better than the England average for children and

young people with a diagnosis of asthma. This meant children and young people with asthma were less likely to have a lot of hospital re-admissions than the England average.

Competent staff

- Information we saw on the wards and in the departments showed most staff had received an appraisal in the last 12 months. Staff we spoke with during the inspection confirmed this. All of the nursing staff we spoke to told us they felt well supported by their ward teams and the senior nursing and managerial staff.
- All band 6 nursing staff had attended, or had dates to attend, advanced paediatric life support (APLS) training. This would ensure there was an accredited nurse on duty during every shift.
- Nursing staff told us they received regular one to one coaching every quarter. Allied health professionals and play specialists told us they received regular supervision.
- The service had clinical nurse specialists (CNS), these were nurses who had gone through extra training to provide advice for: oncology, diabetes, and constipation. This ensured children and young people had access to specialist nursing staff with specialist skills.
- The hospital had a clinical practice facilitator who monitored staff training and competence. The band 6 nurse had been in post for three months. The clinical practice facilitator showed us an action plan they had produced to ensure all staff that provided care to children were trained to a level 3 in safeguarding.
- All new staff received a two week nursing orientation linked to the RCN competencies. This included the corporate induction, mandatory training, and training on the trust's IT systems. All new staff also received a mentor for six months to ensure consistency of support.
- Nursing staff had annual study days covering clinical scenarios and update sessions. Nursing staff told us the practice development nurse or matrons regularly assessed their competence in medicines management and drug insertion.
- Staff told us they had received an induction when they were first employed by the hospital and e-mail prompts from the senior sister when their mandatory training

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was due to be updated. Staff told us the hospital would fund courses in excess of their mandatory training. For example, a play assistant told us, “They will fund extra courses as long as its relevant to our job role.”

- Individual staff had a training record where they recorded their revalidation dates, appraisals, feedback, and training they had attended.
- Staff told us work was in progress on introducing a set of competency document based upon RCN competencies, these would be used to assess staff professional development needs.
- Junior medical staff reported good access to teaching opportunities and said they were encouraged to attend education events. The junior doctors we spoke with told us they received good educational supervision’ and said the consultant staff took an active interest in their teaching. Junior doctors had a weekly teaching programme that was mapped to the royal college of paediatrics and child health (RCPCH) curriculum.
- The medical staff we spoke to all confirmed they had received an appropriate induction when they started work and had an appraisal to identify training needs. Staff said they received access to clinical supervision and good training opportunities.
- Staff informed us that temporary nursing staff must have had relevant and appropriate training and experience, and had to provide evidence of being a registered paediatric nurse (RN60) or a registered nurse who was adult trained but had paediatric experience (RN00). The service kept records of temporary staff inductions

Multidisciplinary working

- There was strong evidence of multidisciplinary team working in all departments, with both internal services and outside providers of services. There were regular weekly multidisciplinary team meetings. We also saw evidence of engagement with external agencies such as social services and networking with other children’s services to share specialist expertise. For example, information on the attendance at hospital of children who were subject to a child protection or child in need (CIN) plan, or children looked after by the local authority, was routinely sent to the allocated social worker.

- In the Picker National Children’s Inpatient and Day case survey 2015 the neonatal unit (NNU) scored better for the question, “Members of staff caring for a child did not always work well together,” at 16% than the survey average of 25%.
- Children and young people had access to an oncology nurse who worked between both Dolphin and Sunshine Wards.
- Neonates, children and young people had children access to paediatric dietitians. The paediatric physiotherapy team covered both inpatients and outpatients.
- Children and young people’s services were within the hospitals on-call service and weekend cover included orthopaedics.
- Medical and nursing staff worked closely with the paediatric psychology team for children with complex needs throughout the referral, discharge and transition processes. There was further support from a paediatric speech a language therapist (SALT).
- Play specialists were an integral part of Sunshine and Dolphin Wards and department teams. Play specialists worked with children to make the hospital environment welcoming and fun. They answered questions children had about what would happen on the ward and reassured children. The play specialists were all NVQ 3 qualified in their specialism. The department also employed a play assistant, the play assistant told us they had applied for funding to train as a play specialist but this was withdrawn due to budgetary restraints.
- The trust had clear pathways and protocols in place in regards to operating theatres; these were based upon the world health organization (WHO) protocols. Almost all operating at Kingston hospital was carried out as day case admissions. Children operated on outside the dedicated paediatric lists were placed at the beginning of the operating list. There were dedicated paediatric outpatient clinics for: general surgery; and orthopaedic surgery.
- Staff told us one of the main challenges with MDT working was young people with mental health needs. This was due to child and adolescent mental health only providing assessments between 9am and 1pm Monday to Friday. However, there was psychiatric liaison

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available for seven days a week. Staff told us where a child or young person had mental health needs a qualified registered mental health nurse (RMN) was employed from an agency to provide one to one care.

- The service had a paediatric haematology oncology service. This was a level 1 paediatric oncology shared care service (POSCU) with the South West London cancer network. The service participated in the national peer review process.
- The paediatric assessment unit (PAU) worked closely with staff from the paediatric accident and emergency (A&E) department and had shared guidelines. Children under the age of one year could be fast tracked from the A&E to the PAU.
- We attended a MDT meeting for the paediatric diabetes team. This was attended by a consultant, specialist diabetes team nurses, family therapist, and psychologist. Staff told us there was a comprehensive skill mix in the team.
- The children and young people's service worked closely with the South Thames retrieval service based at Evelina hospital, to ensure safe inter-hospital transfers of critically ill children to specialist centres. The service had twice yearly training and simulation days with the retrieval service team.
- The administration team told us letters from consultants' were typed in India, before they were sent back to administrative staff and the consultant in question to check and sign. Patients and their GPs each received a copy of the consultants letters. Consultants we spoke with reported this system worked well, with approximately 85% of letters sent out within ten days.

Seven-day services

- Sunshine Ward, the PAU, and the NNU operated a 24 hour service.
- The paediatric diabetes service provided a 24 hour, seven days a week service within a joint service network. This ensured children and young people with diabetes had access to around the clock care.
- A play team was able to provide qualified play specialists and play assistants to children's services seven days a week. The play team were informed of all planned admissions at handover, and were involved in multidisciplinary ward rounds as necessary.

- The pharmacy department was open seven days a week but with limited hours on Saturday and Sunday. There were pharmacists on call out of hours. This ensured children and young people had timely access to medicines.
- Physiotherapy services were available seven days a week. Out-of-hours support was available through an on-call system.

Access to information

- Senior staff were aware of the trust's Caldicott Guardian, this is an appointment whereby the holder has responsibility to ensure the protection of patient confidentiality. This meant patient could be sure their confidential records would only be shared if appropriate to do so.
- GP's were informed of patients discharge on the day of discharge. Care summaries were sent to a patient's GP on discharge to ensure continuity of care within the community. GP's could telephone consultants and registrars for advice following discharge.
- Staff across children and young people's services told us information sharing between wards and departments, and medical and nursing staff was effective. Nursing staff told us medical staff were approachable.
- Staff had access to an electronic patient data management system, whereby patient's information could be accessed by medical and nursing staff.

Consent

- Parents were involved in giving consent to examinations, as were children when they were at an age to have a sufficient level of understanding. Staff we spoke with were aware of Gillick competence, this is a decision about whether a child aged 16 years or younger is able to consent to their own medical treatment, without the need for parental permission or knowledge.
- We observed how staff talked and explained procedures to children in a way they could understand. Services for children and young people at the hospital were caring. We observed a number of examples of compassion and kindness shown by staff across all the departments and ward areas. For example, we saw a nurse explaining in accessible language what she was doing, why she was doing it, and what she would do next to a child who had been admitted to Sunshine Ward.

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- There was a rolling programme of consent audits, which ensured the hospital had mechanisms in place to ensure children, young people, and families were involved in consenting to their care and treatment and this was recorded.
- All the parents we spoke with told us they felt very involved in their child's care. We saw staff spending time with children, young people and their parents to ensure they understood their care and treatment; and were supported throughout their time in hospital, whether as an inpatient or an outpatient.
- The trust had implemented the Friends and Family (FFT) survey. However, staff told us there had been problems with the FFT electronic system and this had made it difficult to get accurate data from the test. Staff told us the hospital's IT team were working to rectify the problem.
- The children's had taken part in the Picker National Children's Inpatient and Day case survey 2015. This was a national survey to assess parents' experiences of neonatal care. Results were significantly better than the 'Picker average' for the following question: "staff were not always available when a child needed attention", the hospital scored 20% in comparison to a survey average of 32%.
- Throughout our inspection, we observed positive interactions between staff, parents and children. We saw staff responding in a considerate manner with children, young people and their families in all of the areas we visited.
- Parents we spoke to told us they had been treated with respect and compassion by the staff and praised staff for their attitude and approach. A parent told us, "The care has been excellent. I'm really happy with all the levels of care." A young person on Sunshine Ward told us, "They've been really nice. They let my mum stay of a night."
- We observed children and young people's privacy and dignity was respected by staff, for example, we saw staff drawing curtains when providing intimate care or treatment.
- Play specialists worked with nursing staff on the PAU and Sunshine Ward to ensure children and young people were not left unsupervised for prolonged periods when they didn't have a parent or carer visiting.
- Services for children and young people at the hospital were caring. We observed a number of examples of compassion and kindness shown by staff across all the departments and ward areas. For example, we saw a nurse explaining in accessible language what she was doing, why she was doing it, and what she would do next to a child who had been admitted to Sunshine Ward.
- We observed a ward round on the NNU. We saw parents being provided with headphones to enable staff to

Are services for children and young people caring?

Good 

We rated the children's and young peoples service as good for caring. This was because:

- Children and young people were supported throughout their time in hospital whether as an outpatient or inpatient. Children, young people and their parent were supported, treated with dignity and respect, and were involved as partners in their care.
- Children and young people were involved in making decisions. Staff spent time talking to children, young people and parents. Children, young people and parents understood their care, treatment and condition.
- Children and young people's relationships with staff were positive. Staff responded compassionately when children and young people needed help and supported them to meet their basic personal needs as and when required.
- Staff helped children and young people and those close to them to cope emotionally with their care and treatment. We observed many examples of compassion and kindness shown by staff across all the ward areas and departments.
- Children and young people's privacy and confidentiality was respected at all times.

Compassionate care

- The trust were rated as performing about the same as other trusts in the 36 questions relating to the caring domain within the children's survey 2014.

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Speak confidentially with parents whose baby was being reviewed. This meant patients confidentiality was protected, but also allowed all parents the opportunity to stay with their baby on the unit.

Understanding and involvement of patients and those close to them

- The trust was found about the same as other trusts in section C2 of the children and young people survey 2014. Questions included, “did the hospital tell you what was going to happen to your child while they were in hospital;” and, “did members of staff treating your child give you information about their care and treatment in a way that you could understand.”
- All of the patients and parents we spoke with said they had been involved in their care and in making decisions around their treatment. For example a parent told us, “There is always someone you can ask questions.”
- There were age appropriate leaflets and booklets for children and young people, which explained the different procedures they could have, as well as their medical or surgical condition.
- Staff encouraged parental involvement in ward rounds. All of the patients and parents we spoke with said that they had been involved in their care and in making decisions around their treatment. We observed staff communicating with children, young people and parents to ensure they understood their care and treatment. Parents we spoke with told us they felt well informed and could ask any questions of the staff if they wished to do so.
- Staff told us children were provided with a Christmas stocking at Christmas and Easter eggs at Easter. Staff assured us they were aware of the need to be culturally sensitive during religious holidays.
- In the Picker National Children’s Inpatient and Day case survey 2015 the neonatal unit (NNU) scored better (17%) than the England average (26%) for the question, “Parents felt they were not always listened to.”

Emotional support

- It was evident from our discussions with staff they were very aware of the need for emotional support to help children and families cope with their care and treatment. Parents and relatives we spoke with confirmed this during our discussions with them.

- The trust’s play specialist team worked alongside nursing and medical staff to provide support to children and young people. Staff were aware of how anxiety could have an impact on the welfare of the child and made provision, where needed, to manage this. For example, play specialists offered support to children who were undergoing surgery to alleviate their anxiety.
- Parents we spoke with told us they felt confident in leaving the ward and leaving their children in the care of staff of the ward.
- Children and young people who were experiencing mental or emotional distress had access to child psychologists.
- Staff told us they could signpost children and young people who had received care or treatment from the service to a local counselling service if they were in need of counselling support. We saw information on accessing counselling services was available on the wards.
- Staff told us the hospital Chaplaincy would offer support for parents and others close to a child who had received bad news. Nursing staff told us they had received training in breaking bad news.

Are services for children and young people responsive?

Good



We rated the children's and young peoples service as good for responsive. This was because:

- Children and young people’s services were planned and delivered in a way that met the needs of children, young people and parents. The needs of different children and young people were taken into account when planning and delivering services.
- Children and young people’s care and treatment was co-ordinated with other services and other providers. There were clear pathways for children and young people when accessing and being discharged from the service.
- Each ward and department catered for the needs of individual children.

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- Complaints were managed in accordance with trust policy and lessons were learnt.

Service planning and delivery to meet the needs of local people

- There was an outdoor play area for young children, which was equipped with outdoor play equipment. There were signposts in the wards informing parents that all children were welcome to use the equipment as long as they were supervised by an adult.
- Sunshine Ward had a large play room for younger children this had a selection of toys available and a selection of children's books and DVD's. There was a stock of DVD players that could be loaned to children and young people as well as a stock of DVD's. The DVD's were stored in a lockable cupboard and stored according to British board of film censors classification to ensure children only had access to age appropriate DVD films.
- Sunshine Ward had a teenagers room furnished and decorated for adolescents. The room included a table tennis table and jukebox. We saw a young person playing table tennis in the room.
- The hospital was found about the same as other trusts in question 39 of the children and young people survey 2014, "how would you rate the facilities for parents staying overnight."
- The NNU had a breast pump room with dedicated breast feeding chairs available as well as a coffee room and full kitchen facilities. Breast Milk fridges were available in each nursery where mothers' could label and store their milk. Donor breast milk was available. Parents, children and young people had access to free WiFi and access to a TV/DVD player.
- Sunshine Ward had overnight beds for one parent to stay next to their child. There was a parents room available, that had television, coffee making facilities and a dining area. Parents had access to a fridge and microwave to store and reheat their own food. We spoke with a parent who told us they had purchased food from the hospital restaurant to enable them to stay with their child. There were also separate toilet and shower facilities for parents.
- The children and young people's service were supported by a local charity, Momentum. The charity had provided funding for a treatment room for children

with cancer in the PAU to be refurbished in child friendly sea theme. The charity had also provided funding for Dolphin Wards décor and the refurbishment of an isolation room.

- The children and young people's team reviewed surgery services and patient pathways to ensure they were child friendly and accessible for children and young people.
- Staff told us children and young people's services at Kingston Hospital had well established relationships with tertiary centres, including an advice line as well as visits from consultants from St George's NNU. The service also had links with the Evelina hospital and Great Ormond Street and other local hospitals.

Access and flow

- There had been 4372 spells in hospital in the previous 12 months. 86% of these had been emergency admissions; 1% had been elective; and 13% had been day cases. The primary diagnosis, 19.4%, for children aged one and under was other perinatal conditions. This was above the England average of 11.7%. The primary diagnosis for children aged one to seventeen was viral infection, 11.4%. This was slightly higher than the England average of 10.8%.
- The multiple readmission rate within 12 months was slightly better than the England average for patients with a primary diagnosis of asthma.
- Emergency readmissions for elective surgery patients within two days of discharge was higher than the England average in the age group one to 17 years. Emergency readmissions for non-elective patients under the age of one year and children between the age of one and 17 years were worse than the England average.
- Staff told us Sunshine Ward took transfers from Dolphin Ward, A&E, and surgery.
- The Children's Outpatient Department ran a number of clinics including: a rapid access clinic for urgent referrals where the child needs to be seen within 48 to 72 hours but did not need urgent attention in A&E. The clinic did not cover surgical or orthopaedic problems. Referrals could be faxed directly to the clinic from G.Ps. Outpatients ran a paediatric clinic where all referrals were triaged by a consultant paediatrician. A wide variety of conditions could be treated, such as wheezes, asthma, failure to thrive, enuresis and constipation,

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feeding, and a reflux clinic, and prolonged jaundice. Referrals for children with surgical problems were sent directly to specialists, such as general surgery, ear, nose, and throat (ENT), or orthopaedic.

- The hospitals follow up ratio for outpatients was 1:1 which was in the top 20% nationally. This ensured children and young people received timely follow up consultations.
- Children's Outpatients also had a number of specialist clinics, which were run in conjunction with tertiary centres. These were not part of the trust's 'choose and book' online booking system, as consultants would triage referrals prior to booking appointments. Clinics included: paediatric diabetes, including insulin pump service; paediatric haematology, paediatric cardiology, paediatric oncology, and paediatric endocrinology.
- There was a paediatric phlebotomy service available for children aged from birth to seven years in the Children's Outpatients department, via an appointment system.
- We viewed the overall average occupancy level for NNU in the previous month. The optimum occupancy level was 70% according to BAPM guidelines. We found the NNU was compliant with BAPM toolkit for neonatal occupancy levels. The indicated that the unit was managing to maintain the availability of emergency cots and providing the optimum safe nursing levels.
- The NNU team discussed planned deliveries of babies with the anti-natal service and delivery suite on a daily basis.
- Staff told us 16 to 17 year olds would be given the choice of admission to an adult or a paediatric area according to bed availability, providing they did not display behaviour unsuitable for a children's ward environment. Staff said this would always be decided in consultation with the young person and their family.
- The service offered adolescent transitional clinics for diabetes, epilepsy and gastroenterology to try and make the move from children's and young people's services to adults services as easy as possible. The service had a transitions nurse to assist young people with transitions in their care and treatment.
- Children could be admitted to the children's wards from the children's emergency department, which was separate from the main emergency department.
- We spoke with the paediatric administration manager who managed the paediatric services call centre. The manager explained how consultants worked with administrators to ensure children received

appointments within the hospitals timescales. The consultant in charge met with the administration team administration team in the morning and afternoon to triage patients and to discuss emergency referrals. The manager told us the paediatric administration team was, "one of the best in the hospital at ensuring timescales are met."

Meeting people's individual needs

- Each ward and department catered for the needs of individual children. This included ensuring there was enough space next to each bed or neonatal cot for a parent to visit.
- All of the inpatient areas had facilities for a parent to stay overnight and sleep. These included pull-down beds next to the child's bed. There was parental accommodation for parents whose children had to stay in hospital for a long period of time. However, staff on the NNU told us this would be provided by a local hotel and not by the hospital, due to a lack of space for a parents bedroom.
- There were sufficient play areas on the wards. Staff we spoke with told us the service could meet the needs of all children admitted to the wards, regardless of the complexity of their physical needs. We observed good facilities for children with disabilities. For example, funds had been made available to improve the ward environment for disabled children. A sensory room had also been created with funds from Momentum charity.
- Adolescents were offered a choice of single sex accommodation on admission, dependent upon their clinical needs.
- Translation services were available for parents and children. Staff we spoke with were aware of the process to access a telephone translation service or face-to-face translator. We observed a telephone translation service being used by a parent during a ward round on the NNU.
- The décor of the children's wards was child friendly and fun. Dolphin Ward had purchased wall décor that was pirate themed. Sunshine Ward had a good range of play equipment for all ages, which was kept to a good standard.
- The parents' rooms provided a variety of written information about treatment and care for a range of conditions.
- Support was available for children with learning disabilities or physical needs from the hospital's registered learning disability nurses, as required.

Services for children and young people

- Staff told us children awaiting an appropriate mental health bed were cared for on the ward whilst awaiting CAMHS assessment. In the interim families were invited to stay with their children on the ward where appropriate. Staff told us an agency registered mental health nurse (RMN) was employed to provide care for children or young people with mental health needs.
- Staff told us the hospital had access to interpreters if required and information in other languages for people whose first language was not English. We did not observe any interpreters being used during our inspection.
- Information for parents on access to patient records was available in all the wards we visited. This explained patients' rights under the Data Protection Act 1998 and the Freedom of Information Act 2000.

Learning from complaints and concerns

- Complaints were managed in accordance with trust policy and lessons were learnt. Staff and managers told us they preferred to resolve concerns "on the spot." Staff said these were not recorded, but if they could not deal with the concern immediately parents would be directed to make a formal complaint. All the parents we spoke with said they had not raised any complaints with the service, and they found staff approachable if they wished to raise issues.
- Information regarding complaints and concerns was on display in the parents' room on Sunshine Ward and the NNU. Leaflets detailing how to make a complaint were freely available. Staff told us information in all languages could be requested on the same day from the hospital's accessible communications team.
- Complaints and concerns were discussed at the monthly senior nursing staff team meetings and departmental clinical governance meetings. Lessons that could be learned from complaints were discussed at the meetings and actions to improve care or services were implemented. Staff told us they received minutes of clinical governance meeting where themes and trends from complaints had been identified.

Are services for children and young people well-led?

Good



We rated the children's and young people's service as good for well led. This was because:

- The leadership, governance and culture promoted the delivery of high quality child-centred care.
- There was a clear statement of vision and values, driven by quality and safety, with defined objectives. Strategic objectives were supported by measurable outcomes that were cascaded through the children and young people's service and throughout the trust. Staff in all areas knew and understood the vision, values, and strategic goals.
- The trust board and other levels of governance within children and families services functioned effectively. Structures, processes and systems of accountability, including clinical governance were clearly set out, understood and effective.
- There was evidence of children, young people and their families being engaged with services.

Vision and strategy for this service

- The children and young people's service had a five year strategic plan, 2014 to 2019. Staff told us they had been involved in devising the paediatric strategy. The strategy included increasing the numbers of advanced neonatal practitioners (ANNP) and the recruitment of five new paediatric consultants. The consultant posts were recruited to in October 2015. The five year strategy plan included the creation of a PAU, which the service had achieved in 2015.
- There was a clear local vision and values, which had been developed with children and young people's staff to ensure they aligned with the trust's vision and values. The values were embedded and underpinned staff behaviours.
- Most of the staff we spoke with understood the vision and strategy for developing the service, and said they felt they were kept informed. Staff were also aware of the trust's vision and values. Staff highlighted to us that

Services for children and young people

the trust's vision and values were communicated on large TV screens in the paediatric departments. We saw the trust's vision and values being displayed on the screens.

Governance, risk management and quality measurement

- The paediatric ward and the neonatal unit (NNU) used a quality dashboard to monitor the quality of services provided. This provided assurances by collecting information on the quality of care and outcomes. The dashboard was red, amber, green (RAG) rated to assist the children and young people's service to identify themes and trends. Staff told us as a result of using the dashboard the service was looking at the service's admission rates. The NNU and paediatric dashboards were regularly reviewed at the children and young people's 'service line' governance meetings.
- There was a governance framework in place and responsibilities were clearly defined. We viewed an organisational flow chart; this gave staff guidance on the structure of the service's governance framework. This included monthly local staff meetings that fed into the paediatric service line meetings, as well as weekly consultants meetings, which provided consultants with the opportunity to meet and discuss issues.
- We viewed the paediatric department's clinical governance programme for 2015/16. The children and young people's service had comprehensive governance meetings in place. These meetings contained a number of standing agenda items including a review of the department's action plan. The action plan monitored current departmental tasks. For example, the November 2015 action plan recorded that all oncology patients were to receive intravenous antibiotics (IVAB) within one hour of admission. We also saw actions had been completed in August 2015 on rewriting patient group directives (PGD), the PGD's were awaiting submission at the time of our visit.
- Staff attending governance meetings fed back to children and young people's team meetings to ensure teams were informed of the key issues. The children and young people's team meetings fed into the wider divisional structure to ensure Trustwide issues were picked up and any concerns from the children and young people's service were reported.

- A risk register was in place which identified the key concerns for the service. The risk register was linked to the trust's corporate objectives. There were nine items on the register. The risk register was regularly reviewed and updated at monthly divisional review meetings. Actions the service had identified to mitigate risks, had been recorded on the risk register. The risk register had been reviewed and updated regularly.

Leadership of the service

- Services for children and young people were well-led. Departmental level leadership was effective. Consultants' roles and responsibilities were in the process of being defined by the trust's job planning process. Staff on wards were unanimous in telling us how the matrons on both the NNU and paediatric wards provided effective ward level leadership. Staff on the NNU were especially complimentary about the changes the matron had introduced since being employed by the Trust.
- The nursing and medical management team were aware of how they fitted into the wider management model for the trust. For example, paediatric consultants had direct access to the clinical director, as did the matrons for children and young people and neonates, and the children and young people's service manager. Nursing team leaders linked directly with the matrons; and junior doctors linked directly with consultants.
- There were governance arrangements that monitored the outcome of audits, complaints, incidents and lessons learnt throughout the service. We looked at copies of governance meetings, risk registers, quality monitoring systems, and incident reporting practices. These demonstrated there were management systems that enabled learning and improved performance, and these were continuously reviewed. For example, the paediatric service had departmental quality assurance meetings and nursing meetings. We viewed minutes from these meetings and saw incidents and complaints were standard agenda items.
- We saw the local clinical leaders and managers encouraged co-operative, supportive relationships among staff and teams, and compassion towards patients. Staff told us local leaders were very visible and approachable. We observed the matrons advising staff on the wards on several occasions. Staff on the NNU told us the matron was relatively new in post, but had

Services for children and young people

introduced a number of positive changes to the running of the service. The matron on Sunshine Ward told us they had the mobile numbers of the divisional director and members of the board and would feel comfortable in contacting them to discuss services.

- Senior ward staff we spoke with said they felt supported by senior management, and if they raised any concerns about the service, they would be listened to. A band 6 nurse told us the director of nursing was willing to assist with work on the wards.

Culture within the service

- Staff we spoke with told us they were proud to work for the trust and felt respected and valued.
- Staff told us there was a very positive culture within teams, and staff supported each other well. Staff told us the culture of the service was very focused on meeting the needs of children and young people who used the service. We observed staff working well together in multidisciplinary teams to provide holistic care to children.
- Staff described an open culture, where they were encouraged to report incidents, concerns and complaints to their line manager. Staff we spoke with told us they felt able to raise any concerns.

Public and staff engagement

- The NNU had taken part in the BLISS Picker parents' survey 2015; this was a national survey to assess parents' experiences of neonatal care. The NNU had an action plan in place in response to the survey. The NNU had met four of the seven survey recommendations and was taking action to address areas for improvement. For example, to the question, "enough privacy was given in the neonatal unit for expressing milk and/or breastfeeding", the action plan identified the need for funding to refurbish the breast feeding room. During our inspection we saw the breast feeding room had been refurbished in response to the survey outcome.
- There were Friends and Family Test (FFT) post boxes on all children's and young people's wards. This enabled parents, children, and young people to take part in FFT patient surveys in both inpatient and outpatient areas. However, staff told us there had been problems with the FFT system and the trust's IT department were working to resolve this.

- The service had introduced, 'vest and pants,' washing line to the ward areas. Children and families could leave questions or comments on the performance of the wards by hanging them on the washing line. Staff told us the 'vest and pants' washing line was devised due to the hospital experiencing problems with the paediatric FFT system.
- The diabetes service ran regular events for children and families. For example, the diabetes service had recently arranged an educational event for children and families. This was a party at a pizza restaurant where children and families were involved in cookery activities and provided with information and advice in an informal setting.
- The service had an 'open day' in June 2015, where members of the public could visit the wards and speak with staff. As part of this Sunshine Ward ran a teddy bears hospital, where children had the opportunity to become familiar with some of the hospital's equipment.
- We saw a number of examples as to how children and young people's staff were kept informed by managers of service developments. Staff we spoke with said they felt engaged in services. For example, staff at a multidisciplinary meeting told us how staff had been involved in devising the Trust's paediatric and neonatal five year strategy.
- Staff received a monthly 'Team Brief' newsletter via email. This provided staff with information on developments at the trust and carried information on projects the trust was focusing on.

Innovation, improvement and sustainability

- The paediatric diabetes team were a top performer in the National Paediatric Diabetes audit 2014 to 2015 due to HbA1C rates being better than the England average.
- The paediatric diabetes team had won the trust's 2014 team of the year award due to their training of paediatric type 1 diabetes children and young people, and the on-going support the team provided to diabetic children and their families.

End of life care

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

Information about the service

End of life care (EoLC) is for patients identified as entering the last 12 months of their life or less. It refers to health care of patients in the final hours or days of their lives, and to the care of all those with a terminal illness that has become advanced, progressive and incurable.

Palliative care is a multidisciplinary approach to specialised medical care for people with serious illnesses, both cancer and other illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress and mental stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

The specialist palliative care (SPC) team for Kingston hospital is made up of clinical nurse specialists (CNS) consultants and staff facilitating the care of patients in the final phase of life. They collaborate with the chaplaincy service, social work, the pain team, pharmacists and cancer teams. The team works closely with the patient and those close to them, the hospital doctors, ward nurses and other professionals in supporting the patient's needs. They also liaise with hospices and other community support agencies.

There were 697 referrals to the SPC team in the year April 2014 to March 2015; 43% of these were non-cancer patients and 57% were cancer patients. Non-cancer patients had illnesses such as heart failure and other heart conditions, dementia, renal failure and respiratory disease. The team

offers short term or long-term support to patients or provides advice and support to ward staff caring for patients at the end of life. The patients are residents of Kingston, Richmond and surrounding areas.

There were 746 adult deaths on wards at Kingston hospital in the year April 2014 to March 2015. Of these, 284 (38%) were known to the SPC team.

The hospital does not have a ward for patients who are dying. Patients in the last days or hours of life are cared for in a side room on the main wards when possible, or in a bed on the ward.

During this inspection, we spoke with over 30 members of staff; who included members of the SPC team, ward nurses, health care assistants, trainee doctors, consultants, allied health professionals, porters, the chaplain, the bereavement officer and mortuary staff. We spoke with two patients and a friend of a patient. We reviewed 16 sets of care records. We reviewed other information and data about the service, which we also considered in making our judgements.

We visited most of the medical and surgical wards, the acute assessment unit, the mortuary, the chapel and multi-faith rooms and the room for relatives.

End of life care

Summary of findings

We found end of life care at Kingston hospital was well-led, effective and safe. Caring was outstanding.

- Hospital services were arranged to enable all aspects of end of life care to be delivered holistically, with care and compassion as a basic principle.
- Staff of all disciplines and levels of seniority demonstrated an impressive understanding of their role in addressing the needs of people near the end of life and those close to them. The specialist team and ward staff provided care and support sensitively and compassionately.
- The Specialist Palliative Care team were highly skilled and responsive. The hospital guide to care for people in the last days of life followed national good practice and the SPC team was leading its rapid and effective implementation across the hospital. They provided an extensive training programme, advice, information and tools to support the use of the guide. Hospital staff, including senior nursing staff, consultants, trainee doctors, nurses and health care assistants understood their role in providing this care.
- There was trust wide commitment to developing excellent end of life care at the hospital. The end of life steering group effectively contributed to and monitored the trust end of life strategy. The group had broad membership, including members of the public, external agencies and a non-executive member of the trust board.
- There were many examples of multi-disciplinary work to improve practice, for example on care of older people wards, the intensive care unit and the acute assessment unit. There was collaboration between the specialist team, ward staff, the chaplaincy service and the pain team to meet the physical and non-physical needs of patients. The specialist team worked with the local authority, and hospice and community health services to provide a seamless service. This included discharging people from hospital to their preferred place of dying.
- Surgical services were taking steps to improve awareness of the need to treat patients holistically

and of when to consider ending active treatment. The SPC team were moving their focus to wards that made fewer referrals to them in order to address gaps in knowledge and awareness.

- The bereavement officer was responsive to the needs of relatives after the death of a patient. Mortuary and porter staff provided a safe and dignified service for the deceased.
- The SPC team, ward staff, and the mortuary and bereavement staff were aware of the varied needs and expectations of different cultures at the end of life and after death.
- The trust undertook regular audits of Do Not Attempt Cardiopulmonary Resuscitation orders and there had been improvements to practice, such as senior medical staff leading the discussions with patients or those close to them.

However;

- At the time of our inspection the trust had not allocated funds to increase specialist palliative consultant and nursing presence at the hospital. This is needed to maintain progress towards meeting the aim of providing excellent end of life care.
- The environment of the chapel and multi-faith facilities needed improvement.
- Staff sometimes used relatives instead of interpreters to have important conversations with people at the end of life who did not speak English.

End of life care

Are end of life care services safe?

Good



We rated the end of life (EoL) services at the Kingston Hospital as good for safe. This was because:

- Kingston hospital encouraged openness and transparency and staff understood their responsibility to raise concerns and report incidents. The specialist palliative care (SPC) team raised concerns about EoLC with staff in a manner that was supportive and avoided blame.
- Infection control practices kept people safe. There were good arrangements in place to manage patients' medication. The patient records we viewed were nearly all completed well.
- Nursing staff were aware that rapid deterioration in a patient might mean they were nearing the end of life. There was prompt assessment and referral for further specialist assessment when this was indicated.
- The SPC team did not provide seven-day cover and there were no cross-cover consultant arrangements. The team had made the case for increased nursing and consultant hours.

Incidents

- The staff on the wards and in the specialist palliative care (SPC) team told us there was an expectation of openness when care and treatment did not go according to plan. When members of the SPC team found examples of poor care, they spoke to the appropriate senior member of staff. During our inspection, we saw an example of a discussion about the care of a patient between a clinical nurse specialist and a ward nurse in charge. The sister addressed the immediate concerns promptly, and decided on the action to take about a member of staff. She said she would use the example in training on the ward. The emphasis on learning not blaming was evident in the manner in which the SPC team raised issues with ward staff.
- The SPC team gave examples of when they reported incidents, such as when a syringe driver was prescribed but not started. The majority of mortuary incident

reports were about patient identification or incomplete checklists/use of out of date checklists. The incident reporting system recorded action taken, such as removing old checklists and providing new ones.

- The trust Serious Incident Group (SIG) met weekly to ensure investigations were adequate and had appropriate recommendations, and that there were action plans arising from these. Staff we spoke with were aware of the expectation of duty of candour, and serious incident reports had a section on openness with patients and/or relatives. There had been no serious incidents reported by the mortuary team or the SPC team in 2015.
- Consultants told us medical and surgical teams discussed end of life care at morbidity and mortality meetings. These included cases when the care had followed best practice as well as those where there were concerns. There was sharing of these lessons across specialties and at grand rounds (meetings of medical staff from across specialities).

Cleanliness, infection control and hygiene

- Infection prevention and control was part of mandatory training for all staff.
- We found the mortuary area to be clean during our inspection. There were regular audits to check compliance with the infection protection and control processes.
- Ward staff identified deceased patients who had an infectious disease and porters placed these in a body bag and used separate fridge storage. Porters, mortuary staff, and undertakers were provided with personal protective equipment such as gloves or aprons.

Environment and equipment

- The syringe drivers for delivering measured doses of pain medication conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia. Ward staff obtained syringe drivers from the equipment store. The syringe drivers had annual maintenance checks and/or corrective maintenance in line with the manufacturer's recommendations.
- The mortuary had sufficient numbers of fridges and a range of sizes for storing bodies from the hospital and the community in normal circumstances, with separate fridges for babies and children. There were further

End of life care

temporary storage facilities on standby in the mortuary if there were high numbers of deaths, and there were arrangements with neighbouring mortuaries in case of emergencies.

- There was an automated temperature measurement system, which facilitated regular checks. An external company checked fridge temperatures out of hours and the mortuary staff on call had access to the system.

Medicines management

- Prescribing Guidelines for the Dying Patient, produced by the SPC clinical lead covered pain management and common symptoms that occur at the end of life, such as agitation, nausea and shortness of breath. These were available on the wards and on the intranet. Junior doctors told us they regularly referred to the guidelines, which they found easy to follow. When a patient's symptoms were difficult to control, ward staff referred to the consultant or to the SPC team, who promptly reviewed medication and discussed possible changes with the ward clinical team. They documented this action in the patient record. Three of the clinical nurse specialists on the SPC team were nurse prescribers. Pharmacists were also available for advice on the wards.
- The SPC team re-audited an indicator relating to medication prescribing in 2014 and found that that in 66% of cases PRN (as required) medication was prescribed for the five key symptoms that may develop during the dying phase. This was better than the national average of 50% reported in the 2013 national survey of care of the dying. The team re-audited the indicator because the published national survey results indicated a worse performance than the England average, but this was at odds with other data from the survey.
- The trust had introduced electronic prescribing, which reduced prescribing errors. The SPC team had identified the risk of the system making it more difficult for medical staff to specify opioids for both pain and breathlessness. The chief pharmacist informed us they had added this to the pharmacy risk register, and by the time of our inspection they had assessed and resolved the issue.
- There was a guide for medical staff to follow on the prescription of anticipatory medication. These were prescribed for patients, including those discharged to

their own home or a care home, to manage pain and common symptoms, if required. This prevented delays in symptom and pain relief and reduced the likelihood of readmission.

- We saw a list of nurses in all wards of the hospital who were trained in the use of syringe drivers. The SPC team had identified the risk of a shortage of nurses with this competency because of the high turnover of staff. Measures to reduce this risk included training of all newly qualified nurses joining the trust and providing refresher training. Ward nurses in charge kept information on competency assessments of nurses in setting up and managing syringe drivers. Hospital staff could discharge patients from hospital with a syringe driver in place, which was immediately returned and replaced by a syringe provided by community health or hospice teams.
- We looked at nine sets of notes to check the prescription and administration of medication. There had been a review of the patients' medications in all cases, the writing was legible and administration documented. When a syringe driver was in use, this was documented by way of a checklist. When appropriate (in four cases) medications for the end of life and anticipatory medicines had been prescribed and administered appropriately.

Records

- Hospital staff used electronic patient records to record patients' needs and care plans, medical decision-making and review, and risk assessments. When members of the SPC team were involved in the treatment and care of patients at the end of life, they recorded the discussions and agreed action on the electronic system. Nurses began the individual care plan for nursing care of the dying when the patient reached the last days of life. These were completed manually. We looked at five of the paper care plans and saw the nurses had completed these regularly, with notes about communication with the patient/family, details of care and a minimum four hourly assessment of symptom management.
- We reviewed 16 sets of patient records, both paper and electronic, and found they were generally completed appropriately. We found one example when documentation did not appear to reflect the care provided to the patient.

End of life care

Safeguarding

- There were procedures to keep children and vulnerable adults safe. Staff had access to the trust safeguarding policy on the intranet. Safeguarding was part of the trust annual mandatory training; 88% of staff had completed the safeguarding children training and 87% safeguarding adults training. Staff we spoke with knew who to contact if they wanted further advice.
- The social worker who worked with the SPC and cancer teams told us she was available to discuss nurses' concerns and to advise them and signpost them to the safeguarding lead at the local authority if appropriate. She also became involved in advising and signposting staff when a patient was a carer for a member of their family who was a vulnerable adult.

Mandatory training

- The mandatory training programme for nursing staff and the education programme for junior doctors in training included end of life care (EoLC). There was a section in the staff training manual on EoLC. There was also a short section relating to EoLC in trust induction for new staff.

Assessing and responding to patient risk

- Risk assessments, such as risks of developing a pressure sore, were completed on the electronic patient record system and the system flagged the need to update these. Nursing and health care assistant staff monitored all inpatients regularly and used an Early Warning Score (EWS) to identify patients who were deteriorating.
- The SPC team had worked with trust medical and nursing staff on the recognition of the dying patient. Staff told us this had improved the prompt identification of patients moving into the palliative care phase and of patients at the final phase of dying.
- Health care assistants and nurses monitored the comfort of patients who were in the final phase of dying and recorded symptoms on the individual nursing care plan. Nursing staff reported changes in condition, such as signs of discomfort or agitation, or change in breathing to medical staff.
- The SPC team responded promptly to referrals, seeing 90% of referrals on the day of referral; 9% within 24 working hours, and the remaining patients seen within 48 hours. We observed a daily meeting of the SPC team to review patients, attended by the team on duty that day. They allocated patients to be reviewed that day,

including those in the final phase of dying, those whose symptoms were difficult to manage, and patients who were being discharged. Any risks were flagged for immediate response.

Nursing staffing

- The SPC team had eight clinical nurse specialists, making up five whole time equivalent (WTE) posts. The team had made the business case in December 2015 for additional staffing to provide seven day working, in line with recommended practice. The Saturday service was well used and the trust recognised the importance of providing a prompt and equitable response to all patients.
- There were two non-clinical posts (currently staffed by nurses), the care of the dying coordinator and the EoLC facilitator (one WTE post). The SPC team recognised there would be benefits to extending the hours of this work, which covered the whole trust, but there were currently no plans to do this.
- There were concerns about the high turnover of nursing staff, the shortage of nurses on some wards and the use of agency staff, all of which had the potential to affect the care of patients at the end of life. The risk of a shortage of nurses was on the trust risk register, and steps taken to recruit more staff, for example from overseas, and to reduce turnover.

Medical staffing

- The clinical lead for palliative care was 0.4 of a WTE post, and the second consultant 0.2 of a WTE post. There was therefore only four-day palliative care consultant cover at the trust, and no cross-cover arrangements during leave or other absence. The end of life steering group had recognised the risk for patients with complex needs of not receiving expert consultant involvement in their care and the risk for the hospital of compromising the effectiveness of end of life care provision. The team had made the business case to increase palliative care consultant presence to 1.2 whole time equivalent posts.

Are end of life care services effective?

Good



We rated Kingston Hospital end of life care service provision as 'good' for effective. This was because:

End of life care

- The Specialist Palliative Care (SPC) team were highly skilled and knowledgeable. The trust guide to end of life care (EoLC) followed national good practice and the SPC team was leading its rapid and effective implementation across the hospital. There was a multifaceted education programme to develop staff knowledge and understanding of EoLC. Staff were able to find further information and tools to improve their practice.
- Consultant and nurse leads in EoLC on the wards, in particular on medical wards, promoted adherence to best practice.
- The SPC team participated in national and local audits, and used the results to make improvements to services.
- There were many examples of good multidisciplinary working, within the SPC team, within ward based teams, across the trust and with external agencies.
- Care planning for the last days of life addressed people's needs. There was regular monitoring of the care plan, which prioritised good communication with the patient and/or those close to them. Patients were provided with effective pain relief, nutrition and hydration at the end of life.
- The trust audited the Do Not Attempt Cardiopulmonary Resuscitation forms and had an action plan in place to improve their completion and recording of these.

However;

- There was not enough specialist palliative consultant cover to provide fully effective clinical leadership within the trust and at regional and national forums.
- The patient record systems did not collect data on key indicators for end of life care.

Evidence-based care and treatment

- The Specialist Palliative Care (SPC) team reviewed published reports and guidelines relevant to end of life care (EoLC) and palliative care and developed their guidance, education programme and resources to help staff follow best practice. The best practice included the Leadership Alliance for the Care of Dying People 'Five Priorities of Care', released in 2014, which promoted individualised care planning delivered with compassion, and the involvement of the patient and those important to them in making decisions about treatment and care.

- The SPC team had responded promptly to the report of the independent review of the Liverpool Care Pathway and introduced a replacement, with the support of the End of Life Strategy group, within a month of the publication of the report. The Principles of care for dying patients, summarised in an easy to follow guide for staff, started with identifying the potential that a person was likely to die in hours or days. This was followed by a multidisciplinary team (MDT) assessment by staff involved in caring for the patient and a discussion about the care plan with the patient or patient's family or both. The guide included prompts for staff to consider in the daily review of the patient. There were flow charts for medical staff to follow on the control of pain and other symptoms. Other trusts had used the Kingston hospital guide in their programme to replace the Liverpool Care Pathway.
- The SPC team developed an individual care plan (ICP) for nursing care of the dying patient, informed by the five priorities of care and the hospital's survey of staff support needs for dying patients. The SPC team retrospectively audited 20 sets of patient notes before and after piloting the ICP. The audit found staff had followed good practice more since its introduction. The results of the audit contributed to the revision of the ICP, which was then adopted throughout the hospital. The local community health provider adapted the care plan for the community setting.
- The trust was reviewing their EoLC strategy in light of the latest evidence from research and the NICE guideline on end of life care published in December 2015. The trust guide, Principles of care for dying patients, already reflected the recommendations in the guideline.
- The SPC team had implemented many of the specialist palliative care measures identified by the National Cancer Peer Review Programme. The SPC team agreed and recorded individual patient's management plans at their regular meetings, produced audit data and provided patients and carers with written information. Members of the team attended local and national forums, which discussed and promoted good practice in palliative care.

End of life care

Pain relief

- The SPC team were knowledgeable about pain relief and three of the clinical nurse specialists were nurse prescribers, which meant they responded promptly to control pain without having to wait for a doctor's prescription
- The SPC clinical lead worked with the pain team and hospital pharmacists to reinforce good practice in pain relief at the end of life. She wrote 'Palliative Care: Chronic Pain and the Terminal Phase' as part of the hospital June 2015 guidelines for the management of common medical emergencies. This highlighted that severe pain was a medical emergency and needed rapid response and regular review. The guidelines described steps to take to respond to pain and provided links to other information on the intranet.
- Instructions on managing pain were also included in the hospital documentation on the principles of care for dying patients. The guide encouraged staff to contact members of the SPC team for advice in complex cases and to use the telephone advice line out of hours.
- We saw examples in the records of pain control managed with PRN (as required) analgesia. Some patients had syringe drivers, which delivered measured doses of drugs over 24 hours. We saw examples of appropriately prescribed syringe drivers, which nurses checked regularly to make sure they were functioning correctly and the patient was receiving the correct doses of drugs.
- The responses from relatives to the local bereavement survey indicated that 95% of the 63 patients who required pain relief received enough for their pain. This was better than the England average in the 2013 national survey of care of dying.

Nutrition and hydration

- The trust expected nurses caring for patients in the last twelve months of life to encourage patients to take food and drink, and to think about alternatives to the usual hospital menu. There was a prompt to staff to consider the benefits of a referral to the speech and language therapist for patients who found it difficult to eat solid food.
- The assessment of nutrition and hydration support needs was one of the six sections of the individual care plan for nursing care of the dying patient. In addition to

assessing the patient's needs and taking action to address these, there was a prompt to record concerns raised by the patient or their family about nutrition and hydration and the outcome of any discussions.

- The ward staff responsible for the care of the patient discussed the use and review of clinically assisted nutrition or hydration, with the involvement of the patient and/or family. A member of SPC team sometimes contributed to this discussion and supported the patient and/or family in making decisions.

Patient outcomes

- Results from the Royal College of Physician's National care of the dying audit of hospitals 2013 were published in May 2014. The audit included 49 cases from Kingston hospital. The results indicated the hospital performed worse than the England average on in five out of the seven key performance indicators. By the time of our inspection the SPC team and other trust staff had taken action to address all the areas identified for improvement.
- The nominated medical lead for EoLC had worked with doctors in training to introduce a decision summary document for dying patients, which included a section for a daily medical review. This was adapted for entry on the electronic patient record system. During our inspection, we saw this in use on the care of older people wards; the objective was to extend its use to other wards in the trust. This would enable the trust to record multidisciplinary team (MDT) decision-making and review electronically.
- We saw, and were told about, examples of how staff followed the trust guide on EoLC during our inspection.
- Staff on medical wards explained how they discussed patients who might be in the last phase of life and focused on alleviating symptoms and supporting the patient and their family. Staff on the acute assessment unit had identified the rapid deterioration of a patient admitted from the Emergency Department. Staff requested urgent medical assessment, which confirmed the end of life was near, there was discussion with the family, who agreed with the care plan for the patient. The CQC team inspecting the intensive care unit also found good practice in decision-making and care planning for the end of life, involving the patient and/or their family.

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- It was not surprising to find there was less awareness of the trust EoLC guide on the surgical wards. Nurses on the care of the older person ward, where surgical patients sometimes stayed, noted surgical teams were more task oriented than medical teams. A trainee doctor told us there was less training and less exposure to good practice in EoLC in surgical services compared to other areas of the hospital. The figures from 2014/2015 indicated fewer deaths in the surgical wards were known to the SPC team. However, there was increasing awareness of the importance of recognising and addressing the needs of dying patients in surgical services. A trainee doctor told us a consultant at the clinical governance meeting earlier in the month had raised the need to consider Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions with patients at the end of life and suggested trainee doctors should remind the team of when this was appropriate. The trainee doctor gave us an example of when the consultant accepted his suggestion that there should be a decision about whether a patient receiving active treatment was nearing the end of life. There was a discussion with the patient and their family, the SPC team was consulted, and the patient discharged to their preferred place of dying. The SPC team told us they were targeting wards that made fewer referrals to the team, including rolling out training to surgical wards.
- The SPC team had taken other actions to make sure the trust improved their performance against the indicators measured in the national audit. The actions included conducting a bereavement survey, including EoLC in medical and nursing induction, developing guidelines for referral to pastoral care, updating the bereavement booklet for relatives, and extending the teaching of communication skills.

Competent staff

- The members of the SPC team were highly skilled and well-trained. They had opportunities to undertake personal development opportunities to enhance their skills. All of the team had advanced communication skills training. Two CNSs had trained as trainers in communication skills in difficult conversations.
- The SPC team had developed an education plan for the trust as part of the funded quality improvement scheme for EoLC for 2014/2015, and they had adapted the plan in the light of experience. The SPC team told us there was interest in EoLC training, but because of demands

on staff it was increasingly difficult to achieve good attendance at formal training courses. The hospital put on Sage and Thyme® sessions (basic communication skills training for staff in any role, including porters, ward receptionists and volunteers) and Quality End of Life Care for All (QELCA©) (which aimed to develop senior nurses skills) free of charge. However, ward pressures making it difficult to release staff and this had hampered the rollout of these sessions.

- The SPC team had developed a number of strands to the education programme in 2014/15 to overcome the difficulties of releasing staff for training.
- The trust included Palliative and EoLC in the Mandatory Training Manual and in the trust induction training for ward nurses, health care assistants and trainee doctors. The SPC team ran additional sessions in the junior doctors teaching programme, which included communication skills in having difficult conversations. The two palliative care consultants and the medical lead for EoLC encouraged good practice among their peers and other medical staff through dissemination of audit findings and case discussions at forums, including 'grand rounds'. They, and other members of the SPC team, had delivered 11 ward-based teaching sessions to medical staff. The SPC team had also delivered nine sessions to a total of 79 health care assistants. The team had delivered several sessions to the medical and nursing staff on the orthopaedic wards. The trainers assessed attendees before and after the sessions to make sure the training was effective. Trainee doctors told us how the teaching had raised their awareness about the importance of recognising when a patient was at the end of life and of following the trust guide in promoting good EoLC.
- The Care of Dying Coordinator on the SPC team oversaw the use of the individual nursing care plan. She had provided one to one support and teaching to 407 nurses and health care assistants on all wards, between April and October 2015. The work was continuous and faced the challenge of agency staff and staff turnover, and the need to come in at nights to work with night staff. One of the inspection team went with her on her visits to a ward and saw her making sure nursing staff had received teaching and understood what was expected of them. She took care to check the understanding of nurses from overseas whose first language was not English.

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- All health care assistants, nurses and therapists we spoke with understood their role in providing palliative and EOL care. Nurses and health care assistants, including a bank nurse, confirmed they had received this training, and spoke with us confidently about their role, for example in enabling privacy, symptom control, and supporting patients and those close to them.
- The link nurses for EoLC played a key role in supporting good practice. All wards nominated a link nurse, who was expected to attend quarterly training. The SPC team told us one ward was currently without a link nurse, and some link nurses did not always attend the training day. They said they had the authority to address these shortcomings to make sure all wards had an active link nurse in EoLC. We spoke with two link nurses who demonstrated how they reinforced good practice in palliative care and EoLC care by reviewing patients with their staff and checking the quality of care for each patient during their shift. One of the link nurses had spent a week at the local hospice.
- The chaplaincy service contributed to induction training and provided other training sessions to staff. They talked with the consultant group about addressing spiritual pain along with physical pain and supported staff in using language that was appropriate for people at the end of their lives.
- Staff knew about the resources available on the palliative care section of the intranet. There was information on EoLC on a board in one ward we visited, including the Five Priorities of Care. Staff knew where to get other information held on the ward, such as the leaflets for patients and their relatives about dying.
- Mortuary services provided training to hospital porters in the transfer of deceased patients. The SPC team recently started providing information leaflets and training to porters on handling the deceased with dignity and respect.

Multidisciplinary working

- The key to the progress in developing EoLC at the trust was close working relations within the SPC team, with the 'extended' team of social worker, chaplains, pharmacy and cancer services, with the ward hospital staff, and with community based services.
- The weekly specialist palliative care meetings were well attended. One or more palliative clinical nurse specialists (CNSs) attended every meeting and one of the palliative care consultants attended 90% of meetings. There was regular attendance from the chaplaincy team, the local hospice and the social worker attached to the SPC team. We observed one of the weekly meetings, at which members discussed all aspects of the care and treatment of each of the patients supported by the team, with appropriate challenge and request for further information. This included a discussion about spiritual needs, and whether the patients and those close to them would like to talk to the chaplaincy service.
- We observed one of the weekly meetings of palliative and cancer CNSs. The purpose of the meeting was to review patients' care pathways and if, appropriate, to move patients from disease specific care to palliative care. It was also an opportunity to share information about incidents and complaints and to share updates from local and national forums and initiatives.
- We accompanied a CNS from the SPC team to a ward and saw her supporting the work of nursing staff in a constructive and practical way to enhance the care of patients. All the staff we spoke with, including junior doctors in training, knew the team and said they were readily accessible. They said they contacted the team if they wanted to check something and always received a response to requests for advice. Senior nursing staff told us they referred patients to the team when there were concerns about symptom management.
- The trust guide, Principles of care for dying patients, placed the responsibility on the ward MDT to assess patients who might be at the end of life, with the involvement of all staff with responsibility for caring for the patient. The SPC team, and medical and nursing staff with commitment to good EoLC enhanced MDT working, in particular on the care of older people wards. The EoLC facilitator and other members of the SPC team had attended the daily medical ward meetings to promote discussion about patients who might be entering the last days of life. This discussion had now become routine practice on the medical wards, whether members of the SPC team were present or not.
- We observed parts of three MDT board meetings on medical wards, led by a consultant and attended by nursing and therapy staff, doctors in training and a discharge coordinator. We heard discussions about whether patients were at the end of life and what action

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members of the MDT should take to help with this decision. There were additional meetings on the care of the older people's wards specifically to discuss patients at the end of life, which were consultant led.

- The discussions at the separate nursing and medical handovers on medical wards included information about patients at the end of life. A health care assistant told us the handover highlighted the patients who had not been comfortable during the previous shift so they could prioritise the comfort of these patients.
- The SPC team nominated team members to attend cancer MDT meetings for the different specialties to comply with expectations of cancer review measures. Attendance was variable, and neither of the consultants was able to attend the cancer of unknown primary MDT meetings because of there was no member of staff free to attend.
- The SPC team, the social worker attached to the team and the trust discharge coordinators facilitated effective working with external agencies. We spoke with the social worker, employed by the local authority, who worked with the palliative care and cancer teams. She had access to the social services electronic case system and liaised with other local authorities. She was in frequent contact with the CNSs and helped families who needed a social services assessment and/or support on discharge. She also provided practical support to families, for example, supporting a relative to receive benefits while they cared for of a patient at home at the end of their life.
- There was close working with the local hospice. The two SPCT consultants had joint posts with the hospice, sharing of good practice in palliative and EoL care. The rapid response nurse at the hospice contributed to the discharge for local patients by assessing patients who wanted to die at home. The hospice enhanced support team led by a consultant, with therapy and care worker staff, provided care and treatment in coordination with district nurses.

Seven-day services

- The SPC team provided a six-day service, Monday to Saturday 9am to 5pm. This did not meet the recommendation of seven day working, but there was an arrangement through 'Careline' for access to telephone advice from the local hospice at other times. We spoke with a hospice nurse who had been on call the week of our inspection and had received two calls

from junior doctors. She passed them onto the consultant on call to discuss the specific issues, for example the appropriateness of using a syringe driver. She told us the London Ambulance Service had called about whether to transfer a dying patient from their home to the hospital. After talking to the relative, it was agreed; in this case, it would be appropriate. The nurse on call contacted the Emergency Department to inform them of the patient's imminent arrival. Junior doctors confirmed to us they made use of the out of hour's telephone line and received appropriate advice from the consultant.

- Staff told us of examples of discharge over the weekend when people wanted to die at home. However, rapid discharge was more difficult to arrange then because there were fewer staff working, including medical staff with decision-making responsibilities, therapists and staff to coordinate the discharge.

Access to information

- Trust staff had access to 'Coordinate my Care' (CmC), an electronic record which allowed healthcare professionals to record a patient's wishes with their permission and ensures their personalised care plans available for all those who support them, including the 111 telephone help line, GPs, ambulance and community services. A message was automatically sent to the patient's GP when the record was created. The SPC team had promoted the creation, updating and use of CmC records for patients at the hospital. This included training doctors and nurses in the ED to access and use of the records.
- When a patient was discharged to their preferred place of dying, hospital staff gave information to ambulance crews about where to take the person if they died while being transferred.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The SPC team and senior doctors and nurses understood that it was important for people who had capacity, to make decisions about their treatment and care in the last year of their life, in particular decisions about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders. We observed a discussion at a ward MDT meeting where there were differences in opinion about a patient's mental capacity and it was decided to

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get further views, including the opinion of a social worker. The DNACPR policy stated that when a patient had expressed their wishes in an advanced care plan, this should be respected.

- We saw cases of patients at the end of life where there was no DNACPR order in place because the patient's families were not ready to agree with the decision. This emphasis on supporting families as their relative reached the end of life was in line with the trust guide. The risk of DNACPR orders not being correctly recorded had been on the trust risk register since 2014. The most recent trust audit in December 2015 had found improvements in following the trust DNACPR policy. Three-quarters (19/26) DNAR forms had been signed or countersigned by a consultant. The consultant had signed half the 26 forms, specialist doctors in training or middle grade medical signed the others half. A junior doctor we spoke with on a medical ward confirmed consultants led discussions on DNACPR. The doctor had taken part in a best interest meeting to discuss the treatment and care of a patient assessed as lacking capacity to make a decision about this.
- Medical staff were expected to complete both an electronic form and a paper form, and this resulted in inconsistencies.

Are end of life care services caring?

Outstanding



We rated EoL services at Kingston Hospital as 'outstanding'. This was because:

- Hospital services were arranged to enable all aspects of end of life care to be delivered holistically, with care and compassion as a basic principle.
- Staff of all disciplines and levels of seniority demonstrated an impressive understanding of their role in addressing the needs of people at the end of life.
- Members of the specialist palliative care (SPC) team were highly effective communicators. They enabled patients and their families to talk about their concerns and helped them understand the options for care and treatment.

- We observed examples of staff interacting with patients and those close to them with kindness and dignity. Feedback from patients and their carers found that staff treated patients with dignity and respect, explained what was happening and were caring towards the relatives of patients. The SPC team was highly valued by patients and those close to them.

Compassionate care

- The importance of communication and compassion was a consistent theme in the conversations we had with staff of all levels of seniority. The two health care assistants we spoke with on the care of older people wards, for example, demonstrated an impressive understanding of the needs of dying patients and their families. They said they paid particular attention to patients in side rooms to check they were comfortable and to see if family members wanted anything. They made sure patients and/or families knew about the services available, such as the chaplaincy service, and offered them meals. One of them talked about the importance of recognising anxiety and 'soul pain' as well as pain management and symptom management. The other said, 'It is a privilege to be with a person at the end of their life. I might be the last person they are with.' A nurse told us how important it was to give patients and their families' time, and to look for cues for when they might want to talk about things.
- During our inspection, a member of the CQC inspection team accompanied one of the clinical nurse specialists (CNS) when she visited a patient and sat in on the discussion, with the patient's permission. The CNS allowed the patient to talk about her worries and responded with kindness and compassion. She went through each of the patient's symptoms and talked about what might help with these. She checked the patients understanding of the options and at the end of the visit made the agreed changes to the care plan. This included changes to medication, which she discussed with a doctor. She spoke to the senior nurse on duty about aspects of care and nutrition.
- We observed another member of the SPC team visiting patients in the last stage of dying. As well as checking that the ward staff were delivering the appropriate care and alleviation of symptoms, the co-ordinator checked the patient was comfortable, and spoke with them and stroked them.

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- The results from the local survey of bereaved relatives in 2014 were better than or similar to the average percentages reported in the optional bereavement survey conducted by some hospitals as part of the national audit of the dying in 2013. Over 75% of the 80 people who participated, thought healthcare staff treated their relative with respect and dignity; 77% said that nurses had time to listen and 79% said that doctors had time to listen. 92% reported that the explanations they received were easy or fairly easy to understand, compared to an England average of 82% in the national survey. Fifty-six per cent remembered a member of the healthcare team talking to them about symptoms might arise when the patient was dying compared to a national average of 46%). In the question about whether they were adequately supported during the person's last two days of life 84% said yes, compared to an England average of 76%
- Staff told us, and we saw examples, of staff taking time and care to respond to the dying person's needs and preferences. There was music in one of the side rooms we visited where a patient was in the last days of life. There was a note on the wall that the family had requested the radio play music. A ward nurse told us that the wife of a man in the last hours of life, who was also being treated in hospital, was brought to the ward in her hospital bed to be with him while he died. Another patient was able to spend time with her pet in a room in the hospital.
- The bereavement officer provided a compassionate and responsive service to bereaved families and provided further advice. She telephoned relatives every day to update them when there were delays with releasing the body, for example, when there was an autopsy.

Understanding and involvement of patients and those close to them

- Involvement of, and communication with, patients at the end of life and those close to them was central to the hospital guide, Principles of care for dying patients. The senior responsible clinician, who identified that a patient under their care was likely to die, had the responsibility to discuss the care plan with the patient and/or their family and to respond to any questions or concerns. Medical consultants generally led this discussion or delegated it to middle grade doctors. We were told of examples when consultants, such as surgeons asked junior trainee doctors to take on this task, and did not follow the trust principles. Trainee doctors on duty at night were sometimes the only medical staff available to talk to families of patients near death because the consultant had not taken the opportunity to identify the dying patient during the day. However, the junior doctors we spoke with said they were well prepared for this task because of the training they received and the observation of good practice. Members of the SPC team sometimes attended the wards to provide support to doctors in communicating with families and patients.
- We saw good recording of discussions with the patient and/or their relatives. This included discussions about resuscitation. We saw an example when the family did not wish to discuss this and there was a decision to postpone the discussion to another time.
- Ward staff we spoke with knew about the importance of finding out about the spiritual needs of patients and their families and there was a section in the ICP to document action, such as a referral to the chaplaincy service. Two permanent chaplains and four bank chaplains provided the chaplaincy service, which was available at short notice at all times for anyone who was dying, whatever their religion or lack of religion. Roman Catholic, Muslim and Jewish clerics also worked at the hospital and were on call. There was a recruitment initiative working with volunteers already selected and trained by the hospital to receive specific chaplaincy training. These volunteers, who included a Jewish and a Muslim volunteer, were also available at short notice. The wards had information about how to contact them.
- Other volunteers were available to sit with patients who did not have relatives or friends with them. A nurse told us of an example of when they requested an additional health care assistant to stay with a dying patient whose relatives were unable or unwilling to be with them.
- Members of the SPC team spent time with patients and relatives who were anxious, distressed or angry.
- The SPC team had carried out a patient survey in 2014 to ask patients or their relatives their views of the team. Nearly all the 25 people who responded said the team made a difference to their experience in hospital; 20/25 said they made a difference to a great extent, and 3/25 said a little bit of difference. One of the respondents said 'a big thank you to all the team - I hope you know what a

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difference you make'. We saw, and were told about, other tributes that families paid to the SPC team and ward staff for the compassionate care given to their relatives in the last days of their life.

Are end of life care services responsive?

Good 

We rated end of life care at Kingston Hospital as a good service for responsiveness. This was because:

- The trust had worked with partners externally and with staff within the hospital to provide a responsive and flexible service to patients at the end of life.
- Hospital staff were identifying patients nearing the end of life and having discussions with the patients and/or those close to them to make sure their care and treatment met their individual needs and preferences. When there were concerns that patients' symptoms were not controlled adequately, staff referred to the Specialist Palliative Care (SPC) team, who responded promptly.
- There was a comfortable room for relatives and friends of people at the end of life to use. There were fold out beds on the wards so that they could sleep in the patient's room.
- The chaplaincy team provided spiritual support for different faiths.
- The hospital worked with community based services to give people choices at the end of life. This included organising rapid discharge so people could die at home if they wanted to.
- The bereavement officer and mortuary staff were responsive to the needs of family and friends of the deceased.

However;

- The chapel and multi-faith facilities needed refurbishment.
- Staff sometimes used relatives instead of interpreters to have important conversations with patients at the end of life who did not speak English.

- The high turnover of nursing staff on some wards made it difficult to provide a responsive service.

Service planning and delivery to meet the needs of local people

- The Trust End of Life Care (EoLC) Strategy reflected the National End of Life Strategy, the Commissioning Strategy Plans for Kingston and Richmond Clinical Commissioning Groups and other commissioning partners in SW London and Surrey.
- There was a chapel and a male and a female multi-faith room in the hospital. However, the facilities were not comfortable. The chapel was too warm and the corridor on which the faith rooms were dingy and poorly decorated. We were told there were plans for refurbishment.
- Ward staff moved patients at the end of life to side rooms whenever possible to provide privacy with their family and friends. The SPC team obtained hospital charitable funds to buy a fold out beds for each ward so family members could sleep overnight if they wanted.
- SPC team members also made a successful bid for charitable funds to buy furniture, lamps, and plants to refurbish the Willow room, which was available for relatives or friends of patients at the end of life. Staff gave families and friends the code to the lock on the room, which was close to the medical wards, so they could take a break or have a meal there whenever they wanted. Staff used the room to discuss difficult topics with families. The room was pleasant, well-furnished and quiet. Staff pointed out there was no room for families in the surgery wing of the hospital. They said it was possible to find a quiet place to talk to relatives.
- There were some free parking tickets for family or friends of a dying patient. Staff were also able to arrange for all day tickets that were cheaper than the usual charge for additional family or friends who wanted to stay at the hospital to be with a dying patient.
- The ward EoLC link nurses had drawn attention to the poor quality of trolleys to transport deceased patients. The SPC team had raised this issue, and the trust had agreed the purchase of six new trolleys with covers. Porters we spoke with were clear about their role in preserving the dignity of patients who had died.

Meeting people's individual needs

- The chaplaincy team provided spiritual support for different faiths. The team included an Iman and a Rabbi who worked a few hours in the hospital as well as being

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on call. The hospital chaplains were part of the Kingston multi-faith group and had contacts with a number of faith communities. The chaplain told us of an occasion when there was a dying patient who was Korean and had no spiritual contacts within the community, and so the chaplaincy service contacted the local Korean church.

- There were few patients at the end of life who did not speak English. No-one we spoke with had used the interpreting service. Staff said members of the extended family who were involved in conversations about end of life care sometimes interpreted for the patient, although they recognised this was not good practice for important discussions. Staff told us of an occasion when a nurse who was from the same country as a patient came to help with discussions with a patient who found it difficult to understand English.
- The trust risk register included the risk of poor patient experience because there were not enough nurses or nurses did not have the right skills. The risk of being too busy to give patients and their family's time and attention was a theme in our conversations with staff and in complaints and survey comments. The trust had mitigated the risk by recruiting more nursing staff from overseas and these staff received an extra week's training after the usual induction of two weeks. A practice development nurse told us overseas nurses were well supported, and often already had a good understanding of the importance of end of life care.
- The Individual care plan (ICP) for patients in the last days of life began with a section for nurses to record the communication and support needs of patients and family. Nurses had completed this section in the ICPs we looked at.
- When the SPC team discussed dying with a patient or those close to them, they usually asked them if they wanted a copy of this conversation in writing. We were not clear whether ward staff were encouraged to follow this practice.
- Each ward had NHS and hospital specific information leaflets for patients and their relatives about what to expect during the last phase of life. There was also information about the facilities available and the chaplaincy service in a hospital information leaflet. Staff showed us where these leaflets were kept and said they gave them to patients and or those close to them.
- Ward staff gave relatives a leaflet with information on 'What to do when someone dies' which covered all the

practical tasks following a death in the hospital, as well as information about tissue and organ donation and the emotional response to bereavement. There was also advice on carrying out a funeral without the use of a funeral director.

- The bereavement officer and the mortuary staff were responsive to the needs of the families of the deceased, including families of people who died outside hospital and were transferred to the mortuary.
- The bereavement officer provided relatives and friends with advice and answered questions about the practical tasks that they needed to take care of. She suggested contacting the chaplaincy service to provide support to families if this seemed appropriate. If relatives raised concerns about the end of life care received at the hospital, she took appropriate action by arranging a meeting with the lead nurse for the ward or by contacting PALS so that the person could make a complaint.
- Mortuary staff came in out of working hours, for example, when a child died or relatives needed a quick release of the deceased for religious reasons. Mortuary staff said hospital medical staff completed a death certificate quickly if requested, and gave an example of a ICU doctor coming in on his day off to do this for a Muslim patient. The trust had changed the policy for verifying deaths of patients when the death was anticipated and a DNACPR was in place, so site managers were able to do this and speed up the process out of hours.
- The public entrance to the bereavement office opened onto a small, but comfortable seating area, which led to the viewing room where relatives and friends were able to see the body. Mortuary staff took care in preparing the body for viewing. There was access for wheelchairs.

Access and flow

- Patients receiving palliative and end of life care were cared for on the wards, with advice and support from members of the SPC team or the cancer teams.
- The SPC team and other trust staff worked with the community hospice service and with other community based health services so people were able to spend the end of their life in their preferred place. Close working relations with the local hospice helped hospital staff identify when a bed might be available for a patient who wished to die there. There was a rapid discharge process for patients in the last days of life who wanted to die at

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home or in their care home. The end of life care facilitator, who often coordinated this process, had updated a guide to rapid discharge and had created a community resource folder.

- An occupational therapist (OT) we spoke with, who began working at the trust one week before our inspection, was aware their team prioritised the rapid discharge of patients who preferred to die at home. A nurse on a care of older people ward described the rapid response to get someone home within 48 hours. This included a review by the SPC team, an OT assessment, and arranging a home care package with visits from district nurses. SPC team staff told us that at least 24 patients were rapidly discharged home in 2014-2015. However, there were no reliable figures on the number of people who were asked where they wanted to die or how many had died in their preferred place. An audit of a small number of patients on the SPC team list found most were asked about their preferred place of death, but it had not been possible to find out whether they had died in their preferred place. The SPC team were looking at ways of collecting this information.

Learning from complaints and concerns

- There had been three complaints by relatives about end of life care in the year to December 2015. Most of the concerns raised were found on investigation to be about misunderstandings about the care and treatment of the patient. The trust responses, signed by the chief executive, apologised that staff had not explained everything clearly. Improving communication skills was a key component to the training programme for EoLC.

Are end of life care services well-led?

Good 

We rated the end of life services at Kingston Hospital as 'good' for well-led. This was because:

- There was strong commitment at board and senior management levels to provide the care people needed at the end of life.
- The SPC team was well respected in the trust and provided coherent and supportive leadership to hospital staff in their work of treating and caring for patients at the end of life.

- There were examples of effective leadership from medical and nursing staff on the wards and in the intensive care unit to ensure good practice was being followed.
- The end of life strategy group oversaw the work of the SPC team and the implementation of the end of life strategy.

Vision and strategy for this service

- Staff at all levels understood the importance of working to provide a dignified death to patients, to support their choice of where to die, and to work with those close to them before and after death to provide emotional and spiritual support. These objectives were part of the terms of reference of the End of life strategy group.
- The strategy group had broad membership, in addition to the SPC team and bereavement officer. A deputy director of nursing chaired the group, and membership included the Non- Executive Director (NED) for EoLC (who was also the trust board chair), the medical lead of EoLC, nursing, consultant and junior medical staff, user representatives, and hospice and community health services representatives. The group approved the 2012 to 2015 End of Life Care Strategy and discussed reports and guidance, such as the independent review of the Liverpool Care Pathway, the results of national audit for the care of the dying and the local bereavement survey. The SPC team was writing the 2016 EoLC strategy in light of the NICE guidance on EoLC, published in December 2015.
- The NED, the deputy director of nursing and other members of the strategy group took responsibility for disseminating information to the trust board, the Overview and Scrutiny Committee, and other forums. Members of the SPC team made a presentation at the trust Annual General Meeting in October 2015.

Governance, risk management and quality measurement

- The EoLC strategy group's terms of reference included identifying key risks associated with EoLC, receiving audit results and taking action, identifying processes and resources required, and addressing key challenges to support dying patients. The group met quarterly, reviewed information collated by the SPC team and the results of audits, and decided on action to achieve further improvement. The group allocated actions to members and the SPC team, maintained an action log

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and reviewed these at the following meeting. The EoLC strategy group was accountable to the Patient Experience Committee chaired by the Director of Nursing, to which it provided reports every six months. There was progress in making all specialties accountable for the quality and responsiveness of EoLC, with ICU and medical specialties taking increasing responsibility for measuring their effectiveness. The Service Line performance review meetings, which were central to the trust accountability processes, included EoLC.

- The trust's recently revised organisational structure placed the SPC team in cancer services, which was part of Clinical Support Services. The team already worked closely with cancer services and expected to receive good support in the new structure. However, the SPC team had recently been allocated responsibility for managing their budget without additional resource or training to carry out this task. There had been no assessment of the impact of this change on the team's existing commitments.
- The risk register for cancer and palliative care had risks relating to EoLC, which were added in October 2015. These risks, such as the lack of seven-day SPC team cover and the low consultant cover, were also discussed at the strategy group. A member of the SPC team was allocated to attend the risk and governance meeting.
- Some risks relating to EoLC were appropriately held by the trust. The risk of failing to demonstrate a robust process for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions had been regularly reviewed since its addition to the trust risk register in 2014. There had been a series of audits, with improvements identified. However, actions such as changes to the electronic patient record system had not been implemented by the time of our inspection.
- The SPC team collated information about their activity, for example the number of staff receiving training and the patients referred to the SPC team. Audits provided further information about the work of the team and of EoLC at the trust. However, not all information about the assessment and care of patients receiving palliative and EoLC was recorded on the electronic patient record. For example, there was no reliable information about an assessment of spiritual needs or the number of people who were able to die in their preferred place.

- The SPC team produced an annual report, which described the team's activity and progress with meeting the agreed objectives on EoLC. The report's appendices contained audit results and action plans.

Leadership of the service

- The NED and the deputy director of nursing on the strategy group played a role in maintaining an overview of EoLC at trust board and committee level.
- Members of the SPC team were well respected in the hospital and in the wider community. They succeeded in balancing the allocation of responsibility to trust staff with their role of supporting staff, encouraging improvements and of accepting patient referrals. The SPC clinical lead and CNS lead had additional responsibilities in ensuring that the work of the team was effective, but the success of the team was based on sharing of responsibilities and the flexibility of team members in taking on tasks. Other services with responsibility for EoLC, such as the bereavement officer and the chaplaincy services also contributed to good practice and effective working. However, the low SPC consultant hours placed limits on the role of the clinical lead in providing leadership in the trust for palliative and end of life care.
- The enthusiasm and ability of the nominated medical lead for EoLC in educating medical staff had influenced the approach to patients at the end of life. The Acute Assessment Unit had improved its recognition and care of patients admitted to the unit who might be close to the end of life. There was strong leadership on some medical wards from consultants, senior nurses and link nurses in reinforcing good practice in EoLC. The Intensive Care Unit had introduced improvements, audited these and taken action to address the findings. Surgical specialties had acknowledged the need to think holistically about their patients, but were not yet offering leadership on EoLC. There was a new post of consultant for care of older people to work with surgical specialities, which was expected to reinforce the increasing awareness of good practice in EoLC. Palliative and EoLC in cancer services was well supported through clinical nurse specialists and counsellors. There was no SPC team presence in other outpatient departments at the time of our inspection.

Culture within the service

- The SPC team, members of the EoLC strategy group, the care after death team, link nurses and hospital staff in

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general were highly motivated to improve the experience of people at the end of their lives. Staff who had been at the trust for a short time, and those who were temporary were able to articulate the trust expectations. Other staff we spoke with who had worked at the trust for some time, such as charge nurses, link nurses and health care assistants, were passionate about contributing to a good death. Many people we spoke with praised the role of the SPC team in modelling effective communication and patient centred care. Staff also told us that the single site hospital, with good communication and a culture of openness and respect for others contributed to the spreading of good practice.

- Staff were aware of the need to support each other after a death of a patient. The SPC team sometimes supported a debrief for the ward team who had cared for a patient before their death. One of the SPC team ran regular 'Schwarz rounds', which were open staff from all disciplines to discuss emotional and social issues that had arisen in caring for dying patients.

Public and staff engagement

- The user representatives on the EOL strategy group played a key role in informing developments in the service. Volunteers, who were members of the well-established trust volunteering scheme, supported people at the end of life by sitting with patients and working with the chaplaincy service.
- The SPC team gathered staff and public feedback from surveys. There was a survey of doctor and nurses support needs for the care of dying patients in 2014 following the introduction of the new guidance in 2013. Nearly 50 medical and nursing staff, including health care assistants and consultants, responded to the survey.

Innovation, improvement and sustainability

- The SPC team's knowledge of good practice in EoLC, supported by an active strategy group with influence in the trust, encouraged innovation and improvement.
- There was swift and effective action to implement the recommendations of the independent review of the Liverpool Care Pathway in 2013 and to introduce the Principles in care for dying patients. The guide was subsequently been adopted by the London Cancer Alliance as a resource.
- There were many other examples of improvements to services in response to good practice guidance, and the results of local and national audit. For example, the SPC team had revised of the patient/carer information leaflet and the national '5 key priorities of care' had been added to the trust mandatory training booklet. At the time of our inspection, there was a pilot on the care of older people wards of a proforma to support the recognition of the dying patient to help medical staff make decisions and improve care. There were plans for an audit and for the form to be used more widely, and for the information to be recorded on the electronic patient record.
- There was close working with the local hospice, a leader in palliative care, including consultant cross-site working. The clinical lead was participating in a joint research project on people with dementia in the last 12 months of life.
- The Chaplain, who began working at the trust in autumn 2015 and worked closely with the SPO team, described the 'will to innovate and develop' care of dying patients. The chaplain was discussing an initiative to provide all end of life patients with a spiritual assessment.

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

Information about the service

There were over 591,220 first and follow-up outpatients appointments booked at the hospital between July 2014 – June 2015. Ophthalmology, trauma and orthopaedic, obstetrics, physiotherapy and genito-urinary medicine were among the most attended clinics in 2014/2015, and they accounted for 39% of all outpatients appointments seen at the hospital. The imaging department included magnetic resonance imaging (MRI) and computerised tomography (CT) scanning, ultrasound, nuclear medicine gamma camera, DEXA scanner, fluoroscopy rooms, interventional radiology room and x-ray areas. Individual outpatients clinics were co-ordinated by corresponding surgical or medical specialities and patient pathway co-ordinators within these specialities.

The outpatient inspection took place over three days, 12-14 January 2016, during which we visited a range of services. This included the Royal Eye Unit (REU) and the William Rous Unit, where breast clinic, diabetic, various cancer clinics, general surgery, and haematology clinics took place. The orthopaedic, dermatology, oral and ear nose and throat (ENT) departments were inspected. We also visited cardiology, the urology outpatients, the pain clinic, sexual health department and a range of diagnostic departments.

We reviewed documentary information supplied prior to our visit and provided on request during the inspection. In addition, we took into account feedback from discussion and written communications from stakeholders. During our visit we made observations of activity levels, staff interaction with patients and other people using the

service, and made checks on the environment and equipment used by patients. We spoke to a range of staff within focus group discussions before our visit as well as 73 during the visit itself. This included consultants, radiographers, radiologists, matrons, nurses, healthcare assistants, executive lead staff, receptionists, patient pathway co-ordinators, administration staff, and technicians. We spoke with 24 patients and three relatives, and reviewed four patient records.

In addition to our main visit to the outpatient areas, we undertook an unannounced visit on 26 January 2016, in which we checked and reviewed medical records, equipment, staffing levels and staff training records. We observed interactions between patients and staff, and reviewed care and treatment. We inspected the environment where services were provided and looked at an additional seven patient records.

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Summary of findings

We rated the outpatients and diagnostic imaging services provided at Kingston Hospital as requiring improvement, as the services were not always safe and responsive.

- Medicines were not always stored safely and checks on emergency resuscitation equipment were not performed routinely. Other items of equipment used for patient care had not always received an annual service or maintenance check.
- Incidents and adverse events were reported and investigated. Lessons arising from these were learned and improvements had been made when needed. However, people did not always receive a written apology in accordance with the duty of candour.
- The method for tracking medical records was reliable; however, patient original records were not always available prior to appointments.
- People's privacy was not always achieved in outpatient and diagnostic areas.
- People were not always made aware of waiting times.
- There were no designated outpatient areas designed specifically to meet the needs of individuals living with dementia.

However;

- Cleanliness and infection control procedures were adhered to and potential risks to the service were anticipated and responsive actions planned.
- There were sufficient staff with the right skills to care for patients. Staff who had been provided with induction, mandatory and additional training specific for their roles.
- Staff had appropriate safeguarding awareness and people were safeguarded from abuse.
- The hospital was significantly better than the national average for new to follow up ratios for the period between July 2014 – June 2015.

- Cancer referral targets had improved and most had been met for quarters one to three, 2015/16.
- Referral to treatment times were better than the England average.
- The new to follow up outpatient rates of 29 to 38 against the national figure of 25 to 55, were significantly better than the national average between July 2014 and June 2015.
- Waiting times for echocardiograms and portable monitoring for cardiac patient were three to four weeks at the time of our visit, which was good when compared to other similar services.
- A multidisciplinary team approach was in effect across services provided within the outpatients and diagnostic imaging department.
- Patients treatment and care was delivered in accordance with their individual needs. Patients told us they felt involved in decisions about their care and they were treated with dignity and respect.
- People's concerns and complaints were listened to and responded to and feedback was used to improve the quality of care.
- The leadership, governance and culture with the outpatient and diagnostic imaging services promoted the delivery of person centred care.
- Staff were supported by their local and divisional managers and were encouraged to contribute to the development of the services.
- In the main, risks were identified and addressed at local level or escalated to divisional or board level if necessary.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated the safety of outpatient and diagnostic imaging services at Kingston Hospital as requires improvement. This was because:

- The safety of people who used the services could not be assured as medicines storage and equipment maintenance checks were not always carried out.
- Incidents were reported, investigated and lessons were learned and improvements had been made when needed. However; people did not always receive a written apology in accordance with the duty of candour.
- Patient records were not always available prior to outpatient appointments.

However;

- Safety performance targets were established, monitored and reacted to.
- Cleanliness and infection control procedures were adhered to.
- Potential risks to the service were anticipated and responsive actions planned.
- Clinical staff had appropriate safeguarding awareness and people were safeguarded from abuse.
- There were sufficient staff with appropriate skills to ensure people were safely cared for.

Incidents

- A formal process was used for reporting, investigating and learning from incidents, errors or near miss situations. Nursing and other clinical staff described to us the system they used and the investigating process.
- Risk managers validated incidents for levels of harm, ranging from; none, low, moderate, and severe. They also ensured incidents met the correct criteria, including those considered a serious incident (SI) or Never Event. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been

implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

- We observed staff following the procedures which had been put in place as a result of two Never Events related to wrong eye lens insertion. These had occurred on the 5 April 2014 and 6 August 2014, but weren't identified until March 2015. As a result the SI investigation was not completed until September 2015.
- Investigation of incidents had contributed to changes in practice and shared learning. Staff provided the example of actions taken following the insertion of the wrong lens during eye surgery. Clinical staff were aware this incident fell into the category of a 'Never Event,' and as such required full and detailed investigation prior to the development and implementation of an action plan.
- In the ophthalmology department, a check list had been developed and a notice board was placed in each treatment room to record patient details. This was to prevent surgeons from using incorrect data for patients and inserting incorrect implant into patient eyes. There was evidence the staff learnt from incidents and that action plans were developed to address any issues identified.
- The Strategic Executive Information System (STEIS) captured all Serious Incidents. Serious Incidents (as defined in the Serious Incident Framework) can include but are not limited to patient safety incidents. Where an incident fulfilled this criteria, it was managed through the SI investigation process as per the 'Serious Incidents Framework' (2015).
- Staff reported patient safety incidents, via their local risk management systems, to the National Reporting and Learning System (NRLS). Service line teams reviewed individual incidents and also reported these through their scorecards to performance meetings. Minutes of the meetings reviewed by us confirmed there was a shared learning as a result of incident reporting.
- Other examples of action taken as a result of learning from an incident were described to us. For example, a

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checklist had been developed with regard to eye treatment and staff were all present to check and agree before the patient had the correct side to be treated marked.

- Clinical governance meetings provided staff with the opportunity for discussion of incidents. All incidents were investigated using a root cause analysis tool, taking into account the factors which may have contributed to the incident. The managers we spoke with confirmed information relating to reported incidents was collated and discussed by management at clinical governance meetings, and minutes we saw confirmed this.
- Mortality and morbidity meetings included discussions related to patients who attended outpatient services.

Duty of candour

- We were told that information about duty of candour was circulated to all staff from their divisional managers. Clinical staff told us information about duty of candour was made available to them at team meetings and their responsibilities for being open and transparent with patients when they made mistake.
- We saw evidence of duty of candour in action when the consultant in the ophthalmology department gave us an example (i.e. letters to patients offering apology and inviting them for a meeting to discuss the incident) of what the department did when they dealt with the Never Event incident.
- We reviewed information, which reflected serious incident reporting and learning from the event in the REU. This had related to the injection of medication into tissue of the eye on two separate occasions. We reviewed written information sent to one patient, in which the consultant reconfirmed the discussion of the incident and advised the matter would be investigated. We read the final response and findings. However, we noted that neither letter contained an apology, which would be expected as part of the duty of candour regulation.

Cleanliness, infection control and hygiene

- Cleaning audit data submitted prior to our inspection visit showed 100% compliance. This comprised cleaning programs in all areas of the outpatients and diagnostic imaging department (OPD) and diagnostic imaging department.

- There was a program of monthly matron-led Assessments of the Care Environment (ACE). This was where matrons led on the inspection of all areas under their control to check on cleanliness and whether infection control measures were adhered to in those areas.
- The Infection Prevention & Control Team (IPCT) met quarterly and submitted information to the trust board. The infection control scorecard reported 100% compliance against the Hand Hygiene Audit and this was in line with the trust target between April 2014 – March 2015.
- As part of ‘Saving Lives Campaign’, the Out Patient Department (OPD) achieved 100% observed compliance with hand cleaning and staff being bare below the elbows on all assessed criteria between September 2014 – September 2015.
- Staff had access to and were observed using personal protective equipment including gloves and aprons in all areas visited.
- There was access to infection prevention and control policies and procedures via the trust intranet to guide staff. We sampled a number of the documents on the intranet and these were in date and current.
- We observed staff complying with local infection control policies, which included correct hand hygiene practices and the removal and disposal of clinical waste.
- The handling and management of surgical specimens in the outpatient eye theatre was done in a safe manner, with labelling of each sample and completion of relevant forms.
- Surgical staff working in the outpatient eye theatre were observed to follow National Institute for Health and Care Excellence (NICE) guideline CG74, Surgical site infection: prevention and treatment of surgical site infections (2008).
- Equipment used for patient treatment and care was checked and found to be suitably clean. Green labels indicating the date and person who had cleaned it had been attached on items in a number of outpatient areas.
- Nursing staff who worked in the urology outpatient clinic explained how they cleaned cystoscopes after use,

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prior to returning them to be decontaminated in the designated department. A tracking system was used to record which cystoscope had been used on each respective patient.

- Infection control link nurses were available in outpatient areas. For example, there were two nurses with responsibility for infection prevention and control in the orthodontic department. Monthly meetings with staff included discussion of infection prevention and control. The minutes we saw confirmed these meetings had taken place.

Environment and equipment

- The outpatient environments we visited mostly supported the safe delivery of diagnosis, treatment and care. The exception to patient safety were swinging saloon doors, which we observed on an open doorway to screen a waiting area from the main corridor in the x-ray department. These were not safe for people entering in a wheelchair, pushchair or with limited mobility due to the nature of the swing action. Staff told us the doors had been fitted immediately prior to our visit.
- Safety signage and visual warning lights were displayed externally on rooms where x-ray or laser procedures took place. The Radiation Protection Supervisor ensured all expected safety checks were undertaken.
- The radiation protection group, laser group and decontamination group all reported to the health and safety committee.
- Separate areas were provided in the outpatient operating theatre of the Royal Eye Unit (REU) and in the orthodontic clinic for the management of clean and dirty instruments and associated practices.
- A recovery area was provided for patients having intravenous sedation or a general anaesthetic in the orthodontic clinic.
- There was access to emergency equipment, including, a 'hypobox' system for the treatment of patients with hypoglycaemia, oxygen and resuscitation items.
- Checks of resuscitation trolleys had not always been undertaken. For example, in the REU staff had only been checking the trolley on four of the working days. During January 2016, there were nine dates where the resuscitation trolley in the William Rous outpatient area was not checked. The dates of safety checks on the suction machine on the resuscitation trolley in the general outpatients were not clear. Further, the suction on one of the resuscitation trolleys in cardiology was out of date for its maintenance checks (due 2014) and there was no maintenance checking record on the second resuscitation trolley. Both of these issues were reported to staff who responded immediately to the concern.
- Patient examination couches were in need of maintenance checks in the general outpatient area. Maintenance checks on the two treadmills used in cardiology were out of date, one was due in 2012 and one in 2014.
- We found two out of date fire extinguishers in the x-ray room within the emergency department.
- Instruments used for patient treatment and requiring decontamination and sterilisation were processed through the on-site sterile supplies department.
- Single use items of equipment were readily available and stored appropriately in most areas. There were empty boxes of some items and out of date 2.5ml syringes in the William Rous area.
- Maintenance contracts with external providers had been arranged for larger items of technical equipment, such as orthodontic examination chairs and ophthalmic examination tables/mounts.
- The Gamma camera in Nuclear Medicine was 14 years old and had failed, including an occasion when a patient had already received their radioactive injection. This presented a number of risk factors, including the patient having to be exposed to a second dose of radiation for rearranged scan. The equipment was on the risk register along with an action plan for resolution of this.
- The online equipment inventory for audiology and ENT was very detailed with maintenance information and recommended dates for replacement identified.

Medicines

- Medicines were topped up each week in the REU and staff working there told us they were supported by a pharmacy technician and two pharmacists. The chief pharmacist regularly met with the matron as many of the medicines used in ophthalmic services had a high cost attached, which required monitoring.

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- Within the REU we found there were storage arrangements for eye drops; however, one cupboard was unlocked and eye drops were easily accessible. Fridge temperature checks had not always been carried out. Temperature checks on the medicine fridge in the red area of the general outpatient department had only started on the day of our visit.
 - In the urology department medicines were stored in a locked cupboard secured to an internal wall. However, this cupboard was easily accessible, as it was not in a locked room. Nursing staff in the urology department told us they requested a top-up of medicines as required.
 - Medicines, which included steroids and local anaesthetics used within the orthopaedic department were secured within a locked cupboard in a treatment room.
 - Controlled drugs used in the orthodontic clinic were observed to be stored and managed safely, with respective records completed and retained. Staff told us the everyday medicines were topped up weekly by pharmacy.
 - We found two medicine items in x-ray cubicles, which should have been stored in a lockable cupboard. Staff addressed this immediately.
 - In-house medicine prescribing forms were easily accessible, on the desk of an unsecured consultation room within the blue area of general outpatients.
 - We found recommendations made by the Anti-Terrorism Squad had not been addressed for the safe monitoring of radionuclide medicine delivery. The close circuit television covering the entrance / exit area used for delivery of this product was broken and had not been fixed. We alerted estates to this as a matter of urgency.
 - Staff checked and signed in the delivery of Radioactive Isotopes. Monitoring of this took place every three years by the environment agency. We saw disposal records for the radioactive material.
- Records**
- Electronic patient records were not in use in the majority of outpatient areas. We were told by a member of staff this was because the electronic record system was not set up to enable the required level of detail. However, we were subsequently told paper records were being used until the electronic system was rolled out to the department.
 - It was recognised by staff that patient records were not always available, particularly when patients attended a number of different departments. A recent audit showed 2% of patients were seen in outpatients without their full medical record available. Staff in all outpatient areas we visited reported they did not always have each patient's hospital records in advance. Where notes had not been provided a temporary 'orange' set of notes were made up for staff to use. These contained where possible printed off copies of test results.
 - There was a variation in the provision of notes in advance of clinics across the different outpatient clinics. For example, staff in the REU told us with the exception of patients having surgery; they did not get the notes the day before the clinics. Notes for the morning's patients were delivered first thing and the afternoon clinic notes came at lunchtime. This did not give staff time to review notes to check if all information was available.
 - Where patient notes were not provided in the original format staff told us they escalated this through the completion of an incident form. The matron of the REU met with the medical records department weekly to discuss such incidents. However, incidents relating to medical notes not in original format were not recorded on the risk register, even though they were recorded into the electronic incident system.
 - We visited the medical records department during the unannounced inspection. We were told notes were electronically tagged and barcoded to allow the notes to be traced whenever they were at the hospital. Before any notes left the department, the notes was scanned and the destination was noted on the system. The medical records staff demonstrated to us how the notes were tracked using the barcode on the computer system. The staff in medical records prepared the notes and took them out to various clinics at least 24hours before the scheduled clinic. We saw completed sets of medical notes ready for clinic for the following day neatly arranged on shelf.

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Safeguarding

- Training data provided to us prior to inspection showed 100% compliance with safeguarding training in all OPD areas. The matron had a tracking system which tracked clinical and alerted staff of their mandatory training dates. All clinicians working in the sexual health department had been trained up to level three safeguarding standards.
- The Director of Nursing and Patient Experience was the executive lead for safeguarding children and adults, with the Deputy Director of Nursing supporting them with respect to adults. A safeguarding specialist nurse was also part of the team. There was a named doctor for child safeguarding and one other child safeguarding lead.
- Nursing and other clinical staff who spoke with us had a good understanding around the vulnerability of children and adults and were able to explain what indicators they would be concerned about. The reporting route was understood and staff were aware of the availability and access to the safeguarding leads.
- Staff told us they did see children in the outpatient department who were referred with possible non-accidental injuries. Vulnerable children and adults were identified in advance to staff. Members of the sexual health multidisciplinary team discussed sexual exploitation and female genital mutilation cases routinely at their monthly team meetings.

Mandatory training

- Staff told us they completed training in a range of mandatory subjects, including fire safety awareness, safeguarding (both adult and children), basic life support, infection prevention and control, information governance, mental capacity act (MCA), deprivation of liberty safeguards and equality, diversity & human rights. Most of the courses were completed every three years.
- Corporate induction training was provided for all staff and was compulsory for all staff to attend. There was also a service specific induction; this was specific to the department where staff worked and their role. We saw records held within the outpatients and diagnostic imaging department, which showed the induction

records for new staff were comprehensive and up-to-date. All of the staff we spoke with confirmed they had received their mandatory training in line with the trust's policy.

- The computerised log showed 100% compliance with mandatory training in the diabetic outpatients, breast clinic, maxillo-facial clinic, eye clinic and in the general OPD areas.
- We saw examples of staff training records showing completed training. We also saw examples of the monitoring, which showed staff had undertaken all mandatory training, such as health and safety, infection prevention and control, moving and handling, safeguarding and basic life support.
- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if requested.

Assessing and responding to patient risk

- There were clear procedures in place for the care of patients who became unwell or patients who deteriorated whilst waiting at the clinic. Staff we spoke with told us about emergency procedures and the escalation process for unwell and deteriorating patients. However, they stated these had not been used often as the department did not often have acutely unwell patients.
- The hospital had systems and processes in place for responding to patient risk. Staff were noted to be available in all the waiting areas of the clinics so that they would detect patients who appeared unwell and needed assistance. Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for people living with dementia or learning disability, and elderly or frail patients with more than one medical condition.
- Rapid access and walk-in services were available across medical and surgical OPD specialities. These included a clinic for patients who had suffered an eye problem and another for those with a suspected heart attack. These patients were offered rapid assessment and treatment, with all necessary investigations performed on the same day as the clinic.
- Emergency equipment was available in all areas.

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- Emergency assistance call bells were noted in all patient areas including consultation rooms, treatment rooms and the x-ray suite. Staff we spoke with told us when the call bells were used they were answered immediately. Staff we spoke with were aware of their role in a medical emergency.
- In the diagnostic imaging department, staff we spoke with knew who their radiation protection advisor and radiation protection supervisor was. Staff explained how they would report any concerns about safety to their line manager. We saw local rules and copies of the Ionising Radiation (Medical Exposure) Regulations 2000 in place.

Nursing staffing

- We were told there were 107.42 planned WTE staff in outpatients including nursing staff, with actual staffing of 87.97 WTE and a vacancy figure of 19.45 WTE.
- The outpatient clinics were staffed by registered nurses and health care assistants. Each clinic was run by registered nurses and was supported by health care assistants.
- The outpatients and diagnostic imaging department used a staffing contingency plan to assess daily whether they had sufficient numbers of nursing staff in the department. The plan included a staff escalation protocol that instructed staff on procedures to follow when staffing levels fell below the level required to run the department safely.
- Staff told us use of agency staff in outpatient clinics was very occasional. The trust reported an average rate of 2% usage of agency staff for all OPD areas between July 2014 – June 2015. Overall, there were a sufficient number of staff in post to run all of the scheduled clinics in the hospital and community sites clinics when required.
- Nursing staff turnover was reported as being at 36% between April 2014 and March 2015. Data demonstrated that nursing staff vacancy was at 18.34% and a sickness rate of 2.37%.
- Nurse staffing in the orthopaedic outpatient was made up of seven nurses, some of whom were part time, and two plaster technicians.
- There were eight whole time equivalent (WTE) nurses working in the Maxillofacial/ENT & orthodontic

outpatient department. This included a matron (band 7), a band 6 sister, one band 5 nurse and six band 4 working full time. In addition, there were five part time band 5, a band 4 part time and one hygienist.

- There were 19 nursing staff supporting the delivery of services in the REU. In addition to matron, there were four band 6 and six band 5 nurses, four technicians, two of whom were band 4 and two band 3 staff. There were four band 2 health care assistants. There were no children's trained nurses working in the department.
- A separate team of nursing and operating department practitioners worked in the outpatient theatre in the REU. All of the staff that we spoke with felt that there were enough staff of a suitable skill mix to manage the workload. Within the REU, there were 25 WTE nursing staff with no current vacancies.
- The matron for REU told us, the use of Band 2's, Band 3's and Band 4's roles provided a mixture of clinical and administrative support which had helped the department with their staffing needs. She told us staff employed in this role could move between different areas of the department and respond to urgent needs of the department.
- Patients who required recovery following sedation or a general anaesthetic in the orthodontic clinic were cared for on a one to one basis. Two operating department practitioners supported these clinics.

Radiology staffing

- The main outpatient radiology, CT and ultrasound department had 30 radiographers in total.
- There were 18 radiologists, of whom not all worked full time hours. Seven radiologists worked part time in the breast screening.
- Nursing staff turnover within the imaging department was reported as being at 3.6% between April 2014 and March 2015.
- The overall nursing vacancy rate for the imaging department was reported as being at 3.6% and sickness rate was at 0.2%. between April 2014- March 2015.

Medical staffing

- We observed there was a sufficient number of doctors to run all scheduled outpatient clinics. The average vacancy rate for the hospital was 15.27% and there was

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a sickness rate of 0.2%. Consultants and registrars provided cover for each other at times of annual leave or sickness whenever possible. All medical staff we spoke with confirmed cancellation of a clinic was a last resort.

- Medical staffing was provided by the relevant specialty running the clinics in the outpatient department. Medical staff were of mixed grades, ranging from consultants to junior doctors. There was always a consultant to oversee the clinics, and junior doctors felt supported by the consultants.
- Trust policy stated medical staff must give six weeks' notice of any leave in order that clinics could be adjusted in a timely manner. The outpatient department had not audited compliance with this policy; however, we were told where the policy was not met, staff escalated this to divisional leads to be investigated.
- Senior nursing staff told us there were no medical doctors directly employed for the outpatients department to manage and run clinics. Medical staffing was provided by the specialities. For example in trauma and orthopaedic department, there were 11 doctors, which included consultants and registrars who covered outpatient appointments.

Major incident awareness and training

- Major incident files and action cards were seen in outpatient areas. Training had been provided to staff and most staff who spoke with us about this were aware of the procedures to follow.
- The trust had a business continuity management plan which had been approved by the management team. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The hospital major incident plan covered major incidents such as winter pressures, fire safety, loss of electricity, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, and loss of water supply.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

- Care and treatment was provided in line with appropriate professional guidance.
 - Regular and meaningful clinical audits were carried out.
 - Care was delivered by a range of skilled staff who participated in annual appraisals and had access to further training as required.
 - A multidisciplinary team approach was in effect across services provided within the outpatients and diagnostic imaging department.
 - There was shared responsibility for care and treatment delivery.
 - Patients were provided with sufficient information about their treatments and had the opportunity to discuss any concerns they might have about their care and treatment.
 - Radiology services were available 24 hours a day, seven days a week.
- However;
- The outpatients department did not operate seven-day services as routine but some evening and weekend clinics were available to meet rising demand.

Evidence-based care and treatment

- World Health Organization (WHO) guidelines formed the basis of trust policies, for example in surgery, with regard to safety checks. Staff in interventional radiography and the ophthalmology theatre used appropriate treatment checklists based on WHO. The most recent audit in interventional radiography showed a considerable improvement from the previous audit with a much higher level of documentation of safety checks via the WHO checklist.
- Royal Eye Unit protocols were based on Royal College of Ophthalmologists (RCO) and British & Irish ophthalmic guidelines, for example, exclusion guidelines. Staff met every month to discuss case studies, topics of interest and guidelines in line with best practice.

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- Staff we spoke with explained the evidence-based systems, such as the standard operating procedures in place to ensure procedures were undertaken in line with best practice.
- The trust had a radiation protection supervisor to lead on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) Regulations. Staff were able to identify this individual.

Pain relief

- There was a dedicated pain clinic, which took referrals from GPs, consultants and other departments within the hospital, particularly rheumatology. This service was well used, with a range of medical, physiotherapy and psychological input. A satellite clinic in Raynes Park was also available.
- UK Pain Society guidelines were used to form the basis of treatment and local guidelines for management of acute and chronic pain were drawn up by a specialist nurse and consultant. Trust policies and guidelines were available on the hospital intranet. Clinicians met weekly to discuss best practice and evidence-based approaches to pain management.

Equipment

- The staff in the pain and phlebotomy clinics reported a patient label printer had not been replaced when broken, meaning that there was no efficient way in which to label specimens or records.

Patient outcomes

- Kingston Hospital was one of the first trusts in the UK to have received Improving Quality in Physiological Services (IQIPS) accreditation for its audiology services. Accreditation is awarded to services following an assessment against 26 standards, which look at areas such as patient experience and clinical care. The accreditation process involves a four-year cycle with annual surveillance by a two-day visit.
- The radiology department were not currently accredited by The Royal College of Radiographer's Imaging Services Accreditation Scheme. Senior staff within the department identified this as a key goal for the coming year.
- Audits were routine and meaningful across outpatient departments. We saw examples of on-going audits in

the diabetic clinic, the audiology department, the radiology department, the Wolverton Centre and the Royal Eye Unit. The trust provided an audit programme for 2015/16, which also included the rheumatoid, plastic surgery, neurology and dermatology departments. Information held by the Audit Centre as at October 2015 showed these audits were in progress. There was a dedicated team to help clinicians to interpret and share results from these, often causing changes in existing practice. For example, The Wolverton Centre had identified a gap in service provision for those using drugs in a sexual context and developed patient information leaflets and promoted staff knowledge around this topic. We saw examples of two meetings set up to discuss such audits during the course of our visit.

- The follow up to new rate remained below the England average for the period July 2014 to June 2015 at 2.36, placing the trust in the middle quartile.

Competent staff

- Outpatient staff were clear about their roles and the work they completed. The skill mix for individual clinics was reviewed and adjusted to meet the needs of patients attending the individual clinics. In particular, the radiography department had focused on skill mix of staff within their department, offering in-house ultrasound training to one radiographer each year to help improve retention of sonographers. Three staff in the department were currently training in chest x-ray reporting to fill a gap in service provision.
- Most clinical, administrative, and clerical staff in outpatients and diagnostic imaging told us they had appraisals with their line managers. In these annual appraisals, personalised performance goals in line with trust values were set for the year and these linked to their HR scorecards. For example, a member of staff told us they wanted to be a clinical tutor and this was a goal in their appraisal for the coming year.
- Within the outpatient department, managers had also initiated one-to-one discussions with junior staff about their development.
- All staff we spoke with were positive about the training and development opportunities given to them and the

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quality of this training. We spoke to a number of staff offered development opportunities to progress within the department in which they worked, for example, two porters who had become radiography assistants.

- All new staff completed an induction programme to prepare them for their role. A range of education and learning sessions were available to assist all staff develop and maintain their skills.

Multidisciplinary working

- Staff across the trust worked together in a multidisciplinary approach. There was consistent evidence of collaboration across different services within outpatients and diagnostic imaging.
- Some senior staff in radiology reported their department sometimes suffered increased pressure and budgetary constraints because of the impact of other departmental working throughout the hospital. They told us annual networking events had now been set up to hopefully enable senior staff to better understand the pressures and growth across departments and alleviate many of these issues.
- Multidisciplinary team (MDT) working was evident throughout the department. The majority of meetings such as governance meetings and risk groups involved a range of allied health professionals, nurses and managers. Other MDT meetings happened regularly, with some departments meeting weekly and others monthly. Staff we spoke to felt able to challenge the views of consultants or other clinicians, with one member of staff in the Royal Eye Unit commenting that there was 'no hierarchy' within their department.
- Consultants dictated GP letters, which were then typed in India, before they were sent back to administrative staff and the consultant in question to check and sign. Patients and their GPs each received a copy. Consultants we spoke with reported this system worked well, with approximately 85% sent out within ten days. One consultant reported there could sometimes be delays if he was on leave but otherwise, this process 'happened within days'. Five patients in the William Rous unit reported good contact between the hospital and their GP and confirmed they received copies of the

clinic letters to their homes. However, one patient in the Royal Eye Unit reported that his GP was not updated by the consultant and he had to give him his last clinic letter himself.

- The trust works within the South West London partnership and much of the pathology testing had moved across to St George's hospital. Staff reported there was constant communication regarding urgent issues or results. However, two members of staff from different departments flagged up issues where pathology results were lost as external services did not share the same computer system as the Kingston outpatients department. One member of staff did comment that staff now held monthly meetings to address these issues. This matter was now on the risk register after escalation to the pathology director.

Seven-day services

- Most clinics in the main outpatient department, as well as the William Rous Unit, did not routinely provide a seven day a week service. However, in order to deal with appointment backlogs some outpatient services were running clinics in the evenings and some clinics were available Saturdays between 9am and 5pm. These clinics were usually dependent on staff completing extra overtime hours and so this limited access to out-of-hours clinics.
- Community dentists had a rota for out-of-hours emergency clinics at weekends from 9.30am to 12.30pm and on two evenings during the week. However, staff told us that the evening clinics would stop in April because 'they are not cost effective'.
- The radiology department had systems in place to ensure 24/7 access to diagnostic imaging, through a mix of overtime working, on-call radiographers and outsourcing to external partners. However, there were no dedicated porters for the radiology department employed out-of-hours, causing considerable delays and increased waiting times for scans. An audit performed in the A&E department confirmed that lack of porters caused the most delays in obtaining radiology results.

Access to information

- All staff we spoke with said they had access to policies, procedures, NICE and specialist guidance through the hospital's intranet. Overall, staff were positive about the

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trust's intranet and reported managers communicated effectively with them via e-mail. However, not all staff had access to computers – for example, in the phlebotomy department.

- The temporary staff induction checklist included access to the computer system.
- Some areas such as the diabetic clinic also held these policies and procedures as a hard copy. These were dated and marked with expiry dates. In the radiology department, key safety protocols such as 'Pathways for Prevention of Contrast Induced Neuropathy' were displayed in all relevant clinical areas, as well as the name of the Radiation Protection Supervisor.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Within the outpatient area, we observed and staff confirmed they had access to a policy for consent, examination or treatment. We were told in most cases verbal consent was obtained; however, consent was formally obtained and signed for when a patient was to have an invasive procedure. This would include for example, a cystoscopy, eye surgery or injection.
- Consent audits across the outpatient department ensured the process for recording consent from patients undergoing procedures was undertaken in accordance with the trust's 'Policy for Consent to Examination or Treatment'. We saw an updated copy of this policy, reviewed in November 2015. All cases reviewed in the ophthalmology department had a consent form in the notes; however, in two cases the risks and benefits were not documented on the consent form. In radiology, the audit found 76% of consent forms were scanned into the computerised record system, and the other 24% had documented evidence of written consent having been obtained.
- The superintendent radiographer provided a telephone consultation to all patients coming in the department before their appointment to check they were aware of the procedure and what to expect
- When patients thought to lack capacity to consent to treatment, staff held best interests meetings. We saw evidence of this in the ophthalmology department, where meetings took place every two months in a specially blocked out clinic slot.

- In the Albany unit, staff showed us different consent forms used for people with learning difficulties and reported Mental Capacity Act training was included as part of their dementia awareness training.

Are outpatient and diagnostic imaging services caring?

Good



We rated the outpatient and diagnostic services at Kingston Hospital as good for providing a caring service. This was because:

- People were treated with kindness, dignity, respect and compassion whilst they received care and treatment.
- People who used the services and those close to them were involved as partners in their care and received the support they required to cope emotionally with their care, treatment or condition.
- Consulting and clinical treatment room doors were kept closed, and staff knocked before entering clinic rooms to maintain patients' privacy.
- Patients and relatives commented positively about the care provided to them by the staff from all the clinics visited.

Compassionate care

- We observed staff communicating and supporting patients in a kind and compassionate manner in the Royal eye Unit (REU). Nursing staff and doctors working in the William Rous outpatients were observed to interact positively with one another and patients. We heard staff apologising for delays and presenting in a friendly manner, greeting and introducing themselves.
- Staff were described very positively by patients and relatives who spoke with us in the various outpatient departments. For example, in the urology clinic we were told by a patient it was a "fantastic service" and that they had always been treated with dignity and respect. Where individuals also attended other outpatient clinics they commented on these too. The Glaucoma clinic and Endoscopy clinic were commented on very positively, with staff described in the latter case as "very good" and "lovely." Staff working in the orthopaedic clinics were described by one patient as very respectful and

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courteous. A relative accompanying a patient to the orthopaedic clinic said they always had a good experience and staff had looked after their mother “very well.”

- A relative who had used the cardiac outpatient service told us the staff were “wonderful” and very good, providing an efficient service. This same person told us the children’s Epilepsy outpatient service was “excellent.”
- A patient who was a frequent attendee at the REU told us the “whole thing is extremely good” and they had no complaints whatsoever. This person told us staff were very respectful and treated them with dignity, adding, “If I was paying, I couldn’t get better.” A relative accompanying a patient who had been attending the outpatient department for some years told us the staff were “very helpful, kind and patient.”
- Friend and Family information for December 2015 displayed in the orthopaedic outpatient area showed 93% of respondents would recommend the service. Responses arising from the Friends and Family Test (FFT) were emailed to staff and reviewed by the patient experience group.

Understanding and involvement of patients and those close to them

- Patients and relatives who spoke with us in the outpatient clinics reported feeling involved and understanding what they were attending the departments for, the types of investigations they were having and the expected frequency of attendance. One patient commented on the consultant, describing them as “very good” and noted how they put them at ease.
- A parent of a child attending a clinic told us the staff were very helpful and they felt able to ask questions. They commented on how staff had explained everything to them and how good staff were at getting their child to co-operate.
- A patient attending the orthopaedic clinic told us they had been given “plenty of information” about what was happening. Other patients told us they had clear information within their appointment letters and staff were very informative.

Emotional support

- The doctors working in the outpatient clinics were described as “approachable” by one patient, who went on to say they could ask questions. Another patient told us they were happy attending the outpatient service, where everything was explained and information such as side effects of medicine were made clear.
- The chaplaincy team told us that they made occasional visits to the outpatient areas and would always attend, if requested, in order to offer spiritual support.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

We rated the outpatients and diagnostic imaging services at Kingston Hospital as requiring improvement for not being responsive to patient needs. This was because:

- There was inconsistency in how well patients were kept informed of waiting times in some clinics. Some patients were experiencing long delays of up to an hour or more.
- People’s privacy was not always achieved in outpatient and diagnostic areas.
- There were no designated outpatient areas designed specifically to meet the needs of individuals living with dementia.

However;

- Cancer targets had improved during 2015 and most had been met for quarters one to three, 2015/16.
- Referral to treatment times were better than the England average. The percentage of patients who completed the referral to treatment pathway within 18 weeks was consistently better than the England average and the trust standard of 95% for 2015/16.
- The new to follow up outpatient rates of 29 to 38 against the national figure of 25 to 55, were significantly better than the national average between July 2014 and June 2015.

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- Waiting times for echocardiograms and portable monitoring for cardiac patient were three to four weeks at the time of our visit, which was good when compared to other similar services .
- Services had been planned and were being delivered to meet the needs of most people.
- People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.

Service planning and delivery to meet the needs of local people

- A full range of outpatient services were available to meet the needs of the local population, including specialist clinics. These included for example, breast clinics, cardiac, colorectal, colposcopy, Urogynaecology, urology, ophthalmic, orthopaedic, sexual health, oral and ear, nose and throat (ENT).
- Outpatient clinics were supported by diagnostic services including Magnetic Resonance Imaging (MRI) scans, x-ray, Computerised Tomography (CT) scans and ultrasound scans. Interventional radiography included cardiac procedures and there was outpatient endoscopy. Outpatient surgery included ophthalmics, oral, ENT and orthodontics.
- Evening and weekend outpatient clinics were not commonly happening. The senior outpatient team told us lack of outpatient nurse availability limited options for additional service activity.
- There were dedicated clinics for patients with learning disabilities in the audiology and ENT OPD.
- The community sites (Outreach) clinics provided range of services closer to more remote areas for patients. They had nine community site locations, which provided different services, such as one-stop echocardiograms at Surbiton and radiology at Raynes Park.

Access and flow

- GP's referred the majority of new patients attending the outpatient departments, although patients reported on variation in promptness of this and other difficulties. For example one patient had been seen by three GPs before they were referred. It should be noted the trust has no control on the referral pattern of GPs.

- Follow up appointments were arranged according to the request of consultants. Patients attending the pain clinic were sometimes referred from the physiotherapists and there were consultant-to-consultant referrals, such as from rheumatology to pain clinics.
- We were told by staff the system for making appointments from GP referral was not linked to the choose and book process, which was run in an entirely different way. Duplicate appointments sometimes occurred when a GP referred directly as well as using the choose and book system.
- Additional information provided to us by the trust was that some GP referrals were made outside of the e-referral system, particularly for cancer referrals where the appointment needed to be booked at short notice. In this case, a referral was faxed or mailed by the GP and then manually booked by the staff. When duplicates were identified they were corrected as part of the cancer and 18 week tracking processes.
- There was no consistent approach across all the OPD clinics to providing telephone or text reminders to people in advance of appointments.
- Opening hours for outpatient clinics varied. For example the urology clinic was open Monday to Friday for appointments 9am to 5pm. Specific clinics were held on different days and at variable times. The paediatric urology clinic was held once weekly, urogynaecology twice and there was also a one stop haematuria clinic, where patients had their investigations and results on the same day. A vascular clinic also took place in the urology outpatient department once a week for follow up of patients post-surgery.
- Orthopaedic clinics were held between the hours of 8.30am and 4.50pm. General outpatient clinics took place between the hours of 8am and 5.30pm. One stop breast clinics took place on Mondays, Tuesdays, Wednesday and Friday mornings.
- The highest number of outpatients seen in the period July 2014 to June 2015 was in ophthalmology, with 38,467 appointments.
- Ophthalmology, trauma and orthopaedics, obstetrics and physiotherapy were the top five outpatient service areas, with 39% of all outpatients seen in one or other of these.

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- The senior outpatient managers told us the introduction of patient pathway co-ordinators had improved the appointments system.
- Waiting times for echocardiograms and portable monitoring for cardiac patient were three to four weeks at the time of our visit. This was better than the six week target.
- The percentage of patients who completed the referral to treatment pathway within 18 weeks was consistently better than both the England average and the standard of 95% from September 2014 to December 2015. Over the same time period, the percentage of patients on incomplete referral pathways who had been waiting to start treatment for less than 18 weeks was also better than the England average and the standard of 92%. Trust performance was close to or above the national average for treatment of all cancers within two weeks of urgent GP referral during 2014-15, and consistently slightly better than the England average between April and December 2015. The trust recorded a slightly lower numbers of cancer patients who received their first definitive treatment within 31 days of diagnosis than the England average during 2014-15, but was close to the England average during the first three quarters of 2015-16. More patients were treated within 62 days of urgent GP referral than the England average during Q2 of 2013-14 to Q3 of 2015-16, with the exception of Q1 of 2014-15 when fewer patients were treated within 62 days than the England average.
- Patients reported variations in having an appointment arranged. One patient attending their first appointment told us they had been waiting since August 2015 to be seen. When they had contacted the department on advice of their GP, staff told them they had not been heard of. This patient told us getting through the door was an issue but once in the hospital, the staff were “excellent.” Another patient told us they had waited three months for their initial appointment, which they said added to their anxiety. Other patients told us they had received their initial appointment very quickly. One patient said it had taken a month to get an appointment and they had not been given a choice, with no option to bring forward. They told us they were scared to lose the appointment if they tried to change it and didn’t attend the one arranged.
- Patients who spoke with us in the William Rous department reported waiting between 15 minutes or “not too long”, once they arrived for their appointment.
- Waiting times for patients once they have arrived in the department were not displayed when we visited the Royal Eye Unit (REU), although a staff member told us they could be displayed on a television. Patients who spoke with us in the REU told us they expected to have a wait once they arrived, but staff did not always keep them informed of delays. Similarly, not all of the patients in the orthopaedic clinic waiting area had been told of expected delays. We did observe notices on doors of the fracture clinic stating there was a 30 minute delay.
- Patients attending the fracture clinic told us they received generic appointment letters, which did not indicate who they were seeing. As a result they were not always made aware of any delays.
- Waiting times in the CT department varied, with patients telling us they were sometimes seen quickly and at other times reporting long delays. On the day of our inspection, two patients told us they had been waiting beyond the time indicated initially but they had been updated.
- A patient who had attended the phlebotomy outpatient clinic previously reported it to be a “free for all”, adding that despite a raffle ticket approach, it was busy and people waited some time.
- The Hospital Episode Statistics (HES) data from July 2014 – June 2015 showed that 6% of patients did not attend their appointments, which was slightly better than the England average of 7%. We were told by trust managers that the hospital's 'did not attend' (DNA) rate was continuously monitored to enable changes and adaptations to be made to minimise waste of resources.
- Did not attend (DNA) appointments varied across the outpatient departments and reception staff told us they were happening less since a text message system had been introduced. During our visit three patients out of 12 DNA their urology appointment. Staff told us they phoned DNA patients and offered another appointment. Where they failed to attend a second appointment, their GP was informed by letter.

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- Staff had a system for managing DNA patients who were booked to have ophthalmic surgery as an outpatient. All patients arrived first thing in the morning. Where there was a DNA, staff were then able to contact someone else on the waiting list and bring them in sooner.
- Service line managers approved cancellation of clinics. If it was at least six weeks in advance of the planned appointment, the booking officers were informed and they sent a letter to patients. Patients were telephoned if a clinic was cancelled less than six weeks before the original appointment.
- Overbooking of clinics was only allowed if requested by the clinician or where the patient was about to breach the referral to treatment target.
- Hospital Episode Statistics for July 2014 – June 2015 showed that 591,220 outpatient appointments were made. We noted that 67% of patients attended either their first or follow up appointments. The data showed the hospital's ratio of follow-up to new appointments was better than the England average. The new to follow up rates of 29 to 38 against the national figure of 25 to 55.
- Out of the total appointments made, 13% had been cancelled by patients and 13% by the hospital. The hospital cancelled appointment of 13% was higher than the England average at 7%.

Meeting people's individual needs

- Specialist clinics were available for a range of conditions, such as respiratory matters, diabetes, pain management, voice therapy, colposcopy and one stop breast care clinic.
- Hearing loops were available in waiting areas.
- We observed the outpatient areas to be accessible to all, although space was limited in some areas. Patients waiting on the corridor outside the orthopaedic clinic had little space to enable them to position their lower limbs when in a plaster cast. A patient who spoke with us told us it had been difficult and uncomfortable when they had a cast on and had to sit in this area.
- Building work was taking place to upgrade the outpatient facilities in order to meet the needs of people using the service. During our visit we observed extreme levels of noise from building activities, which impacted on the fracture clinic rooms particularly. Noise levels made it difficult for medical staff to be heard when holding discussion with their patients.
- It was not possible to provide people with privacy and ensure their dignity was fully respected in the main waiting area for CT. Inpatients were coming to the department on beds, which were placed in the middle of the area where outpatients were seated. Staff told us no action to address the matter had been taken, despite it being on the risk register. There was no action plan on the risk register to address these concerns. There was lack of privacy for patients attending phlebotomy services, and the area was very cramped.
- Clinical nurse specialists, such as breast care nurses and diabetes nurses, were readily available in respective clinics.
- Information was displayed in the various waiting areas about any support services available for patients. This included helpline numbers and support networks for specific illnesses.
- The William Rous Unit was bright and spacious, with plenty of seating and access to drinks and patient information leaflets. However, leaflets did not appear to be available in other languages and there was no signposting to indicate this. The exception to this was information leaflets in English and French were seen to be available in the audiology and ENT department.
- Privacy during consultation and procedural treatment was achieved in the urology outpatient, as there were two clinical examination rooms and a separate treatment room.
- Children attending the urology department were seen on a day when no adult clinics were taking place. They waited in the internal waiting area and had access to toys. The children's waiting area in the main outpatient was taken over by building work and as a result there was no designated area for children to wait.
- A father of a child attending an outpatient clinic described the service as "efficient" and told us the appointment had been made for a convenient time. They commented on having access to drinks in the waiting area and toys being available for their child.

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Other comments made by relative accompanying patients included; the staff are “incredibly capable at handling so many different clinics and it was “very reassuring to see a well-run service.”

- The recovery area in orthodontics did not have an area suitably decorated or presented for children’s use. A room used by children attending orthoptist appointments had been decorated with child friendly pictures.
- Despite there being a chaperone policy, one patient who spoke with us before having a scan told us they were worried as they had asked for a chaperone on a previous visit but were told there was no chaperone available. After their scan on this occasion they told us they were very happy, as all the staff were female. There was information available for patients who required a chaperone on display. Nurses and healthcare assistants acted as chaperones when needed.
- Mobility and manual handling assessments were carried out by nursing staff in the urology department and where a hoist was required they told us this could be arranged.
- Translation services were available face to face and via a triple phone link system. In addition there was a broad range of languages spoken by a number of outpatient staff. Staff told us they generally booked interpreters in advance, but also encouraged patients to bring someone with them who could interpret for them. It should be noted that the use of family members as interpreters is not considered to be best practice.
- There had not been any particular focus on outpatient areas taking into account individuals living with dementia needs.
- Adults and children with learning disabilities who attended outpatient clinic were treated as individuals, taking into account any specific needs. For example, staff told us they would involve carers, family and appropriate interpreters as required. Where individuals had a personal passport, they would use this to ensure their approach minimised stress and anxiety.

- Nursing staff told us they were sometimes aware in advance when a patient with learning disabilities or dementia needs was attending. In both cases such patients usually attended with a carer or family member, who they would involve as much as possible.
- There was a good sexual health outreach service and provision of service alerts for vulnerable patients. New material was developed where service gaps were identified, for example, information on ‘chemsex’.
- Patients who spoke with us commented in the main positively on the responsiveness of clinical staff and receptionists. We were told the reception staff were excellent, always pleasant and helpful, providing explanations where able. One patient told us they could not praise enough the doctors and nurses, stating they did a “great job.”
- We noted the volunteers worked very proactively within the hospital, they were helpful and respectful towards patients. We spoke with patients who commented positively on the help and support that was provided by the volunteers, commenting that they were always ready and willing to assist patients and visitors to the hospital.

Learning from complaints and concerns

- Information was displayed in outpatient areas informing people how they could complain or provide feedback on the service. One patient told us they would speak to reception initially if they had a complaint.
- The top concerns raised by people in December 2015 related to the ‘oral’ OPD (two complaints about care and treatment and one each for appointments, information governance and communication), radiology appointments (four complaints), and dermatology appointments (two complaints). The final area was the urology office (two complaints about appointments and one about communication).
- Staff working in the sexual health department told us complaints were resolved where possible at local level.

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Are outpatient and diagnostic imaging services well-led?

Good 

We rated the outpatient and diagnostic services at Kingston Hospital as good for being well-led. This was because:

- There was a clear vision and focused strategy to deliver good quality in each of the service lines.
- The governance framework ensured staff responsibilities were clear and that quality, performance and risks were all understood and managed.
- The leadership and culture reflected the vision and values, encouraged openness and transparency and promoted good quality care.
- People who used the service, the public and staff were engaged and involved.
- Services continuously sought to improve and to ensure sustainability.

However;

- There was a lack of awareness around the responsibilities for equipment safety checks, and lack of oversight with regard to storage of medicines.
- Local governance meetings at departmental level were not always happening in all areas of the outpatient services.
- Some risks had not been identified on the risk register.

Vision and strategy for this service

- The majority of staff we spoke with were clear of the values of the trust. They were committed to work towards achieving the broad vision and strategy. Staff showed a good understanding of the values and vision of the trust and felt able to raise concerns. There were long term strategies in place for each of the divisions. These took into account the trust's goals and clearly highlighted key priorities. This allowed assessment of long term risks related to finances and the quality of the service for each area, such as clinical outcomes and patients' experience.

- There were separate service line strategies, which included plans for restructuring waiting areas, addressing lack of capacity and flexible working. Staff were aware of the challenges they faced in their own service area such as an increased amount of referrals or environmental constraints.
- Staff told us there was little board visibility in the outpatients department and the executive team were not regularly engaging with staff directly. However, they were aware of the key performance indicators set for their clinics and how they performed in relation to them.

Governance, risk management and quality measurement

- Governance meetings were used as an opportunity to discuss audits, incidents and surveys, although the frequency of these at department level varied from monthly to quarterly, due to activity/time demands. Within the REU patient clinics were not arranged at an agreed time so that a multidisciplinary governance meeting could take place. However, whilst there had been two outpatient governance afternoons during the previous year and the staff wished to continue these bi-monthly, the meetings had been cancelled. This was because the service lines would not agree to the closure of the outpatient department to hold the meetings.
- There was a pro-active approach to incident reporting and staff were encouraged to report all incidents, regardless of harm or fault. The risk management team, including the health and safety officer, reviewed all reported risks on a regular basis and monitored the progress of action plans.
- The medical director chaired a weekly Serious Incident (SI) Group where all SI investigations were discussed, actions signed off and completion of actions were tracked. The Clinical Commissioning Group (CCG) quality lead attended the meeting and the reports were sent to the CCG once approved.
- Never Event investigations were chaired by a non-executive director and the actions taken were tracked by the Trust Board. The group also reviewed infection control audit results and reported to Public Health England (PHE) as and when required.
- Separate outpatient risk registers were provided to us and these all identified service related risks, which were rated by current risk status and target level of risk.

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Action plans and review dates were included. For example, the radiology risk register identified two major risks; one with respect of delayed treatment of patients due to long reporting times for plain film studies. The second related to delayed patient care as a result of the gamma counter camera breakdown leading to six-week diagnostic target breaches. The trust had submitted an action plan with key dates for managing these risks.

- We noted however, that risk registers did not include the issue of medicines storage or equipment safety checks, indicating a lack of oversight of these areas.

Leadership of service

- The leadership structure and arrangements varied within the OPD, with some units having service line accreditation whilst others did not. Those accredited had greater autonomy for managing resources, budgets and decision-making, which had a positive impact on the department, staff and service delivery. For example, the REU had chosen to replace a doctor's salary with three part time optometrists and were researching the recruitment of a nurse consultant. The sexual health department, which was accredited, had developed their website and electronic patient records by way of having budgetary control. Radiology staff told us service line accreditation was very good, and allowed them to deal with local issues, giving staff on the shop floor more of a chance to say what was happening.
- Whilst senior leaders were generally proactive, we found there was a lack of awareness around the responsibilities for equipment safety checks. There was a lack of oversight with regard to inappropriate storage of medicines.
- A number of clinical staff working in outpatients and radiography had worked at the hospital for many years. Nursing and radiology staff reported to us favourably on the leadership and managerial style of line managers, with their approachability and supportive attitude expressed to us. Other staff commented positively on team work and generally enthused about it being a nice place to work, despite the high level of activity.
- Morale was said to be good and staff told us they were well supported, despite the demands and challenges. Managers were said to be available to support staff and to provide advice where needed.

- Staff told us the executives were not particularly visible, although they received weekly communication from them via e-mail. The executive team were also described to us as having a genuine desire to help and improve things and putting in effort to do so. There was an awareness and acceptance they had challenges too.

Culture within the service

- A colleague within the ophthalmic service described it as a "fantastic team," whose members all felt privileged to work at the hospital. There was a family feel within the team and a good sense of feeling valued, although it was hard work.
- Radiology staff told us there was an open culture but it was sometimes difficult to deal with "vocal staff."
- Staff had been trained with regard to Duty of Candour. This was initially classroom-based training but this has since changed to online learning. We were told that patients were invited to meet with the management to discuss incidents and the management offered apology to patients. However, there was no monitoring or audit about these Duty of Candour requirements.
- The culture was one which recognised positive work and achievement. For example, a member of staff in the fracture clinic had been awarded 'star of the month' for creating a positive learning environment for student nurses.
- Staff told us they were treated fairly, with equal opportunities for training and development, career progression.

Public and staff engagement

- The majority of staff we spoke with in outpatient areas were happy and felt engaged at all levels. The exception to this was radiology staff. We were told by radiology staff there were no team meetings in x-ray, whilst others told us a meeting took place on a Wednesday. A small number of radiology staff told us senior staff (at executive level) did not look after staff. For example, the staff room in radiology had no hot water and despite promises to fix this, it had not been addressed in the previous three years. These radiology staff who spoke with us added that the focus was on targets, rather than patients. Despite this, the same staff told us there were monthly meetings with the CEO. Communication was said by one member of staff to be weak at times and in

Outpatients and diagnostic imaging

particular information needed to be shared with staff more effectively. Some staff in the radiology department told us no feedback or changes were made when they completed incident reports.

- Consultant medical staff who spoke with us in a pre-inspection focus group, and also during the visit, expressed problems with agreeing job plans. For example, sub-specialties had not been taken into account and there was a lack of time for certain activities, such as reporting plain film x-rays, training junior staff, and undertaking audit.
- The hospital invited feedback from a range of service user groups, carers and families in order that services could be improved and reconfigured to meet the needs of the population. The service hosted annual functions, which allowed staff to meet with each other in order to allow peer relationships to develop as well as to allow staff to seek feedback from each other. The sexual health team held monthly meetings to discuss issues that arose, and patient experience group members fed back issues, which contributed to change. For example, waiting times.
- Patient feedback was widely disseminated across each of the clinical settings and included initiatives including 'You said, we did' noticeboards, as an example.

Innovation, improvement and sustainability

- An annual visionary day was held in order to celebrate staff achievements. Three staff working in sexual health received an award, on the recommendation of patients.

- Patient pathway co-ordinator roles had been developed in order to make the experience better for patients, with one point of contact for the duration of their attendances. This had created an efficient and co-ordinated approach.
- Training of voluntary staff ensured they were able to support people. Volunteers added a great deal of value to the patient experience and as a talent pool for the future workforce, with many having gone on to work for the hospital.
- The superintendent radiographer had undertaken to contact each patient having interventional examination and angioplasty in order to check the patients understanding and to prepare them.
- There was a proactive approach to career progression, which included a change of role for some staff, such as portering to radiographer assistant. Rotation within the different diagnostic services helped to facilitate learning. Staff told us there was good internal promotion.
- Stonographers were paid at a higher band than usual in order to increase recruitment and retention.
- The proportion of head scans required at night was between 70%-80%, and in order to respond to this, junior radiographers were receiving training in this area first. Protocols were also under review in order to reflect those of the local hospital who formed part of the multidisciplinary review.
- Pathology services had moved forward and there were working arrangements with another local hospital. The partnership worked across southwest London and the Kingston hospital was a 'spoke' of the partnership.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of outstanding practice including:

- The Wolverton Centre, for providing comprehensive sexual health services; for provision of service alerts for vulnerable patients, including young people, and those with a learning disability.
- A comprehensive dementia strategy, which enabled staff to support people living with dementia. A dedicated dementia improvement lead provided visibility and support to staff, ensuring positive interventions were implemented. The carer's support pack, therapeutic activities and a memory café contributed to the enhancement of services.
- The trust's engagement with 'John's campaign', promoted the rights of people living with dementia to be supported by their carers in hospital. To facilitate this, there was open visiting and a free car park for respective carers and relatives. Family members and carers were offered beds to stay overnight if needed.
- The specialist palliative care (SPC) team stood out as highly skilled and effective. They supported staff to provide good quality, sensitive care to patients at the end of life and to the people close to them.
- Staff of all disciplines demonstrated an impressive understanding of their role in addressing the needs of people at the end of life and of providing sensitive and compassionate care.
- The paediatric diabetes team were a top performer in the National Paediatric Diabetes audit 2014 to 2015 due to HbA1C rates being better than the England average.
- The trust participated in the Sentinel Stroke National Audit Programme (SSNAP), and achieved an A rating for the period January 2015 to March 2015.
- The physiotherapists in the critical care unit had reduced the length of stay for their patients through the early implementation of rehabilitation.
- The engagement and involvement of volunteers was recognised as an invaluable team to support service delivery.
- Patient pathway co-ordinators in outpatients had impacted positively on the effectiveness of appointment arrangements.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that individuals who lack capacity are subjected to a mental capacity assessment and best interest decisions where they require restraint. Such information must be recorded in the patient record.
- Make improvements to ensure medicines are not accessible to unauthorised persons; are stored safely, and in accordance with recommended temperatures.
- Make improvements to the systems for monitoring of equipment maintenance and safety checks in order to assure a responsive service.
- Ensure that the Duty of Candour is adhered to by including a formal apology within correspondence to relevant persons and that such a record is retained.
- Ensure the management, governance and culture in ED, supports the delivery of high quality care.

- Improve the quality and accuracy of performance data in ED, and increase its use in identifying poor performance and areas for improvement.
- Ensure all identified risks are reflected on the ED risk register and timely action is taken to manage risks.

Action the hospital SHOULD take to improve

- Review patient outcome measures to consider how performance can be improved.
- Staff should have timely access to regular training with respect to the Mental Capacity act (2005) and Deprivation of Liberties Safeguarding.
- Review length of stay and ways of decreasing this in care of the elderly and cardiology services.
- Take steps to embed debriefings after operating lists across all surgery services, as part of the World Health Organization (WHO) Surgical Safety Checklist.

Outstanding practice and areas for improvement

- Ensure better compliance with hand hygiene and cleaning of clinical equipment in the emergency department.
- Review the skill mix and flexibility of staff within ED in order to respond to changes in activity levels and demand surges.
- Improve ED staffs understanding and compliance with the trust's incident reporting procedures, complaints handling and application of learning from these.
- Ensure there is accurate performance information in the ED.
- Seek ways of consistently improving patient flow through the ED.
- Ensure the systems for routine safety processes such as recording timely observations of patients, checking resuscitation equipment, and making sure medicines and cleaning chemicals were stored safely.
- Ensure adequate and safe facilities for patients with mental health needs.
- Ensure staff use computers securely in ED and do not share login cards
- Improve staff engagement in main operating theatres.
- Establish a robust system for ensuring required surgical instruments are readily available.
- Increase visibility and leadership engagement within theatres.
- Optimise pre-assessment procedures in order to limit cancellations on the day of scheduled surgery.
- Take steps to ensure all nursing staff understand how to communicate with vulnerable and elderly patients in an appropriate way.
- Improve responsiveness of nursing staff to patient call bells at weekends.
- Consider how the environment and facilities in the CCU could be improved.
- Review CCU records in order that capacity assessments can be documented.
- Explore the benefits of having a follow up services available for patients who have used CCU so they are able to reflect upon their stay and can address long term psychological concerns.
- Review maternity service bed capacity in order to address the increasing activity.
- Ensure midwifery staff have access to required equipment.
- Review staffing levels in maternity services in order to avoid delays of induction and elective caesarean sections.
- Ensure children have an appropriate waiting area in the fracture clinic.
- Review areas used by children and young people with a focus on age appropriate décor.
- Ensure staff working in children's and young people's services have access to up to date editions of the British National Formulary (BNF).
- Ensure registered nursing staff levels in children's and young people's services are in accordance with RCN and BAPM guidelines.
- Review the specialist palliative consultant and nursing presence at the hospital in order to maintain progress towards meeting the provision of excellent end of life care.
- Review the environment of the chapel and multi-faith facilities.
- Consider how the environment on medical wards and in outpatients can be developed to enhance the experiences of people living with dementia.
- Provide greater privacy for inpatients who attend the CT scanning unit.
- Reinforce best practice around the use of appropriate interpreters.
- Ensure information about chaperones is made easily available in all OPD clinics.
- Ensure waiting times and clinic delays are appropriately displayed and communicated to waiting patients.
- Have a consistent approach to sending reminders to patients about their appointments, to minimised non attendance.
- Ensure that patient examination couches are checked and maintained as appropriate in the general outpatient area.
- Address recommendations made by the Anti-Terrorism Squad for the safe monitoring of radionuclide medicine delivery.
- Ensure proper systems are in place to facilitate governance meetings in each outpatient service.
- Consider how daily cleaning schedules can be completed and quality checks and sign off of these are routinely undertaken.
- Arrangements around equipment storage should be reviewed so that shower rooms are not used.
- Utility rooms containing hazardous chemicals should be locked, with additional provision for secure storage of such products.

Outstanding practice and areas for improvement

- Fire safety precautions should be reinforced with staff to ensure fire doors are not propped open.
- The policy for medicines management is followed to support the use of patients own medicines.
- Review existing arrangements to ensure that suitable governance and assurances mechanisms are in place with regards to the trust's statutory duty to ensure that directors are fit and proper.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Systems and processes were not established or operated effectively to ensure the safety of service users. This was because; <ul style="list-style-type: none">• Equipment in use by patients had not always been serviced and safety checked.• Resuscitation trolleys were not always checked to ensure they were fit for use.• Medicines were not always stored safely and could be accessed by unauthorised individuals.• Temperature checks on storage units were not always carried out. Regulation 12 (2) (e) & (g)
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour A formal apology was not always included in all letters written to relevant persons during and following the safety incident review process. Regulation 20 (1) (2) (d) & (e)
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Individuals who lacked capacity were not always subject to a mental capacity assessment.

This section is primarily information for the provider

Requirement notices

Individuals were being restrained without evidence of mental capacity assessment or best interest decisions having been formally made and recorded.

Systems and processes were not sufficiently established around training of staff with regard to the Mental Capacity Act (2005) and Deprivation of Liberties Safeguarding.

Regulation 13 (1) (2), (4) (b), (5) & (7) (b)

Regulated activity

Nursing care

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided in ED because;

- The quality and accuracy of performance data and its use in identifying poor performance and areas for improvement was not adequate.
- The management, governance and culture in ED, did not support the delivery of high quality care.
- Risks in the ED service were not always identified, analysed and managed.

Regulation 17 (1) (2) (a) & (b)