Chelsea and Westminster Hospital NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Requires improvement

Summary of findings

End of life care	**Requires improvement** 
Outpatients and diagnostic imaging	**Requires improvement** 
HIV and sexual health services	**Outstanding** 

Summary of findings

Letter from the Chief Inspector of Hospitals

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

The Chelsea and Westminster Hospital is a 430-bed general hospital, based in Kensington, North West London. The hospital employs over 3,000 staff. It provides a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour adult and paediatric A&E departments and an Urgent Care Centre and outpatient services. It also provides specialist services including burns, high-risk obstetrics and neonatal care for patients from London, the South East and further afield.

As well as inspecting the eight core services at the Chelsea and Westminster Hospital, we also inspected: the HIV and sexual health services at the Kobler Clinic and John Hunter Clinic for Sexual Health, located in the St Stephen's Centre next to Chelsea and Westminster Hospital; the West London Centre for Sexual Health (WLCSH) which is located at Charing Cross Hospital in Hammersmith; 56 Dean Street and Dean Street Express (at 34 Dean Street), which are both sexual health clinics located in Soho, central London.

The team included CQC inspectors and analysts, doctors, nurses, Experts by Experience and senior NHS managers. The inspection took place on 9 and 10 July 2014 with unannounced visits on 21 and 25 July 2014.

Overall, we rated this hospital as requires improvement. We rated it good for providing caring services, but it required improvement for providing safe, effective and responsive care and for providing services that are well-led.

We rated HIV and sexual health services as outstanding and critical care and maternity as good; we rated A&E, medical care, surgery, children and young people's services, end of life care and outpatient services, as requires improvement.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- Patients told us their experiences of care were good. However, the results of the NHS Friends and Family Test were below (worse than) the national average for inpatient wards, and above the national average for A&E.
- National data indicated that the trust was similar to other trusts for reporting incidents but was potentially an under-reporter of patient safety incidents resulting in death or severe harm. We found that incidents were reported, investigated and appropriate action was taken in most cases. However, learning was not always shared across the trust. Incidents were under-reported in outpatient areas and some areas had not undertaken appropriate investigations. Serious untoward incidents took a long time to investigate, with only 36% being reported within the 45-day standard. Staff in a few areas identified that there could be a blame culture when reporting serious untoward incidents.
- The trust was clean and infection control practices were observed. Most staff followed the trust's infection control policy, including being bare below the elbows, and observed hand hygiene. Infection control rates were within an acceptable range for Clostridium difficile (C. difficile) but were higher than the expected range when compared to other trusts for MRSA in 2013/14 – but no cases had been reported from April 2014.
- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms, including new pressure ulcers, venous thromboembolism (VTE or blood clots), catheter urinary tract infections and falls. The hospital was better than the national average in all areas except for the incidence of pressure ulcers in surgery, which was higher than average. The information was monitored throughout the hospital but the results were not displayed for the public in clinical areas.

Summary of findings

- The National Early Warning Score (NEWS) was used effectively to identify deteriorating patients. Care pathways were being used to standardise care for patients who were acutely ill. Seven-day services had been developed in emergency care and mortality rates were lower (better) than the expected range.
- Most medicines were stored safely but some medicines were not appropriately locked or stored at correct fridge temperatures.
- Not all staff had appropriate knowledge of the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards to ensure that patients' best interests were protected. There was guidance for staff to follow on the action they should take if they considered that a person lacked mental capacity.
- Nursing staffing levels had been reviewed and assessed using the Safer Nursing Care Tool in some areas but had not been completed across the trust. Some staff involved in this work were not clear about what tool had been used and some staff indicated that that the trust had taken a 'one size fits all approach' and had not taken the complexity of patients into consideration. Some staff also reported that there could also be an unresponsive culture when they tried to report significant staff concerns. There had not been a board report to demonstrate appropriate application of the Safer Nursing Care Tool across the organisation. Nurse recruitment was a recognised as a priority for the trust, as some wards were below establishment. Around 85 nurses and midwives had been recruited and it was intended that they would be in post by the end of the year. Bank (overtime), agency and locum staff were used to fill vacancies where possible, but some areas, including the acute assessment unit (AAU), and children's services did not always have safe staffing levels.
- Medical staffing levels did not meet national recommended standards in A&E and palliative care medicine. However, there was a comparatively higher number of consultant staff in other specialities, which was improving access to specialist care.
- Agency nurses did not have access to the electronic patient records, including risk assessments, prescription and administration records. Therefore, the electronic system could only be updated by a permanent member of staff, which resulted in delays in updating records. The agency staff also had to rely on information provided at handover to identify the risks for the patients they were caring for. This also caused delays in updating the electronic record and administering medication.
- The trust had a major incident procedure, which most staff were aware of. Most staff had participated in training in how to respond to major incidents.
- Staff had access to a range of mandatory training and attendance was monitored electronically and by paper. However, completion of this training was below the trust's targets. Staff were supported to access training, there was evidence of appraisal but the clinical supervision was not well embedded. The profile of nursing and midwifery needed to be raised, there were examples, where staff were qualified and experienced to delivery care, such as ordering tests and prescribing, but were restricted from doing so.
- The trust had a learning disability 'passport' in which key information about how the individual should be supported was documented. However, this document was not widely used in the trust and many staff were not aware of it.
- There had been an increase in demand for services, and the capacity in some areas of the trust, such as A&E, experienced difficulties in meeting this additional demand. Staff reported that a contributing factor to this increase was due to the local reconfiguration of services across London. However, as many of these changes had been recently introduced there was no evidence to support this view.
- Patient care in A&E was good but the service was under increasing pressure as attendances were increasing and this was causing delays in assessment and treatment.
- Emergency medical care was well supported by consultant staff. There were good outcomes for medical patients, for example, in stroke care and for heart attacks, but diabetes care needed better coordination.
- Overall, the trust was not meeting the national target of 18 weeks for surgery and patients had longer waiting times for general surgery, trauma and orthopaedics, urology and plastic surgery. Patient outcomes varied and compliance with the Five Steps to Safer Surgery checklist needed to improve.
- Critical care services were good and the outreach team was responsive and supportive of patients in the hospital who required access to specialist critical care.

Summary of findings

- The maternity department's leadership and culture needed to improve to support staff and ensure women did not have interventions that might not be needed.
- The Chelsea Children's Hospital officially opened in March 2014 and provided bright, modern and child-friendly facilities. However, the leadership of the service needed to improve its governance arrangements for safety and compliance with national standards of care. The culture in the neonatal unit also needed to improve.
- End of life care standards were being rolled out across the hospital but these needed to be monitored. Overall, the hospital performed well in the National Care of the Dying Audit.
- Waiting times for outpatient appointments were within national waiting times. At times, appointments could be cancelled at short notice and it was difficult for patients to contact the service by telephone.
- We rated the HIV and sexual health services as outstanding.
- Patient discharge was supported by the rapid response teams in A&E and coordinators in other services. However, some patients reported that their discharge from the wards felt "rushed" and there could be long waits, particularly in the discharge lounge for transport or medication. Providing discharge summaries to GPs was taking longer than 48 hours.
- The hospital at night team triaged (assessed and prioritised) patients and escalated safety issues. Junior doctors appreciated that they were only contacted when there was a concern, making their workload manageable.
- The trust had introduced Schwartz rounds (monthly one-hour sessions) for all staff to discuss aspects of the emotional and social dilemmas that arise from caring for patients. Staff who had attended were positive about the learning and emotional support and the focus on improving outcomes for patients.
- The trust was supportive of art and music therapy and there were excellent examples of uplifting art on display, and music was played on Thursday lunchtime in the main corridor of the trust.
- Staff were positive about working for the trust and said it was a friendly and positive place to work but it was not without its challenges, which staff described as concerning IT, human resources, staffing levels and support from leadership.
- Staff were aware of the trust's vision. Most service areas had a strategy or transformation plans that identified how the service would develop and build capacity to respond to the predicted increase in attendances and admissions under 'Shaping a healthier future'.
- The leadership team had created an environment where all members of staff were part of quality project teams. These teams were then given time to undertake innovative projects and research to improve the quality of the service. As a result, a number of staff throughout the hospital had been nominated for the trust's award for clinical excellence. Staff told us how these projects had led to improvement to services.
- There were examples of the trust's research that were nationally and internationally recognised (see below).

We saw several areas of outstanding practice, including:

- The A&E department staff had taken part in a research project to routinely test patients for HIV (with their consent). This had now been embedded practice for over a year and testing had resulted in a higher-than-normal proportion of patients being identified as HIV positive.
- The clinical sterile services department (CSSD) had introduced a metal detector which was used to identify surgical equipment that had been incorrectly discarded into rubbish bags. The aim of this initiative was to promote staff safety and reduce the cost of lost equipment.
- The burns unit had international recognition and published numerous research papers annually, which identified best practice.
- The physiotherapy team in intensive care had an extensive research portfolio. For example, they had developed an innovative simulation-based physiotherapy course to improve quality and safety, and developed a standardised functional score assessment tool to improve compliance with National Institute for Health and Care Excellence (NICE) guidance. The tool is now used in more than 50% of intensive care units nationally.
- The female genital mutilation (FGM) service in maternity had achieved a national award for innovation and care.

Summary of findings

- The neonatal palliative care nurse had developed national standards on caring for very young babies with life-limiting conditions who need palliative or end of life care on neonatal units. These standards had recently been shared with medical royal colleges and other hospitals for national use.
- The HIV and sexual health services provided outreach clinics at London's G-A-Y Bar, Manbar and Sweatbox Gay Sauna, and in hostels and community venues to engage with hard-to-reach groups such as the Chinese and Muslim communities, young people and people socially excluded or those who used Supporting People programme services, such as the homeless.
- The HIV and sexual health services gained community engagement through outreach work, taking part in London Pride, publicity stunts such as the Guinness World Record attempt for taking the most HIV tests at G-A-Y Bar on World Aids Day in 2011 and the House of Lords campaign to provide HIV tests for legislators.
- 56 Dean Street and Dean Street Express brought sexual health services to a high street location. Dean Street Express provided fast, self-testing modern facilities for asymptomatic patients.
- Public engagement in the HIV and sexual health services was an integral part of the service and had led to innovation and excellence in services across London. The service had two patient representatives on a part-time basis, funded by the trust to obtain the views of people using the service to help make positive changes.
- The HIV and sexual health services provided speciality clinics such as: SWISH for people employed in the sex industry; CODE clinic for men who were into harder sex or using drugs during sex; Pearl clinic for people with a learning or physical disability; and cliniQ and the Gold Service for the transsexual community. CliniQ and the Gold Service are the only specialist sexual health clinics in the country for the transsexual community. The model for this service was led by the transsexual community through public engagement.
- The HIV and sexual health services have consistently been shortlisted and won awards for a variety of projects every year since 2007. One of their most recent awards was for the work with the West London African Women's Service for dedication to improving the care of women living with FGM. The trust had won the BMJ Group Award 2013 for transforming patient care using technology, and the adult sex project of the year at the Brook Sexual Health Awards 2013 for Dean Street at Home and cliniQ.
- The leadership team had created an environment where all members of staff were part of quality project teams. These teams were then given time to undertake innovate projects and research to improve the quality of the service. As a result, a number of staff throughout the trust had been nominated for the trusts award for clinical excellence. Staff we spoke with told us how improvement to services had been undertaken through these projects.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must ensure that:

- Patients are cared for in appropriate areas in the A&E department so that there is safe monitoring of their condition.
- All staff in A&E receive training in mental health awareness, and when and how to safely restrain patients.
- All staff receive training in the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards.
- Pain scores are recorded and reassessed for all patients in the A&E department.
- Consultants in A&E sign off and agree to the discharge of patients with complex needs in line with national guidance.
- There are suitable environments in outpatients areas to ensure accessibility for patients with a physical disability or poor mobility, to promote the privacy and dignity of patients, and protect patient confidentiality.
- Patient records and care plans are accessible to all staff, including agency staff.
- Regular checks of medicines are undertaken, that all medicines are stored safely, and are in date and fit for use.
- Nurse staffing levels are compliant with safer staffing levels guidance.
- A recognised acuity tool is used in all areas and staffing levels and skills mix reflects the findings of these as well as national guidance.
- Appropriate equipment is available and regularly checked and records maintained.
- Compliance with the 'five steps to safer surgery' checklist is improved and is embedded in surgical practice.
- The incidences of pressure ulcers in surgery and critical care are reduced.

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- A record of the termination of pregnancy (TOP) forms (HSA4) sent to the Department of Health is kept by the trust.
- Compliance with statutory and mandatory training is improved.
- All staff use the incident reporting system, and that feedback is provided and learning from incidents is cascaded and shared. There should be evidence of appropriate action in response to any never event (serious harm that is largely preventable).
- Risks identified on the risk register have appropriate actions to mitigate them, with timely reviews and updates. Information on risks should be owned by the divisions.
- The safety thermometer is embedded across the trust and information on avoidable harms is available and displayed for the public to access.
- The time taken for the root cause analysis investigation of serious incidents improves so that issues are identified quickly to prevent recurrence.
- Clinical guidelines are up to date, in line with national guidance and action is taken as a result of audits.
- Governance and risk management procedures in children and young people's services improve.
- The trust continues to support staff and investigate and resolve the culture of intimidation and bullying identified in the neonatal unit.
- Staff are aware of and use the trust's learning disability passport and operational standards for people with a learning disability are appropriately assessed and implemented.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) forms are appropriately completed so that the decision and sign-off is clear and there is appropriate communication with patients, their relatives or carers.
- End of life care standards are appropriately monitored against national standards.
- Patients receiving end of life care are appropriately identified and referred to the specialist palliative care to receive timely support and treatment advice.
- There is an operational policy or guidance for the management of a deceased patient's belongings.
- Clinical governance arrangements are simplified so that there are effective processes to prioritise and escalate concerns.
- Discharge summaries are sent to GPs in a timely manner and include all relevant information in line with Department of Health guidelines
- Support is given to frontline nursing staff to be involved in change and to ensure there is a just culture.
- Staff in lower pay bands feel they are treated similarly to all staff in the trust.
- Cost improvement programmes are developed and are also reviewed by the board.

In addition the trust should ensure that:

- Medical staffing levels meet national recommendations in A&E and palliative care medicine.
- Develop the nursing and midwifery profile so that their advanced skills can be used appropriately; this is particularly the case in A&E, maternity and for end of life care.
- Agency staff receive appropriate induction when working in the hospital.
- Patients living with dementia are appropriately screened and identified and that staff access the tools and advice available to ensure there is consistent care and support in all areas of the hospital.
- Information on staffing levels, safety and performance activity is displayed and accessible to patients and the public in wards and outpatient areas.
- Discharge is effectively planned and organised and patients are not waiting for long periods in the discharge lounge, or waiting after their outpatient appointment.
- Clinical supervision is developed for all staff.
- There is a 'just culture' for all staff when dealing with serious incidents.
- The critical care unit participates in the Intensive Care National Audit & Research Centre (ICNARC).
- There is better multidisciplinary working in maternity and children and young people's services.
- Governance arrangements in maternity continue to improve.
- All staff follow infection control practices, particularly the bare below elbow guidance in ward and outpatient areas.

Summary of findings

- Waiting times meet the national referral time target of 18 weeks.
- Information leaflets and signs are available in other languages where relevant.
- Bereavement support is appropriately maintained when the officer is on leave.
- Outpatients clinics are not cancelled at short notice and patient waiting times are improved to within 15 minutes of clinic appointments.
- Staff engagement improves so that staff feel listened to and consulted about specific issues that affect service development, particularly in A&E and outpatients, and where job roles are affected for administrative, clerical and support staff.
- Patient and public engagement continues to develop to improve services, including formal approaches for patient feedback across all services.
- Human resources, IT and finance support improve for staff, in terms of payroll and consultation on job roles.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	A&E services were under pressure from the increasing demand for services. The flow of patients through the department was meeting the national four-hour waiting time target. However, there were, at times, waits between 40 minutes and one hour for triage. Due to capacity issues, some patients were placed in inappropriate areas within the department for monitoring, care and treatment. This put patients at risk of harm. There had not been appropriate actions to address these issues and the trust did not have interim plans. Safety standards were not being met for medicines management, and staff had limited awareness of the Mental Capacity Act 2005, but there was reporting and learning from incidents. Infection control processes were followed and equipment was available and was regularly checked. Patients whose condition might deteriorate were monitored and escalated appropriately. Best practice guidelines were being used to care for patients and there was participation in research projects. Patients were involved in their care and treatment and were treated with respect. There was a positive culture within the service and a clear vision for the future. The service had governance processes to monitor quality and risks.
Medical care	Requires improvement 	The medical care services needed to improve safety procedures around safe staffing levels, learning from incidents and using the electronic records. The environment was clean and staff followed the trust policy on infection control. Patients whose condition deteriorated were appropriately escalated and action was taken to ensure harm-free care. There were procedures to provide effective and responsive care. Care was provided in line with national best practice guidelines; however, staff did not always adhere to care pathway protocols and local monitoring of guidelines needed to improve. There was participation in national audits and

Summary of findings

outcomes were good for patients who had a stroke or heart attack but were worse than other trusts for diabetes care. There were seven-day, consultant-led services.
Patients received compassionate care and were treated with dignity and respect and services were responsive to patient needs. There was specific care for patients living with dementia, for those who had alcohol problems or a mental health condition.
There were effective governance arrangements but staff felt unsupported by division and trust management. Public and staff engagement needed to improve.

Surgery **Requires improvement**

The surgery division required better procedures to provide safe, effective and responsive care. The hospital's surgical safety checklist was not fully completed for all patients and needed to be updated to improve compliance with the 'Five steps to safer surgery' procedures. There needed to be better learning from incidents and improved use of the electronic records. Equipment was available and appropriately checked but standards to manage medicines were not met. Infection control practices were followed and overall infection rates were within expected levels. Policies and procedures were accessible to staff on the trust intranet but not all staff were aware of these and many had not been reviewed to ensure they were in accordance with evidence-based national guidelines. Practice was not appropriately monitored to demonstrate adherence to standards..
Patients received compassionate care and we saw that they were treated with dignity and respect. Patients and relatives we spoke with said they felt involved in their care. National waiting times, however for patients waiting for surgery were not being met and some patients were waiting longer than 18 weeks. There was strong, supportive leadership at ward and matron level but the service did not have an appropriate governance structure to manage risks. Staff reported that the trust had, at times, a 'blame' rather than a learning culture following incidents. Public and staff engagement needed to improve. There was innovation in some areas and outstanding practice in the burns unit.

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Critical care

Good

The unit had sufficient numbers of nursing and medical staff on duty and there were effective procedures for safe care. The patient Safety Thermometer was not embedded but there were plans to develop this. Medicines were safely and securely stored. Patients received care and treatment according to national guidelines and there was good multidisciplinary team working to support patients. Patient and performance outcomes were compared across North West London but the trust had re-evaluated this and intended to participate in the Intensive Care National Audit & Research Centre (ICNARC) from July 2014.

Staff cared for patients in a compassionate manner with dignity and respect. They involved patients and, where appropriate, their relatives in the care of the patient. Patients and their relatives were happy with the care provided. Emotional and spiritual support were provided. The leadership on the unit was visible and staff were passionate about providing excellent quality care. Governance arrangements supported assurance around quality, risk and safety. There was a culture that supported staff to develop innovative ways of working. Patients' engagement was well developed through a range of feedback approaches.

Maternity and gynaecology

Good

There were effective procedures that supported safe and effective care for women. Staff were caring and compassionate and treated women with dignity and respect. There were adequate numbers of staff to meet the needs of women. The shortage of midwives had been addressed and vacant posts had recently been recruited to. Staff had relevant training and a good awareness of safeguarding and child protection issues. National guidelines were being used but monitoring compliance needed to improve. Overall, outcomes for women were good, although the caesarean section rate was higher than the England average. There was good multidisciplinary working between hospital and community midwives and GPs and across hospital departments.

Women had choices during birth and were involved in decisions about their care and treatment. Staff on the unit were polite and friendly. We observed

Summary of findings

women being treated with dignity and privacy. The environment was clean and spacious. The atmosphere in the maternity unit was calm and peaceful. The antenatal department offered a comprehensive screening programme and the maternity urgent care centre had a triage (assessment and prioritising) system for women. A new governance structure had been implemented in January 2014 and this had improved assurance around quality and safety but there needed to be better monitoring of action plans, and lessons learned from incidents needed to be effectively disseminated to all staff. The monitoring of compliance with guidelines through audit but action plans to address identified issues were not always developed and implemented. The leadership and culture within the department needed to improve to ensure there was effective joint working between doctors and midwives to support women having a reduction in interventions, and so that staff felt supported and listened to. The department demonstrated public engagement, improvements and examples of innovative practice

Services for children and young people

Requires improvement

The Chelsea Children's Hospital needed better procedures to provide effective and safe care for children. There was 24-hour resident paediatric medical cover at all levels, including consultants for paediatrics and the neonatal intensive care unit (NICU). However, nurse staffing levels needed to be monitored so that levels and skills mix were appropriate and in line with Royal College of Nursing guidelines. Incident reporting needed to improve and lessons learned shared more effectively. Staff mandatory training also needed to improve Clinical practice guidelines needed to be updated and monitored to ensure compliance with national standards. Staff were caring and child-centred and we received positive feedback from the majority of children, young people and parents that we spoke with about their caring attitude of staff. The Chelsea Children's Hospital had excellent modern, spacious dedicated and child-friendly facilities. Services were responsive to children's needs and there was good support for children with a learning disability or mental health needs, although out-of-hours support for mental

Summary of findings

health needed to improve. The service needed to develop clear strategies. Governance structures did not provide the assurance around quality, safety and risk and were described as “haphazard” by staff.
The leadership team in the department and the trust was described as “not visible or fully supportive of staff”. The culture in the service overall was described as “good” but staff identified a culture of bullying in neonatal care that needed to be addressed. The trust was taking action to improve the service. Public engagement was good but staff engagement needed to improve. There was innovation in the service in neonatal care, for example, there was outstanding practice in neonatal end of life care, although there was less evidence of improvement in other areas of the service

End of life care **Requires improvement**

The services required better procedures to support safe care, particularly when DNACPR orders are used. The trust had introduced a new toolkit to replace the Liverpool Care Pathway and, overall, there was effective care and good practice observed against national audit standards. More staff, however, needed to be aware of and use the toolkit. Patients had appropriate pain relief, and staff were caring and compassionate and treated patients with dignity and respect. There was multidisciplinary working towards patient-centred care. Patients spoke positively about the way they were being supported with their care requirements. There was no system to identify access to specialist palliative care team support and not all patients were appropriately referred. It was not appropriately documented that patients and/or their relatives were communicated with over the decisions not to resuscitate, and the trust needed to update local policies in line with a recent Court of Appeal judgement on the need for this action. Patients did not always have a clear care plan which specified their wishes regarding end of life care and staff were not always aware of their wishes with regards to the preferred place of death. Some patients and their relatives were not being told in a timely way about dying. The leadership of the service was effective and public and staff

Summary of findings

engagement were being used to improve the service, although methods for patient feedback needed further development. The service had good plans for improvement and sustainability.

Outpatients and diagnostic imaging	**Requires improvement**		The department did not follow appropriate safety procedures for incident reporting and learning, equipment checks, safeguarding and mandatory training and local best practice guidelines were not up to date. Multidisciplinary working needed to improve. Staffing levels in the department had been assessed as appropriate. National waiting times for appointments were being met but some clinics had short-notice cancellations. Patients were positive about their care but they were not always kept informed, for example, about delays in clinics. People with a learning or physical disability required better support to access services. The service had innovative plans for development but local and trust leadership needed to improve during its implementation. Governance and risk arrangements were fragmented and there was not always single responsibility for a programme or target. Staff and public engagement needed to improve.
HIV and sexual health services	**Outstanding**		There were effective procedures to support a safe and effective service for patients. Clinical standards were adhered to and patients were appropriately involved in research and drug trials. The environment at clinics was clean and uncluttered. The clinics at 56 Dean Street and Dean Street Express were trendy, modern and bright. One patient representative told us the team had brought “sexual health and HIV services into the 21 century”. Patients described the service offered at each of the clinics as “exceptional”, “caring”, “confidential” and “quick”. Staff were highly trained and were compassionate and caring. They treated patients with dignity and respect and “normalised” conversations about sexual health. Staff worked in a multidisciplinary way to centre care around the patient. Each location had identified the demographic of the people using their service and provided speciality clinics, outreach, community engagement and counsellors suited to the people using the service.

Summary of findings

The team constantly explored new and innovative ways to deliver the service. National guidelines were being used and most patients could access services at one of the locations within 48 hours. The service reviewed its performance through patient surveys and the patient champions. There was clear governance and strong leadership and staff at all levels felt involved in decisions and ideas that could help the division and individual locations run well. The service was well-recognised at local and national levels.

Requires improvement

Chelsea and Westminster Hospital NHS Foundation Trust

Detailed findings

Services we looked at

Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people;End of life care; Outpatients, HIV and sexual health services.

Contents

Detailed findings

Background to Chelsea and Westminster Hospital NHS Foundation Trust

The Chelsea and Westminster Hospital provides specialist services, including HIV and sexual health, burns, paediatrics, high-risk obstetrics and neonatal care for patients from London, the South East and further afield, and a full range of general medical and surgical services for the local community of around 500,000 people in the four local boroughs of Kensington and Chelsea, Westminster, Hammersmith and Fulham and Wandsworth. The hospital employees around 3,000 staff.

The hospital is a modern, purpose-designed-and-built facility opened in May 1993 and has 430 beds. The trust gained foundation trust status in October 2006 and has more than 14,000 members who are patients, members of the public and staff.

Most services are provided on the main Chelsea and Westminster Hospital site but HIV and sexual health services are based in three other centres - St Stephen's Centre adjacent to the hospital, 56 Dean Street in Soho, and West London Centre for sexual health at Charing Cross Hospital.

The Chelsea and Westminster Hospital had been inspected four times since registration. The last inspection was in September 2013 and the hospital was found to be compliant for all the Regulations inspected.

We carried out this comprehensive inspection because Chelsea and Westminster Hospital NHS Foundation Trust had been flagged as potentially high risk on the Care Quality Commission's (CQC) intelligent monitoring system. We inspected accident and emergency, medical care (including older people's care), surgery, critical care, maternity and family planning, services for children and young people, end of life care, sexual health and outpatient services.

Our inspection team

Our inspection team was led by:

Chair: Gill Harris, Chief Nurse, NHS England North

Head of Hospital Inspections: Joyce Frederick, CQC

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

How we carried out this inspection

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

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

The inspection took place on 9 and 10 July 2014 with an unannounced visit on 21 July and 25 July 2014.

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

Detailed findings

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in Fulham London on 08 July 2014, when people shared their views and experiences of the Chelsea and Westminster Hospital NHS Foundation Trust.

We carried out an announced inspection visit on 9 and 10 July 2014. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, Chaplin, dietician, physiotherapists and pharmacists.

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

We undertook further unannounced inspections on 21 and 25 July 2014 when we inspected A&E, the acute assessment unit (AAU) and ward areas.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at the Chelsea and Westminster Hospital.

Detailed findings

Facts and data about Chelsea and Westminster Hospital NHS Foundation Trust

Chelsea and Westminster Hospital NHS Foundation Trust provides an acute service to around 500,000 people in the four London boroughs of Kensington and Chelsea, Westminster, Hammersmith and Fulham and Wandsworth.

The health services provided by the trust include:
General services for the local community include A&E, maternity unit, and a full range of surgical and medical services for both inpatients and outpatients.

Specialist services for patients from London, the South East and beyond, including paediatric and neonatal surgery in the new Chelsea Children's Hospital, the most extensive HIV and sexual health service in Europe, high-risk maternity care, the regional burns unit for London, and bariatric (weight loss) surgery.

Children care is provided by the Chelsea Children's Hospital, which is located on the first floor of Chelsea and Westminster Hospital. It opened on 18 March 2014 and includes:

- Dedicated children's operating theatres
- Revamped children's wards
- New day surgery ward
- An extended Paediatric high dependency unit
- Expanded surgical recovery area.

The Chelsea and Westminster Hospital NHS Foundation Trust experienced a change of medical and nursing director leadership within the financial year 2013/14

1. Context

- The hospital has around 430 beds.
- The local population is around 500,000, all of which are urban.
- Deprivation is higher than average, but varies (103 out of 326 local authorities), with 4,900 children living in poverty.
- Life expectancy for both men and women is higher than the England average.
- The number of staff was more than 3,000.
- The annual turnover (total income) for the trust was £366 million in 2013/14.
- The trust surplus was £18 million for 2013/14.

2. Activity

- Inpatient admissions: 51,574 (2012/13)
- Outpatient attendances: 690,865 (2012/13)
- A&E attendances: 112,304 (2012/13)
- Deliveries (births): 4846 (4955) (2013/14).

3. Bed occupancy

- General and acute*: 82% (January–March 2014). This was below both the England average of 87.5%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- Maternity was at 57% bed occupancy – lower than England average of 58.6%.
- Adult critical care was at 67% bed occupancy – lower than England average of 85.7%.

*The trust has identified that function bed occupancy is higher than this figure because denominator used for the national return uses an out-of-date figure, which is higher than the actual number of beds that are available at any given time and many beds in the trust are specialist beds are not used in general medicine or surgery.

4. Intelligent Monitoring (March 2014)

- Safe: Risks = 2, Elevated = 0, Domain Score = 2
- Effective: Risks = 0, Elevated = 0, Score = 0
- Caring: Risks = 2, Elevated = 0, Domain Score = 2
- Responsive: Risks = 0, Elevated = 0, Domain Score = 0
- Well led: Risks = 0, Elevated = 0, Domain Score = 0
- **Total:** Risks = 4, Elevated = 0, Domain Score = 4

Individual risks/elevated risks:

- Risk: incidence of meticillin-resistant staphylococcus aureus (MRSA)
- Risk: potential under-reporting of patient safety incidents resulting in death or severe harm
- Risk: Inpatient Survey 2012 "Did you have confidence and trust in the nurses treating you?"
- Risk: Maternity Survey 2013 "Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?"

Detailed findings

5. Safe:

- Never Events reported in past year three (January 2013 to March 2014).
- Serious incidents – Strategic Executive Information System (STEIS) serious untoward incident system 69 (April 2013 to May 2014) - over half of these were for pressure ulcers.
- National Reporting and Learning System (NRLS) (February 2013 to January 2014); no evidence of risk.
- NRLS (February 2013 – January 2014): Potentially an under-reporter of patient safety incidents resulting in death or severe harm: Risk

Death, Acute: 9

Severe harm, Acute: 33

Moderate harm, Acute: 558

Low harm, Acute: 3,441

No harm, Acute: 4,444

Total: 8,485

Safety Thermometer (May 2013 – May 2014)

- Pressure ulcers – higher than England average
- Catheter UTIs – lower than England average
- Falls – lower than England average

Infection control (May 2013 – May 2014)

- 11 cases of C. difficile – no evidence of risk
- 5 cases of MRSA – incidence – evidence of risk (0 cases - April to June 2014)

6. Effective:

- Hospital Standardised Mortality Ratio (HSMR): Lower than expected. No evidence of risk (Intelligent Monitoring)
- Summary Hospital-level Mortality Indicator (SHMI): Lower than expected. No evidence of risk (Intelligent Monitoring).

7. Caring:

- CQC Adult Inpatient Survey (10 areas): within expected range all areas.
- NHS Friends and Family Test inpatient: below (worse than) the England average.
- NHS Friends and Family Test A&E: above (better than) the England average.
- Cancer Patient Experience Survey (68 questions): highest scoring 20% of trusts for three questions; average for 13 questions; and lowest scoring 20% of trusts for 18 questions. This is worse than the England average.

8. Responsive:

- A&E four-hour standard – exceeds the England average during the course of the year (2013/14).
- A&E – time to initial assessment in line with England average; Time to treatment, is longer than standard and below the England average.
- Emergency admissions waiting four to 12 hours in A&E from decision to admit to admission: better than England average
- A&E left without being seen: below the average.
- Cancelled operations: better than expected; 4 operations cancelled but not admitted within 28 days.
- 18 week RTT- June 2014:

- Non-admitted (outpatients) – better than the NHS operating standard of 90%.

- Admitted, adjusted and incomplete (inpatient and day case) – worse than NHS operating standard.

9. Well-led:

- NHS Staff survey (28 questions): better than expected (in top 20% of trusts) for 13 questions; tending towards better for three questions; average for three questions; tending towards worse in five questions; worse than expected (in bottom 20% of trusts) for four questions;
- Use of bank and agency staff – higher than England average.
- Sickness rate is below the England average.
- GMC National Training Scheme Survey (2014): The trust was within expected results for all areas of the National Training Scheme Survey.

10. CQC inspection history

- Four inspections had taken place at the trust since its registration in April 2012.
- Chelsea and Westminster Hospital was last inspected in September 2013. The trust was compliant on this inspection.

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

In the last 12 months, the adult accident and emergency (A&E) department saw about 79,000 patients. The paediatric emergency department was responsible for seeing and treating around 33,000 children during the year. The A&E department was originally built with a capacity for 60,000 attendances annually but is currently seeing in excess of 112,000. The A&E department is divided into an adult A&E, paediatric A&E and an Urgent Care Centre for adults and children. There is a single point of access reception from which patients are triaged (assessed and prioritised) and then streamed to the appropriate areas.

During our inspection, we spoke to around 22 staff members and 22 patients and relatives. We reviewed other documentation from stakeholders, including performance information provided by the trust.

Summary of findings

A&E services were under pressure from the increasing demand for services. The flow of patients through the department was meeting the national four-hour waiting time target. However, there were, at times, waits between 40 minutes and one hour for triage. Due to capacity issues, some patients were placed in inappropriate areas within the department for monitoring, care and treatment. This put patients at risk of harm. There had not been appropriate actions to address these issues and the trust did not have interim plans. Safety standards were not being met for medicines management, and staff hadlimited awareness of the Mental Capacity Act 2005, but there was reporting and learning from incidents. Infection control processes were followed and equipment was available and was regularly checked. Patients whose condition might deteriorate were monitored and escalated appropriately.

Best practice guidelines were being used to care for patients and there was participation in research projects. Patients were involved in their care and treatment and were treated with respect. There was a positive culture within the service and a clear vision for the future. The service had governances processes to monitor quality and risks

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

The safety of the department required improvement. At times there were waits of between 40 minutes and one hour for patients to be triaged resulting in patients with serious and urgent conditions not always being assessed or treated promptly. The department's physical capacity did not met the demand for the service, resulting in some patients being placed in areas that were inappropriate for treatment, and where it was difficult to monitor patients. Consultant cover for the department did not meet the recommended national standards. Pain scores were not always recorded. Medicines were not always stored appropriately. Awareness of the Mental Capacity Act 2005 was limited and staff were not aware of all of the implications of the Act on their daily work. Consultants did not make routine checks on the discharge of high-risk patients, which was contrary to national guidance.

Incidents were reported and lessons were learned and infection control standards were met. Appropriate equipment was available and was regularly checked. Patients whose condition might deteriorate were monitored and escalated appropriately. Staff were trained in what to do in the event of a major incident.

Incidents

- Staff we spoke with at all levels told us that incident reporting was encouraged and discussed alongside any lessons learned as part of the handovers.
- Incidents were appropriately acted on. The department maintained a record of recent incidents that had taken place within the department and the actions that had been taken in response. The majority of incidents reported related to departmental capacity issues and pressure ulcers.
- The findings of investigations into incidents in the department were shared with all staff and used to inform the way future care was provided. Senior staff explained the change that had occurred as a result of learning from an incident. For example, checklists had been introduced that were completed for patients with specific conditions, such as head injuries, to ensure appropriate treatment.
- Mortality and morbidity meetings took place on a monthly basis at which any death that had occurred in the department was reviewed. Root cause analyses following incidents were discussed and any lessons to be learned were shared.
- The department produced a monthly leaflet that was circulated to all staff which reported the details of lessons learned and policy changes as a result of clinical incidents.
- Staff we spoke with, both senior and junior, were able to describe the lessons learned and changes made as a result of previous incidents.

Cleanliness, infection control and hygiene

- The general environment of the main A&E department was visibly clean and tidy. Curtains had dates to indicate when they were last cleaned, according to hospital policy.
- Infection control (hand hygiene) training was part of the trust's mandatory training programme. Data supplied by the trust indicated that 83% of staff had completion this training. However, senior staff reported that the recording system did not capture all of the training undertaken and compliance was higher than indicated.
- We observed staff providing care, support and treatment, during which they followed appropriate infection control procedures to protect people from infection and cross-contamination. Personal protective equipment and hand-washing facilities were available throughout the department. Nursing staff cleaned cubicles in between patient visits appropriately.
- To reduce the risk of cross-contamination between areas such as toilets and clinical areas, the cleaning schedule for domestic staff to complete was colour coordinated to coincide with different coloured mops that staff needed to use in different areas.
- Monthly infection control audits were undertaken by nursing staff in both the main A&E and the paediatric A&E. These audits monitored the general cleanliness of the environment and availability of personal protection equipment, such as gloves and aprons, for staff. Since January 2014 both areas had scored highly, at 95% or 100% continuously.
- Daily infection control audits by ancillary and nursing staff also took place and monitored the cleanliness of

the department and availability of personal protective equipment. The results of these audits showed that nearly all daily cleaning tasks were regularly completed (between 90% and 100%).

- There were appropriate facilities for the disposal of clinical waste, including sharp items. However, on both days of our announced inspection, appropriate waste disposal protocols had not been followed in the paediatric A&E department. Rubbish and used clinical items were on the floors and surfaces despite the presence of nearby clinical disposal facilities.

Environment and equipment

- Staff we spoke with highlighted that there was a lack of space in the department for the numbers of people attending which resulted in people being placed in inappropriate areas while waiting for or receiving treatment. This included the use of benched seating in the corridor which made it difficult to monitor patients appropriately. At times, patients were provided with treatment while on the corridor. In this environment it was often very difficult to provide patients with privacy while they were being assessed or treated.
- Appropriate emergency resuscitation equipment was available throughout the department. These were checked regularly and were fit for purpose.
- Nursing staff reported that there was sufficient equipment in the department and the repair of equipment was undertaken in a timely manner. All the equipment we observed had a sticker to indicate that it had been checked and was in working order. All of the equipment we checked was clean.
- The cubicles within the department all contained appropriate equipment and supplies and the department had a portable x-ray machine. Specialist facilities, including a negative pressure room for burns patients and a room equipped for assessing and treating people with eye conditions, were available.
- There was a specific observation ward with five beds within the department where patients could be closely monitored by nursing staff.

Medicines

- Medicines were not always stored safely. Medicines were in date and most were stored in locked rooms or cupboards. Intravenous fluids were stored securely, in a room with an access code. There were daily checks of the temperatures of fridges and these were recorded. However, the refrigerator in the majors area was unlocked and the maximum and minimum temperatures were not being recorded as per trust policy. There were gaps in the recorded daily temperature checks of the fridge in the paediatric A&E. The department only recorded the temperature at the time of checking and not the maximum and minimum temperature of the fridge over the 24-hour period. This was not in line with the trust's current policy.
- There was an accurate record kept on the use of controlled drugs within the department.
- There were five independent prescribers, three in adults, two in paediatrics. Who had been assessed as competent to prescribe. Patient group directions were used for naproxen, diclofenac and paracetamol. Copies of these were on trust intranet. Only staff who completed competency assessments could administer medicines via a patient group direction.

Records

- Staff we spoke with stated that the storage for medical records would soon be inadequate as the resources for the scanning and storage of old records had been reduced.
- Completion of patient records was variable. The 10 records we reviewed contained documentation of cannula insertions (a tube inserted into the vein) and details of handovers from A&E to the acute assessment unit (AAU). However, the recording of pain scores on initial assessment and recording of reassessments was not always documented.
- The 10 patient records we looked at in the paediatric A&E were not fully completed and pain scores at initial triage were not always documented and there was no record of any reassessment.
- Risk assessments, such as for falls risks for elderly patients, were completed appropriately in the majority of records we looked at.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Some nursing staff we spoke with reported that they received training in the Mental Capacity Act 2005. However, the majority of staff said that their training and awareness was limited. The majority of staff were unaware of how capacity issues needed to be taken into account in their daily work.
- During our unannounced visit, we observed a highly agitated patient within the A&E department who was behaving in a violent manner. Staff made distinct efforts

to treat the patient kindly. However, when the patient was being violent, staff placed themselves in front of the patient where they were subjected to physical assault. This put staff members at significant risk of harm. It took15 minutes for security to attend the department after they had been called. We spoke to staff afterwards who said that the training in restraint was limited.

Safeguarding

- There was a safeguarding policy and procedure which staff were aware of and they knew how to report any concerns.
- Staff we spoke with confirmed they had received safeguarding training. The department's records indicated that all staff had received safeguarding adults level 1 training and child protection level 1 training.
- Records indicated that 100% of paediatric A&E nursing staff had received safeguarding children level 2 training and 94% had received safeguarding children level 3 training.
- A record was kept of all child protection referrals and notifications; these were reviewed by a health visitor daily to ensure that appropriate follow-up actions would be taken by all relevant parties.
- Notes were made on patients' records when domestic violence was suspected.
- The record of safeguarding alerts that had been raised between January and June 2014 all included a record of the actions that had been taken.

Mandatory training

- Data provided by the trust demonstrated that 83% of staff had completed mandatory training. The staff had completed mandatory training in relevant areas such as safeguarding adults and children, as well as adult and children life support. They reported that training in these topics was renewed and updated as per national guidelines.
- All the band 6 nursing paediatric staff had completed mandatory advanced paediatric life support, and all band 5 nursing staff had completed mandatory paediatric intermediate life support.
- The department had a specific induction programme which staff praised for its high quality. It included details about departmental protocols. There was also an induction programme for agency staff that included details about the administration of drugs, record-keeping and patient emergency protocols. Data provided by the trust in June 2014 indicated that only 12% of staff had had local induction training. However, senior staff reported that the recording system did not capture all of the training undertaken and compliance was higher than indicated. Junior doctors identified that there was often not enough time to complete the online induction training.

Assessing and responding to patient risk

- There were guidelines for the streaming of patients to paediatrics, A&E major injuries (majors), minor injuries (minors) or the Urgency Care Centre to ensure they were sent to the correct part of the department for their needs to be met.
- During the inspection the department was very busy and patients were waiting a long time to be assessed. The national target is for all ambulances to handover within 15 minutes and there were fines for all breaches of the 30-minute target. The department breached the national and local target for taking ambulance handovers. Only 66.7% of patients who arrived by ambulance were seen within 15 minutes and only 91.3% within 30 minutes.
- Data for the period April to July 2014 showed that the average time from arrival in A&E to initial assessment was 14 minutes, which met the national target of 15 minutes.
- During the first day of our inspection, we saw several examples where patients with potentially serious conditions experienced lengthy delays of up to one hour and five minutes before being seen, including one person who presented with chest pains and was triaged after 40 minutes. Other patients who experienced lengthy waits were those with abdominal pain and urinary retention. During our unannounced inspection the department was less busy although time to triage was around 20 minutes, patients were seen and treated in under three hours.
- There were escalation policies and procedures for what staff should do when there were delays in patients receiving their first clinical assessment, waiting for speciality assessment, ambulance handovers and waiting more than three hours to be seen. However, these procedures did not cover what action staff should take when there were delays in people being triaged.
- All patients were triaged and a brief medical history and vital signs were taken. A risk assessment was also completed. All patients over the age of 65 had a falls risk

assessment when they attended. The majority of adult records we looked at had evidence that national early warning scores for acutely ill patients had been recorded to identify any deterioration in their condition.
- Staff told us that, due to the physical capacity in the department, some patients with serious conditions would be seated in the department's corridor and may not receive the appropriate level of care and treatment.
- During the inspection we spoke to one patient seated on the bench. She had presented with an allergic reaction, tightness in her throat and shortness of breath. Due to the seriousness of this condition, which was worsening, and the lack of suitable monitoring facilities in the corridor, we alerted staff to this person's condition. Staff then took appropriate and immediate action.
- Consultants did not sign off on the discharge of high-risk patients, which is not in line with national guidance designed to reduce the risk of people being inappropriately discharged and needing to re-attend.

Nursing staffing

- Nurse staffing levels were monitored by senior staff and acted on where necessary. There were currently 60.76 whole time equivalent (WTE) nursing staff (five band 3 nurses; 29 band 5 nurses; 12 band 6 nurses; 9 band 7 nurses; five band 8a nurses and a 0.76 band 8b nurse consultant). Nursing staff indicated that the department did not have enough nursing staff and had expressed this to the trust board. Senior staff reported that the department was now actively recruiting an additional 4.5 WTE nursing staff.
- In May 2014, the vacancy rate for nursing staff was 14.03%; this was better than the national average. The sickness rate for staff working in the adult A&E was 3.63%, which was in line with the trust's own target and 5.76% for paediatric nursing staff, which was above the trust's target.
- To assist at peak times of workload between August 2013 and April 2014, an extra bank nurse/agency nurse was used on each late and night shift.
- During our inspection we found that there were appropriate numbers of nurse staff in the department, based on the number of staff, their skills mix and the types of patients seen within the department.
- The department complied with the national recommendation that there should be a minimum of one nurse to every three patients within the resuscitation bays when they were being used for high dependency patients.
- There were appropriate numbers and skills mix of paediatric nursing staff, including paediatric trained nurses on each shift. These levels were suitable for the volume and case mix of patients seen within the department.
- Nursing handovers between staff took place at the start and end of each shift. These covered details on patients, allocations, the performance of the department and any learning points.

Medical staffing

- There was consultant cover for the department between 8am and 10.30pm Monday to Friday, and 8am and 4pm at the weekend. Consultant staff would be called to the department if needed during the night and there was a specific protocol for this. However, staff acknowledged that this did not meet the recommended 16 hours per day cover recommended for A&E departments by the College of Emergency Medicine (CEM).
- At the time of the inspection, the department had one locum consultant and there were plans for recruitment to raise the department from 6.4 to 7.4 wte consultants. The department did not meet the 10 consultants minimum per department as recommended by the CEM.
- Consultant presence in adult A&E was not in line with the London Quality Standards recommendations and the trust was working with commissioners to address this.
- The trust's information indicated that the number and grade of senior doctors in A&E did not provide 24 hour seven-days-a-week cover at standard 4 level and above at all times. However staff in the department told us that they now adhered to the CEM recommendation of having a standard 4 grade (or more senior) doctor on shift at all times. The department had an establishment of 13 WTE middle grade doctors, at the time of our inspection 1.5 wte posts were vacant.
- The department had 15 junior doctors with plans to increase to 18 WTE doctors in August 2014. The junior doctors we spoke with identified workload and long hours as an issue.

Urgent and emergency services

- Senior staff reported that they had previously had difficulty recruiting middle grades, but as they had now linked the posts with research projects and postgraduate qualifications, this had improved. These low vacancy and sickness rates helped ensure consistent staffing.
- Medical handovers took place at the start and end of each shift where relevant clinical details were passed between staff.
- The paediatric A&E had paediatric emergency medicine trained consultant cover from 8am to 10pm each weekday, and 1pm to 10pm at weekends. There is a resident paediatric consultant between 8.30 pm and 8am. Outside these hours the ward paediatrician was based in the paediatric A&E to provide 24-hour, seven-days-a-week cover via the paediatric department. The trust provided information to state that the paediatric department had submitted a business case for a further consultant because, at present, one weekend in four and for three months of the year, there was no paediatric emergency consultant covering out of hours. This was not in line with national recommendations.

Security

- One security guard was present in the emergency department, 24 hours a day, seven days per week. If security incidents occurred, staff would seek support from a colleague who would be called to the department. Alternatively, support would be sought from the police. Most staff we spoke with stated that the level of security provision met the department's needs.
- In June 2014 a new security policy had been implemented which included the criteria for when patients could be removed from the A&E department.
- Staff told us that that security team was sometimes slow to respond and therefore the police were called for additional support. There had been three incidents in the hospital recently which could have been improved with better communication with staff and patients if security had arrived earlier.

Major incident awareness and training

- The trust had a major incidents policy and procedures. Specific clinical and emergency supplies were available for major incidents and emergencies.
- Staff confirmed that they had received monthly training in what to do in the event of a major incident, for example, what to do in the event of chemical, biological, radiological, nuclear and explosives clinical responses.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

We report on the effectiveness of A&E below. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the A&E department.

There were appropriate pathways for the care and treatment of patients which were in line with national guidelines. There was participation in national audit with good overall outcomes for patients. There was local audit of guidelines but progress had not happened as planned. Staff worked as multidisciplinary teams and services operated seven days a week. Staff received appropriate training and support but nurses who had appropriate qualifications were not able to use their advanced skills.

Evidence-based care and treatment

- The A&E department and the paediatric A&E department used National Institute for Health and Care Excellence (NICE) and CEM guidelines to determine the treatment they provided. There were specific guidelines for areas such as resuscitation, diabetes and non-invasive ventilation which were in line with national guidelines.
- The department was currently taking part in a national research project for the treatment of sepsis and was following the trial clinical guidelines to inform this area of treatment. The department was also taking part in the HALT IT trial which is the use of tranexamic acid for the treatment of gastrointestinal haemorrhage.
- The department used an externally developed and widely used system for triaging patients called the Manchester triage system which is used to manage patients in a methodical way.
- The department had a local audit programme. Of 13 audits identified in the clinical audit plan 2013 – 2015 only three (23%) had been completed or had ongoing

data collection. Five (38%) were planned but not registered and the remainder were in progress but some dates were from 2013. Staff identified other completed audits in areas such as infection control and the quality of x-rays and used the findings to improve practice.

Pain relief

- Records we looked at for adults and children showed that pain scores and reassessments of pain were not always recorded.
- The patients we spoke with in the adult A&E confirmed that they had been given pain medication.
- There were emergency nurse practitioners in the department who were able to administer medicines such as pain relief, using patient group directions. This had reduced people's waiting time for pain relief.

Nutrition and hydration

- Most patients in cubicles in the major's department confirmed that they had been provided with food and drink when appropriate.
- Food and drink were not always offered to patients placed on the benched seating. However, these patients were usually walk-in patients and could obtain their own refreshments from elsewhere in the hospital.

Patient outcomes

- The department participated in a range of national audits including the Pain in Children Audit undertaken in 2011-2012, the Feverish Children National Audit in 2012-2013, the Consultant Sign Off Audit 2012-2013, the Asthma Audit 2009-2010 and the Fractured Neck of Femur Audit 2012-2013. Overall, the department performed better than the England average for Fractured Neck of Femur and Feverish Children audits. The results were more variable in the remainder of the audits where the trust had results both above and below the national medians.
- At the time of the inspection, the A&E staff were routinely testing patients for HIV (with their consent). This testing was done when the patient would not normally have met the criteria for testing and this had resulted in a higher-than-normal proportion of patients being identified as HIV positive.
- Between April and July 2014 the trust's unplanned re-attendance rate was 6.53% which breached the trust's target of 5% although this was better better than the England average of 7%.

Competent staff

- Trainee doctors we spoke with described the clinical supervision they received as "excellent" and praised the access they had to training and education. Junior nurses reported that senior nurses were very approachable.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within adult emergency medicine had rated overall satisfaction with training as similar to other trusts, although local induction and adequate experience were tending towards being worse than other trusts. In paediatric emergency medicine, the trainees also rated their training as similar to other trusts and identified induction and the local teaching as better than other trusts, but handovers were rated as worse than other trusts.
- Staff in the department had access to a range of university-supported specialist education courses to assist with the development of their skills and knowledge.
- There was an ongoing programme of staff training and professional support, including specific training for medical staff on a monthly basis. Morning sessions were used for further training of nurses. Nursing staff were required to complete specific competency booklets in particular topics such as intraveneous drugs and cannulation to ensure they had the skills to deliver safe care.
- Nurses were not able to request x-rays or order some blood tests, despite some staff being suitably qualified to do so; staff said this was a missed opportunity for the department to be able to increase the timeliness of interventions.
- Clinical staff were provided with supervision twice weekly by the department's own practice development nurse at which their performance and practice was discussed.
- Nursing staff had annual appraisals and information submitted by the trust showed that this had taken place for the majority of nursing staff.

Multidisciplinary working

- Senior staff reported that they worked well with other internal departments, including the imaging service and that medical staff from different departments usually attended promptly when requested to do so.

Urgent and emergency services

- Nursing and medical staff stated that they had ready access to the rapid response team, which was a multidisciplinary team, including therapists and community nurses who could discuss and help make arrangements for people's healthcare needs to be met back in the community following discharge.

Seven-day services

- Consultant medical staff were available seven days a week and were on call out of hours. Consultant paediatricians were available 24 hours, seven days a week with out-of-hours support provided by the paediatric department.
- Staff reported they had access to other services out of hours. The therapies team and the rapid response team both worked seven days a week.
- Imaging and pathology services were available out of hours. Routine radiology ran at the weekends with an on-call radiologist on site from 9am to 5pm. Magnetic resonance imaging was available.
- 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 to provide advice to staff on duty, and senior staff on site had access to an emergency drugs cupboard.
- Support from the psychiatry liaison team was available over the weekend.

Are urgent and emergency services caring?

Good

Staff treated patients with dignity and respect, although this could be compromised by the environment in the department. The results of the NHS Friends and Family test were better than the England average. Staff were compassionate and caring and patients spoke very positively about the staff who had looked after them. The environment and service demands created issues around the privacy and dignity of patients. They said they had appropriate information about their care and treatment, although staff were very rushed at times. Emotional support for vulnerable patients was available.

Compassionate care

- We spoke with numerous people in the department who were very positive about the attitude of staff. We observed staff providing care and treatment in a manner that respected people's privacy and dignity.
- The department's response rate to the NHS Friends and Family Test was 21% which was better than the England average. In the most recent response, 67% of patients said they would be "extremely likely" to recommend the department, which was better than the England average. In the comments section, the majority of criticism related to waiting times and the provision of pain relief.
- The CQC Adult Inpatient Survey 2013 showed that the A&E department was better than other trusts in giving patients enough privacy during examinations or treatment.
- Staff stated that the department had been designed for around 60,000 people attending annually, but at the time of the inspection, 112,000 people were attending. Staff told us that this was the reason why people were placed in inappropriate areas such as the benched seating. At times patients were provided with treatment while on the corridor. In this environment it was often very difficult to provide patients with privacy while they were being assessed or treated.
- We observed one patient being treated for a facial injury and had a nose bleed. The patient was in the corridor seating and two nurses were trying to stem the bleeding. The patient's privacy and dignity was compromised during this time. We observed there had been some empty cubicles at this time.

Patient understanding and involvement

- The CQC Adult Inpatient Survey 2013 showed that the A&E department had scored similar to other trusts with regards to patients being given enough information on their condition and treatment. Staff provided detailed explanations to patients about what their care and treatment would involve. However, some patients noted that staff often appeared to be very busy and their interactions with patients could be quite "rushed".
- Overall, people described their care and treatment as "good".

Emotional support

- We observed staff being sensitive to patient needs.

Urgent and emergency services

- Staff supported patients to access emotional support, where necessary and appropriate, through the trust's end of life and specialist palliative care teams, as well as the bereavement team and the chaplaincy department within the hospital.

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

Requires improvement

The A&E services' responsiveness requires improvement. The services were experiencing increasing demand. Staff were working very hard but, at times, were struggling to cope. The flow of patients through the department remained good and the service was meeting the A&E four-hour target. However, times for ambulance handovers, triage and treatment of patients was longer than standard and there were areas of the department that were being used that were inappropriate. Staff were monitoring the reasons for breaches but interim measures had so far been ineffective and trust action was needed. Some IT processes used in the department were a further hindrance to patient flow and to the access to paediatric A&E by young people between the ages of 16 and 18 years.

There was support for vulnerable people with a mental health condition and a learning disability but this was inconsistent. Specific support for patients living with dementia was planned but had not started. There were signs in different languages but not in all areas within the department. Information leaflets were available but these were in English only. Complaints were handled appropriately and there was action and learning as a result. .

Service planning and delivery to meet the needs of local people

- The A&E department was currently divided into an adult A&E, a paediatric A&E and an Urgent Care Centre for adults and children. The trust had started a £10.8 million redevelopment of the A&E department to create more capacity and improve facilities to commence in 2014. The development would address the current issues of overcrowding in both the adult and paediatric waiting rooms, privacy and dignity for patients waiting on benches in the corridor and children with infections who were waiting in the corridor in adult areas, as it was inappropriate to place them in the children's waiting room.
- We were told that the local reconfiguration of services across London would result in the hospital expecting a 65% increase in A&E attendances by 2018/19 because of changes to emergency care pathways and hospital services in London from April 2014.
- Senior staff reported that they considered that these changes were having an impact now although there was no evidence currently to support this view. When the department was under pressure, there were significant delays, such as in the triage process or a lack of beds in the hospital. They could contact the London Ambulance Service and ask for patients to be diverted to other A&E departments. Staff reported that this was now happening more frequently. There had been a 5-10% increase in the number of ambulances attending the department in the past year and an overall increase of 2.5% in terms of the numbers they were treating.
- During our inspection, senior staff told us the process of "intelligence conveying" where ambulance crews divert to other departments that were less busy had not worked appropriately and the department had been under pressure.
- Capacity issues within the department had resulted in the need to use areas such as the ophthalmic assessment room for the treatment of general patients; these areas were not designed for this use. When the waiting area was full, the fracture clinic was used. However, this area was some distance from the main A&E department. All staff recognised the risks of using these areas, and were taking mitigating steps. Staff reported that, to date, there had not been any incidents directly attributable to the placement of patients in clinically inappropriate areas.
- There were specific pathways for the transfer of patients to other hospitals for specialist treatment, including transfer to the local major trauma centre.
- There was a 'winter plan', with increased staffing and cover to deal with the predicted increased attendance in the department over the winter months.

Access and flow

- The trust had achieved the national A&E waiting time target for 95% of attendances in A&E to be admitted,

transferred or discharged within four hours. From April 2013 to March 2014 the trust had achieved 98.3% which was the best performance in England. Performance data for the April to July 2014, demonstrated a slight decrease but the target was still met, and over 95% of patients were seen within four hours.

- The trust performed better than the England average for the percentage of emergency admissions waiting between –four and 12 hours in A&E from the decision to admit to admission.
- The department was better than (below) the England average for the percentage of patients leaving the department without being seen. Between January 2013 and February 2014 this figure was around 2.5%.
- Triage and ambulance handover times were breached during our inspection (see safety)
- People we spoke with often stated that they had been waiting a long time to be initially seen, and that their overall time in the department was lengthy.
- The paediatric A&E saw children and young people up to the age of 16. Young people over the age of 16 could not be entered on the paediatric A&E computer system used by staff. Young people aged 16-18 were asked to attend the adult A&E, unless they were receiving ongoing paediatric specialist care. However, staff in the wider hospital recognised young people as under 18 and they would ask patients to attend paediatric A&E.
- There were informal mechanisms to reduce the length of time that patients would have to wait to be triaged. These included using the GPs on the department to call people in directly. However, these only had limited effect and were not routinely used.
- The department recorded when they 'breached' their target times for the different stages of care and treatment. Between April and June 2014 the most common breaches were delays in the first assessment by a clinician and delays in people receiving specialist assessments. A lack of inpatient and community beds in particular, resulting in delayed transfers was the next most common reason for not meeting target times. Breaches were reviewed by senior staff on a daily basis and reported to staff at handovers. They were also reported as incidents.
- Triage staff reported that having to use two different computer systems at times could obstruct patient flow and was time-consuming. People were booked on to either system depending on whether they were a minor illness/injury or a planned attendance. If they required further investigations they would need to be given an episode number which only one of the systems used. This required reception staff to re-book the patient which could be time-consuming. It could also result in duplicate requests to other professionals being made as both records would not always be checked. Some staff reported that the pathways to some specialities could be improved to speed up the patient flow.
- It was reported by some staff that, at times, some patients, whose GPs were working in the department, had been asked by their GPs to attend the department for primary medical follow-up appointments. These patients would often be seen in between other patients, which impacted on patient flow within the department and was not an appropriate use of A&E resources. We were told this was not an isolated occurrence but happened numerous times each week.
- There was an efficient computer system between the paediatric A&E and the paediatric ward for the requesting of beds which assisted in the transfer of patients between the two areas.
- 19% of attendances resulted in an admission to the hospital in 2013/14, which was better when compared with the national average of 23%.
- Staff reported that there was ready access to the bed management team, including the site managers and said that the team was responsive to their requests.
- Staff said that the critical care team were available for advice and assistance if they needed to contact them.
- Discharge for complex patients was arranged via the rapid response team. This meant that patients were seen in a timely fashion by an appropriate range of professionals to ensure that their needs and ongoing care and treatment would be met in the community.
- Between May 2012 and January 2013, the department reviewed its annual performance in areas, including times taken for specific forms of care and treatment to be provided, staffing and skills mix, appropriate pathways for patients and patient feedback measures. The results of this review showed that the department met the majority of the timeliness targets. Areas for development were specifically identified, these included ambulance handovers and time to triage. The department undertook a follow-up internal review of performance in December 2013, focusing on the timeliness of different aspects of the care and treatment provided. The department results showed that the majority of targets were met.

Urgent and emergency services

Meeting people's individual needs

- Child and adult mental health services were available. There was a mental health management plan specifically for children but not a care pathway for adults. Adult mental health nursing services were available, as were senior psychology and psychiatric services, but these were only available Monday to Friday. Out-of-hours service was provided by another trust. All staff reported that there could sometimes be a delay in senior mental health staff attending to assess patients.
- There was a separate room within the main department specifically for people with mental health needs. This had two exits, comfortable seating, observation windows in the doors and a staff alarm. Patients with a mental health condition often had long waits before being placed in the most suitable location. The trust was working with its commissioners to address this.
- The department had access to an alcohol liaison nurse 9am to 5pm seven days a week. Outside these hours they are able to book an appointment for patients to return the next day to see the alcohol liaison nurse
- There was a learning disability 'passport' in which key information about how the individual should be supported was documented. This information remained with the patient throughout their stay in the hospital. However, this document was not widely used in the department and a significant number of staff were not aware of it.
- There was a plan to introduce a scheme for patients living with dementia whereby former healthcare professionals would be employed to sit with patients and provide support. At the time of our inspection, this scheme had not been introduced and patients were not routinely screened for dementia on the department.
- The service was accessible to people who used wheelchairs.
- The department had made some arrangements for those people who did not speak English. This included a sign on the wall in the admissions area written in numerous languages asking people to identify which language they spoke. This also included details about how to contact the Language Line translation service if needed. However, we did not see these signs in other areas of the department.
- A range of leaflets were available in both the adults and paediatric areas, providing patient advice on a range of issues such as alcohol misuse and sexual health. In the children's A&E there were leaflets about home safety and the care of new-born children.
- The paediatric A&E had toys, a television showing children's programmes, and drawings on the walls to create a child-friendly environment.
- In the paediatric area, parents with potentially infectious children were asked to sit outside the department in the corridor due to a lack of segregated space within the department. As a result, they were exposed to adult patients using the corridor to access the x-ray department.
- Visiting times across the department were not restricted so there were no limitations on the times when friends and family members could visit.

Learning from complaints and concerns

- Senior staff reported that if any negative comments were made via PALS they would be informed of this promptly and steps would be taken to investigate and, if appropriate, take further action.
- The quality of the department's environment was a recurrent theme in the negative feedback given to the Patient Advice and Liaison Services (PALS).
- Senior staff reported that the department would normally get between two and three formal complaints a month.
- There was a complaints policy and procedure which included details about how to record and review complaints. The record received by the department showed that the majority of complaints related to communication and specific clinical issues. The record included details about the actions taken by staff in response to the complaints.

Are urgent and emergency services well-led?

Good

There was a vision for the future of the service. Appropriate governance arrangements were in place to monitor the quality of service provided. Staff spoke positively about the leadership and the culture of the department which was focused on patient safety. The

department was undertaking initiatives to improve the quality of patient care. However, the leadership of the department at busy times to direct care needed to improve.

The senior management team was not always successful in influencing change with the senior team in the trust. The physical plans for the new department had been developed alongside new clinical pathways and protocols, for example for ambulatory care, although not all staff were aware of these plans.

Vision and strategy for this service

- The department had a vision and strategy for its future, which included increasing capacity to meet the current and future service demand due to the reorganisation of services in London as part of 'Shaping a healthier future'.
- The trust had improvement and transformation plans to: rebuild and redesign a larger department; redesign the staffing model to meet needs of new department; and develop an IT strategy to use innovative and efficient ways of working. The plans were awaiting final approval at the time of the inspection.
- The patient pathways and protocols for the new department had been designed at the same time the physical plans as recommended by Department of Health's Health Building Note 15-01: A&E departments – Planning and design guidance. However, not all staff were aware of these design plans or had participated in their development.

Governance, risk management and quality measurement

- The department held monthly clinical effectiveness meetings, routinely attended by the consultants, senior nurses, the professional development nurse and the clinical risk lead. At these meetings incidents were discussed, alongside clinical issues. Following the discussion of incidents, action plans were put in place to prevent recurrences. Minutes of recent clinical effectiveness meetings showed that items discussed included incidents and actions to be taken as well as the results of recent local and national audits, including follow-up actions, which also facilitated staff monitoring the department's performance and being able to respond in a timely fashion when improvements needed to be made.
- Incidents and the actions taken were also discussed at monthly team meetings, in handovers, through emails, by memos in staff pigeonholes, on the shop floor and included in the 'senior house officer (SHO) handbook'. The outcomes of complaint investigations were also discussed.
- A separate, fortnightly clinical indicators meeting was held and attended by a range of clinical and non-clinical staff, where other performance indicators were discussed, such as the time to treatment and time to initial assessment.
- Performance was also reported to the quarterly Medical Directorate Quality and Governance Board. At these meetings, incidents, risks, infection control, morbidity and mortality and clinical performance were discussed.
- The department maintained a risk register which included the details of actions that had been taken to mitigate risks. The issues relating to the capacity of the department and delays in triage and treatment had been entered on to the register. However, few actions had been taken in response and these had had limited effect. The department did not have interim plans to deal with the increasing capacity issues.

Leadership of service

- There were identified lead nurses and doctors on each shift.
- During our inspection we observed consultants and other senior staff members to have a visible presence on the main department providing clinical supervision and ongoing support to staff. However, we noted that, at times when the department was extremely busy, there was a lack of presence or provision of direction by senior staff to organise care and treatment effectively.
- Senior staff stated that they were "team focused" and driven by patient care and not just meeting targets. They said they felt supported by the chief operating officer and the director of operations.
- Senior staff were aware of the performance of the department and where improvements needed to be made. They noted the risks in the departments and provided evidence to show how they had escalated concerns with appropriate senior trust staff.
- Senior staff told us individual staff in the department were taking actions to resolve the triage and ambulance handover delays. Managerial and senior staff in the trust were aware of these and had acknowledged communications, but there was limited support from the most senior staff in the trust to affect the significant change that would resolve the issue in the interim.

Urgent and emergency services

Culture within the service

- The department had a supportive culture, with junior and middle grade doctors and junior nurses that we spoke with describing the support and approachability of the consultants and senior nurses.
- All staff we spoke with described their focus on providing patient-centred care and, while acknowledging pressures on the department, the majority spoke positively of working in A&E.
- However, senior staff noted that staff morale was not good and that staffing and workload issues had had an effect. This information had been highlighted in the NHS Staff Survey 2013 were workload pressures were identified as worse than expected when compared to other trusts.

Public and staff engagement

- Patients and the public were engaged through feedback from the NHS Friends and Family Test and through complaints and concerns. Clinical governance meetings showed patient experience data was reviewed and monitored.
- Senior staff met with their patient representation group on a quarterly basis and feedback from this was presented to staff, including individual members where appropriate.
- Staff told us that senior staff in the trust were approachable and acknowledged concerns but they were frustrated by the lack of effective action taken at senior level.

Innovation, improvement and sustainability

- There was a culture of innovation and improvement in the department with audit and improvement projects being undertaken by staff.
- Senior staff described initiatives that they had taken to provide care and treatment to their patients. This included the pilot and research regarding the routine HIV testing of patients (with their consent), and their trial of a new approach to treating sepsis and the HALT – IT trial.
- The department had a long-term plan for a sustainable future but there was a dearth of interim plans to support staff with current capacity issues.

Medical care (including older people's care)

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

Information about the service

The Chelsea and Westminster Hospital provides cardiology, gastroenterology, respiratory medicine, endocrinology, haematology, oncology and stroke rehabilitation services within the medical division. The trust also provides services to elderly patients and those living with dementia. There is a 44-bed acute assessment unit (AAU) including a level 1 unit and ambulatory care unit (ACU).

We inspected the ambulatory care unit, AAU, neurology and stroke unit (Nell Gwynne Ward), elderly care and dementia unit and general medicine ward (Edgar Horne Ward), respiratory, rheumatology and elderly medicine ward (David Erskine Ward), and gastroenterology and hepatology ward with mixed surgical beds (Rainsford Mowlem Ward) and oncology ward (Ron Johnson Ward).

We spoke with 26 patients, including their family members, 47 staff members, including clinical leads, service managers and matrons, ward staff, therapists, junior doctors and consultants and other non-clinical staff. We observed interactions between patients and staff, considered the environment and looked at care records and attended handovers. We reviewed other documentation from stakeholders and performance information from the trust.

Summary of findings

The medical care services needed to improve safety procedures around safe staffing levels, learning from incidents and using the electronic records. The environment was clean and staff followed the trust policy on infection control. Patients whose condition deteriorated were appropriately escalated and action was taken to ensure harm-free care. There were procedures to provide effective and responsive care. Care was provided in line with national best practice guidelines, however, staff did not always adhere to care pathway protocols and local monitoring of guidelines needed to improve. There was participation in national audits and outcomes were good for patients who had a stroke or heart attack but were worse than other trusts for diabetes care. There were seven-day, consultant-led services.

Patients received compassionate care and were treated with dignity and respect and services were responsive to patient needs. There was specific care for patients living with dementia, for those who had alcohol problems or a mental health condition. There were effective governance arrangements but staff felt unsupported by division and trust management. Public and staff engagement needed to improve.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

The medical division procedures for safety required improvement. Incidents were reported but the learning from incidents was not shared. Nurse staffing levels did not meet safe staffing requirements in the AAU for level 1 patients and there was also high a high use of agency staff on the medical escalation. Staff on the wards were concerned about staffing levels, particularly at night for patients with complex needs. Medical staffing, particularly consultant presence for emergency care, was good.

Patients were appropriately escalated if their condition deteriorated. Equipment was regularly checked, although the cardiac arrest call bell system did not work on the AAU. Medicines were not always stored appropriately. Action was being taken to ensure harm-free care and the incidence of avoidable harms such as falls and pressure ulcers was better (lower) than national average. The environment was visibly clean and staff followed the trust policy on infection control. However, information on safety was not displayed in patient areas. The electronic records systems did not ensure that the safety and wellbeing of patients, as agency staff could not use this to access information; patient information was conveyed at handover or via nurses which could cause delays or missed actions for care and treatment. Staff had good knowledge about safeguarding patients.

Incidents

- Between April 2013 and March 2014 the medical division reported 28 serious incidents through the National Reporting and Learning System (NRLS). Of these, grade 3 and 4 pressure ulcers accounted for the highest number of incidents.
- Staff we spoke with stated they were encouraged to report incidents. Nursing staff knew how to report an incident and said they had done so frequently. Nursing staff told us they received feedback on the incidents they had reported. Minutes of monthly ward meetings confirmed that the themes of incidents were fed back to staff.
- The junior doctors told us they were encouraged to report incidents but did not always receive feedback from investigation findings.
- Incidents reviewed during our inspection demonstrated that investigations and root cause analyses took place and action plans were developed to reduce the risk of a similar incident recurring.
- Mortality and morbidity meetings were run by a junior doctor and consultant who set the agenda. They also included working issues such as liaison with social workers.

Safety thermometer

- The division used the NHS Safety Thermometer, a monthly snapshot audit of the prevalence of avoidable harms, including new pressure ulcers, catheter-related urinary tract infections (UTIs), venous thromboembolism (VTE or blood clots) and falls, to monitor performance in these areas.
- Between May 2013 and May 2014, the hospital division had a lower number of falls, pressure ulcers, new UTIs, and new VTEs than the England average.
- Nursing staff on the medical wards told us they participated in monthly Safety Thermometer audits, however, the audit results were not shared with the staff.
- The hospital used a pressure ulcer care bundle on the AAU to improve assessment on admission and this had reduced the incidence of pressure ulcers and was now being rolled out across the trust.
- Patients, visitors and staff did not have easy access to Safety Thermometer information, because it was not displayed with in the wards.

Cleanliness, infection control and hygiene

- All of the wards we visited were visibly clean and cleaning schedules were clearly displayed on the wards.
- Staff followed the trust infection control policy. We observed that staff regularly washed their hands in between attending to patients, used personal protective equipment such as gloves and aprons, and adhered to the trust's 'bare below the elbows' policy.
- There were isolation procedures and we observed these being used appropriately.
- Data provided by the trust showed that 78% of the staff in the medical directorate had completed hand hygiene training in the last 12 months.
- Hand hygiene gel was available at the entrance to every ward, along corridors, and at the bottom of each patient's bed.
- Hand hygiene audits were carried out monthly which indicated a 95% level of compliance with procedures by staff.

- Patients admitted to the hospital were screened for MRSA. The MRSA screening audit showed that 94.7% of the elective admissions patients and 98.5% of the emergency admissions patients had been screened for MRSA in 2013/14 against the trust's target of 95%.
- During the unannounced visit some medical wards had waste items that had not been disposed of appropriately.

Environment and equipment

- We observed that each ward area had sufficient moving and handling equipment to enable patients to be cared for safely.
- Equipment was maintained and checked regularly to ensure it continued to be safe to use .The equipment was clearly labelled stating the date when the next service was due.
- There were daily checks of resuscitation equipment on all the medical wards and these checks were documented.
- The cardiac arrest call bell system in the AAU did not link to the nurses' station panel and we were told by staff that the alarm was inaudible from the other side of the ward. This risk was noted on the medical directorate risk register in March 2013. Staff told us facilities were working on resolving this issue. However, at the time of our inspection no mitigating action had been implemented to address this risk.

Medicines

- In the AAU, the medicine refrigerator was unlocked and the refrigerator temperature had only been recorded for three of the first nine days in July 2014.
- The AAU had a pharmacist seven days a week to review the medicines for new patients. The other medical wards had a pharmacist visiting Monday to Friday; outside these hours the on-call pharmacist could be contacted.
- We saw that the pharmacist completed the medicines management section on the electronic prescription. They also completed administration records for every patient to confirm medicines reconciliation had occurred.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. Controlled drugs were managed and stored appropriately.
- Agency nurses did not have access to the electronic prescription and administration record. It was printed off for them so they could sign these records when they gave medicines. The electronic system was updated by a permanent member of staff who could sign in to the system. This arrangement resulted in delays in the electronic record being updated. The potential risk to patients could be that patients either missed doses of medicines, received duplicate doses of medicine or did not receive medicines when required as agency staff could not access the medicine records. On Nell Gwynne Ward at 10am we saw the electronic medicines records for patients being cared for by an agency nurse had not been updated to confirm medication had been given from the 8am medicine round.

Records

- Records were kept in both paper and electronic formats and all healthcare professionals documented in the same record. Patients' records were appropriately completed, were legible with dates, times and designation of the person documenting indicated.
- The nurses completed risk assessments electronically. The pressure ulcer risk assessments, nutrition risk assessments, moving and handling risk assessments and falls risk assessments which we looked at were fully completed and reviewed on a weekly basis.
- Risk assessment paper forms were not always completed or easily accessible. For example, staff told us that one patient was at risk of falls but they did not have a falls risk assessment completed. Another patient had a risk assessment following a fall but this was available only in the electronic version and not accessible to agency staff who were unable to access this system.
- Staff expressed concerns that there were no paper copies of care plans at the patients' bedside and not all records were transferred into the system. For example, medical staff were prescribing medicines electronically without consulting patients' monitoring charts at the bedside.
- Care plans were also not accessible to agency staff as these were only in electronic form; they had to rely on verbal handovers of this information. This meant that agency staff were not always aware of patients' specific needs.
- Patient information and records were stored securely on all wards.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent was appropriately sought and documented. We saw that, where patients did not have the capacity to give consent to their treatment, the Mental Capacity Act 2005 was appropriately implemented. This was particularly observed on Edgar Horne Ward for patients who had been diagnosed as living with dementia.
- We observed that patients who did not have the capacity to consent and needed a capacity assessment were identified during the handover on Nell Gwynne Ward and appropriate referrals were made.
- The trust had recently undertaken specific training on the Act's associated deprivation of liberty safeguards for medical staff. We were not provided with evidence to demonstrate how many doctors had completed this training.

Safeguarding

- There were safeguarding policies and procedures and staff were aware of these.
- Staff told us they had attended training in adult and child safeguarding. Information provided by the trust indicated that 100% of staff working on the medical directorate were up to date with level 1 adult safeguarding training and 87% with level 1 children's safeguarding.
- Staff were able to describe situations in which they would raise a safeguarding concern and how they would escalate any concerns. A member of the nursing staff working on the Edgar Horne Ward was able to give examples of when they had used the trust's safeguarding policy to raise concerns.

Mandatory training

- Mandatory training covered a range of topics, including fire safety, health and safety, basic life support, safeguarding, manual handling, hand hygiene and information governance training. Staff told us they were up to date with their mandatory training.
- Data provided by the trust showed that 79% of staff had completed mandatory training as of June 2014.
- There was an induction programme for all new staff and those who had attended this programme felt it met their needs. Data provided by the trust in June 2014 indicated that only 19% of staff had had a local induction. Junior doctors identified that there was often not enough time to complete the online induction training.

Assessing and responding to patient risk

- Risk assessments were undertaken in areas such as VTEs, falls, malnutrition and pressure sores. These were documented in the patients' records and included actions to mitigate the risks identified.
- The medical wards and AAU used the national early warning score (NEWS). Medical and nursing staff were aware of the appropriate action to be taken if patients scored higher than expected. The completed NEWS charts we looked at showed that staff had escalated patients appropriately, and repeat observations were taken within the necessary timeframes.
- Situation, Background, Assessment, Response labels were used in patient records to easily identify deteriorating patients.
- Staff felt well-supported by doctors when a patient's deterioration was severe and resulted in an emergency.
- There was a critical care outreach team which supported ward staff in managing deteriorating patients. Staff across all wards stated that this service was responsive and supportive for them.
- During our inspection on Nell Gwynne Ward, a patient was being nursed in the day room as there had been a leak above his bed on the ward. This area had a piano, plants and intravenous fluids but there was no oxygen or suction and a risk assessment had not been completed to assess if it was appropriate for the patient to be moved to this area, as there were other patients on the ward with fewer dependency needs.

Nursing staffing

- Nursing staffing levels had been reviewed and assessed using the national Safer Nursing Care Tool. The division had carried out an acuity and dependency audit in May 2014. However, nursing staff on the medical wards told us the trust took a 'one size fits all' approach in determining staffing levels and the complexity of patients' needs were not taken into consideration. For example, patients living with stroke needed a higher level of care and staff felt this was not taken into consideration.
- The lead nurse told us the vacancy rate for nursing staff across medical division was 15%.
- Nursing staff on AAU, Nell Gwynne, David Erskine, Edgar Horne and Rainsford Mowlem wards told us they often felt understaffed and pressured. While staffing vacancies

were often filled using the agency staff, their skills and experience varied and it was not always possible to employ the same agency staff who were familiar with the ward.

- The level 1 area on AAU was used for acutely ill patients who needed close monitoring. These patients had complex needs and often required a non-invasive mode of ventilation. The average nursing to patient staffing ratio in this unit was one to four. We observed this during inspection. This was below the staffing level recommended by the Royal College of Nursing of one to two for patients with moderate dependency. Staff told us this ratio did not meet patients' needs and was sometimes "unsafe" due to the complexity of the patients in this unit. During our unannounced inspection the ratio was 1:3 and two patients required non invasive ventilation. Staff told us that a the fourth bed would open at any time and no extra staff would be available.
- The staffing rota for month of June 2014 showed us that on Nell Gwynne, David Erskine and Edgar Horne wards, staffing levels were as planned (with two registered nurses and four healthcare assistants for 24 patient beds) and sometimes additional staff were on duty. However, staff on the wards told us they were concerned about staffing levels because of the complexity of patients with stroke, patients living with dementia and elderly care patients.
- The escalation capacity unit, which operated when there was an increase in demand for patient beds, had a capacity of 10 beds. Nursing staff told us this unit was unfunded and there was no additional workforce to staff these beds. Therefore, staff from other areas of the medical division and a high number of agency staff were used to staff this area. Staff felt this was potentially "unsafe" practice particularly as agency staff did not have access to the electronic patient records system.
- Nurse staffing was recognised as a priority for the trust as a whole and recruitment was undertaken in 2014 for additional nurses. The divisional leads told us the trust had recruited 90 whole time equivalent nurses across the medicine and surgery division.
- The nursing handovers which we observed included a discussion of each patient and their progress and any potential concerns.

Medical staffing

- There was a consultant presence on the AAU from 8am to 8pm seven days a week. There was one dedicated consultant for the level 1 area from 9am to 5pm. There was a consultant for 'post take' emergency care for patients who have just been admitted.
- Patients admitted at night were either seen by the on-call consultant or the next morning by the consultant in charge of their care.
- Junior doctors felt there was an adequate number of junior doctors on the wards out of hours and that consultants were contactable by phone if they needed any support by both the middle grade doctors and consultants. However, they identified that rotas were frequently changed at short notice, as gaps in the workforce were not anticipated, and this did not help to plan time.
- Consultant ward rounds on the AAU took place twice a day. During the day, all new patients were seen by a consultant within one hour following their admission.
- On all the other medical wards, patients were seen by a consultant twice a week. In addition, over the weekend, the on-call consultant saw all new patients and acutely ill patients.
- Medical patients who were on surgical wards were seen by medical consultants and medical doctors. There was a dedicated team for medical outlier patients (those not on a medical ward).
- The medical handover with the 'hospital at night team' we observed was led by the clinical site manager and staff discussed each patient, their progress and any potential concerns.

Major incident awareness and training

- Staff we spoke to were aware of the procedure for managing major incidents such as winter pressure on capacity and fire safety incidents.
- Emergency plans and evacuation procedures were in place. Staff were trained in how to respond to major incidents.

Are medical care services effective?

Good

Care was provided in line with national best practice guidelines, however, staff did not always adhere to care

pathway protocols. Clinical audit was being undertaken and there was good participation in national audit. There were good outcomes demonstrated for patients who had had a stroke or heart attack but worse outcomes for diabetes care when compared to the national average. Local audit programmes needed to improve. There were arrangements for ensuring patients received timely pain relief. Patients at risk of malnutrition or dehydration were risk assessed and referred to a dietician for assessment. Referrals to speech and language therapists were made within expected timescales. Staff had access to specialist training but clinical supervision was not embedded. Junior doctors had rated the training as worse than other trusts in general medicine but similar to other trusts in the medical subspecialties. Multidisciplinary working was evident. The trust was working towards providing seven-day services and this had been developed in emergency care.

Evidence-based care and treatment

- The medical division adhered to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients. Local policies, such as the pressure ulcer prevention and management policy, were written in line with national guidelines and staff we spoke with were aware of these policies. Of the 896 guidelines in the trust 69 were listed under medicine and 12 of these required review
- Compliance with NICE guidance was assessed but areas where there was partial compliance had not been updated for some time. For example, the last update on the asthma guidelines was in April 2013
- There were integrated care pathways based on NICE guidance for stroke patients. There were specific pathways and protocols for a range of conditions, including diabetic ketoacidosis and community acquired pneumonia. The trust had a pathway for patients with sepsis (a sepsis care bundle) to enable early recognition of the sick person and prompt treatment and clinical stabilisation.
- The medical staff we spoke with were aware of these pathways but did not always adhere to the protocols, for example for community acquired pneumonia. The sepsis and diabetic ketoacidosis care pathways were appropriately used by the staff on the AAU.
- There was a local audit programme. There were approximately 72 audit projects in the clinical audit plan 2013–2015. Of these, 20 had been completed and the remainder were still in progress or being planned.

Pain relief

- We observed nurses and junior doctors monitoring the pain levels of patients and recording the information. Pain levels were scored using the NEWS chart.
- Ward staff could access support from the hospital's pain team when needed. For example, staff on Edgar Horne Ward told us the pain team were very approachable and those patients on the ward experiencing a sickle cell crisis were always referred to the pain team and were seen regularly.
- Pain newsletters were visible on all the wards. These newsletters shared learning about pain management and ward staff told us they found these newsletters helpful.
- Patients we spoke with told us they were given pain relief when they needed it.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded on all the medical wards. We observed that fluid balance charts were used to monitor patients' hydration status. Edgar Horne, Nell Gwynne and David Erskine wards had detailed fluid balance charts that were totalled accurately, informing clinical decisions.
- All patients we observed had drinks within their reach. We observed care support staff checked that regular drinks were taken where required.
- The patients we spoke with told us they were always given choices of food and snacks. However, they provided mixed views about the quality and variety of the food available.
- Stroke patients' swallowing was assessed to ensure that nutrition and hydration was provided through an appropriate route.
- A red and blue tray system was used on the AAU and all medical wards to identify patients who needed help with eating and drinking (blue for partial assistance and red for full assistance). We observed on David Erskine Ward that this support was given appropriately to a patient who was given special cutlery and staff had cut up some of their lunch in to manageable pieces.
- The therapists on Edgar Horne Ward had introduced a 'lunching club' for patients living with dementia. The idea was to have lunch together in the day room so that patients could socialise during the mealtime. Staff told us they had found this activity useful, however, they could not always accommodate it due to staffing shortages.

Medical care (including older people's care)

Patient outcomes

- The hospital's overall mortality rates were lower than expected and there were no mortality outliers (outside the expected range) for this service.
- The medical directorate participated in all national clinical audits it was eligible for.
- The trust scored above the national average in most of the indicators in the National Sentinel Stroke Audit between October and December 2013.The trust performed well in the scanning and discharge processes for stroke patients. The trust had performed in line with the national average in multidisciplinary team working, occupational therapy input and specialist assessments.
- The trust's performance in 2012 and 2013 was better than the national average in the Myocardial Ischaemia National Audit Project (MINAP), a national clinical audit of the management of heart attack.
- The trust's performance in the National Diabetes Inpatient Audit (NaDIA) 2013 was worse than expected for most of the 21 indicators, which included medication, assessment within 24 hours, multidisciplinary working and staff knowledge. Five indicators were better than expected when compared to England average. These were: for managing errors, fewer patients being admitted with foot disease, suitable meals, and staff awareness of patients while on the wards.

Competent staff

- Clinical staff told us they had regular annual appraisals but did not receive formal supervision. Staff, however, were supervised clinically and felt that handovers and ward rounds provided them with learning opportunities.
- As of July 2014, 80% of staff in the medical directorate had completed an appraisal.
- Staff had access to specific training to ensure they were able to meet the needs of the patients they delivered care to. For example, staff on Nell Gwynne Ward had completed stroke-specific training and had been assessed against specific stroke competencies based on the London Stroke Nurse Competency Workbook to demonstrate they were competent in providing this care.
- Edgar Horne Ward had an input from a dementia specialist nurse. Staff on this ward had attended a dementia study day. The trust had plans to train a number of staff to become dementia champions by April 2015.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within medical specialities rated their overall satisfaction with training as similar to other trusts. Induction, access to education resources and feedback in cardiology were better than other trusts as was adequate experience in respiratory medicine and workload and study leave in neurology. Induction in respiratory medicine was worse than other trusts. Trainees in general medicine rated their overall satisfaction as worse than other trusts. Handover, adequate experience, access to educational resources and study leave were all worse than other trusts.
- Trainee doctors we spoke to said they were well-supported and the hospital was a safe place to work. Teaching was supported and changes to guidelines were cascaded.

Multidisciplinary working

- Throughout our inspection we saw evidence of multidisciplinary team working in the ward areas.
- Junior doctors and nursing staff told us nurses and doctors worked well together within the medical speciality. We saw evidence of this on the AAU and on the ACU.
- Multidisciplinary team meetings took place on Nell Gwynne Ward once a week to discuss current and new patients. The meetings we attended included various health professionals such as nurses, physiotherapist, occupational therapist, speech and language therapist and discharge liaison team. The discussions at this meeting were patient-centred and action plans were completed following the discussions.
- Monthly Cancer Board meetings attended by doctors, nurses, therapists, and pharmacist were held on Ron Johnson Ward to discuss patient reviews, audit reviews and mortality and morbidity reviews. Speech and language therapists attended Nell Gwynne Ward regularly and patients were also referred to clinical psychologists if necessary.
- Patients' records showed they were referred, assessed and reviewed by physiotherapists, dieticians and the pain team.
- There was involvement of the critical care outreach team in providing advice and support for deteriorating patients on medical wards.
- There was dedicated pharmacy support on all the wards we visited.

Medical care (including older people's care)

- The staff on the ambulatory care unit met weekly with GPs, community nurses and microbiologists to monitor the progress of patients who had been treated in the unit but were now at home.

Seven-day services

- There was a consultant presence on the AAU from 8am to 8pm seven days a week. Patients who were admitted at night were either seen by the on-call consultant or by medical consultants the next morning. There were plans to increase consultant presence to 14 hours.
- On all the other wards we visited, consultant ward rounds took place twice a week. The patients were seen by junior doctors on the other days.
- All new and deteriorating patients were seen by the on-call consultant at night and over the weekends.
- Staff told us consultants were on call out of hours and were accessible when required.
- Physiotherapy services were only available for patients with respiratory conditions and on the AAU over the weekends.
- Routine radiology ran at the weekends with an on-call radiologist on site from 9am to 5pm. Magnetic resonance imaging was available
- 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 to provide advice to staff on duty.
- Support from the psychiatry liaison team was available over the weekend.

Are medical care services caring?

Good

Patients received compassionate care and were treated with dignity and respect. Staff focused on the needs of patients and improving services for patients. Patients and relatives we spoke with said they felt involved in their care and were complimentary and full of praise for the staff looking after them.

Compassionate care

- Results of the NHS Friends and Family Test were displayed on every ward, and there were posters displayed encouraging patients to provide feedback so that the care provided could be improved. Overall, these showed satisfaction with the service provided. However, of six medical wards, only Nell Gwynne and Ron Johnson scored higher than the England average score. The AAU, David Erskine, Rainsford Mowlam and Edgar Horne wards all scored below the England average. The results included the detailed action that wards were taking to address any issues raised from the test.
- The CQC Adult Inpatient Survey (2013) showed that the trust performed about the same as other trusts for all areas of questioning, except for one inpatient question identified under 'nurses'. For the questions 'Did nurses talk in front of you as if you weren't there?' the trust performed worse (in the bottom 20%) than other trusts.
- Throughout our inspection, we observed patients being treated with compassion, dignity and respect. We saw that call bells were answered in a timely manner. Curtains were drawn and privacy was respected when staff were supporting patients with personal care.
- The patients and relatives we spoke with were pleased with the care provided. They told us that doctors, nurses and healthcare assistants were caring, compassionate and responded quickly to their needs.
- Comfort rounds or intentional rounding (where nurses and healthcare assistants regularly checked on patients every two hours) were undertaken. Staff did various checks on patients such as comfort checks, hydration, nutrition, continence, equipment, positioning, mobility and skin survey. Patient records we looked at on Edgar Horne and Nell Gwynne wards, showed comfort rounds were done for the patients every two hours.

Patient understanding and involvement

- Patients and relatives we spoke with stated they felt involved in their care. They had been given the opportunity to speak with their allocated consultant.
- Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.

Emotional support

- On Edgar Horne Ward the hospital had introduced a 'Memory Lane' service. This service offered a piano in the day room and outside bay areas for patients to play.

There was also a 'sonos' music system which allowed different music to be played in different bays and side rooms. Staff and patients said it helped to elevate mood and patient interaction.
- On Nell Gwynne Ward a therapy healing dog was brought once a week. We saw three patients interacting with the therapy dog and having an enjoyable experience.

Are medical care services responsive?

Good

Medical services were responsive to patients' needs. The AAU and ambulatory care unit had contributed to the trust's ability to manage the pressures on beds due to an increasing demand. Patients on the AAU had continuity of care and most patients attending ambulatory care received treatment and were able to return home on the same day. Most patients received care on the same ward and the number of patient moves had decreased. There was a dedicated team to follow up medical outlier patients.

The trust was working with partners to improve the coordination, safety and timely discharge of patients, although patients felt that their discharge from the wards was "rushed". Patients sometimes had long waits in the discharge lounge for transport and medication. There was support for people in vulnerable circumstances, such as people living with dementia, who had alcohol problems or mental health problems. There was flexibility with visiting hours for carers of patients with mental health disorders.

Service planning and delivery to meet the needs of local people

- The 44-bed medical assessment unit with nine level 1 bed for patients who required close observation was open 24 hours a day, seven days a week. Staff told us the unit was always busy and helped to reduce pressures in the A&E department.
- The ambulatory care unit aimed to prevent avoidable inpatient admissions and manage the increasing numbers of patients needing emergency admission, with referrals from a range of sources including directly from GPs. There were consultant-led assessment clinics and a range of services were provided, including intravenous antibiotic treatment for patients who required treatment but not admission to hospital.
- There was a 10-bed escalation capacity unit which opened when there was an increase in demand for patient beds. Staff from other areas of the medicine division and agency staff were used to work in this area.
- Acute medical patients were placed with patients living with dementia on Edgar Horne Ward. Staff told us this was not the most appropriate setting for patients living with dementia, especially when there were several acutely ill patients on the ward who were often disturbed by the noise level.

Access and flow

- There was a trust-wide operational group who were responsible for the coordination of capacity and bed availability. They liaised daily with individual wards to establish the numbers of patients on the ward and determine how many beds were available for new patients. They also discussed any action that was required when wards were at full capacity.
- There was a bed management system that aimed to ensure patients' needs were met when there was an increased demand on beds and the patient could not be placed on a medical ward and therefore cared for on the surgical ward. Senior nursing staff on all the medical wards and the AAU attended daily bed management meetings. However, a bed management meeting we observed had lower than expected attendance from divisions, despite reported bed pressures on the day.
- There were six medical outliers at the time of inspection (patients placed on wards other than one required by their medical condition). There was a team of dedicated consultant and junior doctors to assess and follow up medical outlier patients.
- A patient transfer checklist was completed for all patients transferred internally to another ward. This information was filed in the patients' notes. We saw a checklist that had been completed, including information to ensure that patients continued to receive appropriate care and minimise any risks.
- In June 2014, the division was achieving the 18-week referral-to-treatment time (RTT) target for around 90% of patients. This was the same as the national standard of 90%. Dermatology was the only specialty not meeting the target. The trust was achieving the 62-day waiting time for patients to be seen and treated for cancer, and diagnostic waiting times were within expected targets.
- Staff on the medical wards worked in close liaison with the early supported discharge team and social services.

Therapy staff told us there was poor communication between ward staff and district nurses which had led to delays in discharges on several occasions. However, action had not been taken to address these issues

- Patients we spoke with felt that they were sometimes rushed to go to the discharge lounge from the wards and had to wait for a long time for transport to arrive or for medication. Some of the patients had been waiting in the discharge lounge for more than two hours after leaving the ward. Key performance indicators for the pharmacy department showed the average waiting time for a patient discharge prescription was 78 minutes against a target of 60 minutes.
- We observed that patients in the discharge lounge were regularly checked by the nurses, ensuring comfort, nutrition and offering them meals.
- Staff told us that discharge summaries were usually completed before patients were discharged. These summaries were sent out electronically to patients' GPs within 48 hours of discharge.

Meeting people's individual needs

- A dementia care pathway and care bundle had been developed with a neighbouring mental health trust and was used for treatment of people living with dementia. The bi-monthly dementia steering group, attended by the memory assessment service, social services, Age UK and Healthwatch, had led to the development of an integrated care approach for the treatment of people living with dementia.
- There was support available for patients living with dementia. The trust had recently introduced a 'This is me' booklet for patients living with dementia, developed by the Alzheimer's Society to alert and inform staff to identify and meet the needs of these patients. On Edgar Horne Ward we saw that patients living with dementia had the booklet and it was appropriately completed.
- There was a dementia specialist nurse on Edgar Horne Ward and all staff had completed basic dementia awareness training. The trust had developed a 'dementia care bundle' which helped staff to meet the needs of these patients. A dementia shortcut button on the intranet had recently been introduced, with the aim of simplifying information regarding patient assessments and managing behaviours for staff and had local support groups. It also included details of local support groups.
- On the Edgar Horne Ward a 'butterfly' system was used to identify people living with dementia. However, this system was not used on any of the other medical wards which also cared for people living with dementia.
- Two side rooms were designed for patients with mental health conditions on the AAU. These rooms had mirrors installed which improved observation views for staff. Rooms also had special door handles and shatter-proof glass. We observed one of these rooms being used during our inspection and saw that the patient was supported by two mental health nurses at all times.
- Staff on the AAU told us that visiting hours for carers of patients with mental health problem were flexible. Carers could stay overnight if that was beneficial to the patients and if it was appropriate.
- Patients with drug and alcohol addictions had input from an alcohol liaison nurse Monday to Friday between 9am to 5pm.The trust did not employ permanent specialist mental health nurses but had 45 bank (overtime) mental health nurses employed as necessary. Staff told us that it was easy to request support from a mental health nurse if needed.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. If they were unable to deal with concerns directly, staff directed patients to the Patient Advice and Liaison Service (PALS) which offered advice on how to make a formal complaint.
- Where patient experiences were identified as being poor, action was taken to improve the situation. For example, staff on Edgar Horne Ward explained how they had responded to a higher-than-expected number of patient falls. Patients assessed as being at high risk of falls were given a yellow identity band, a falls risk assessment was developed and patients were offered non-slip socks.
- Staff told us that ward sisters investigated complaints and gave them feedback about complaints they were involved in.
- Patients we spoke with felt they would know how to complain to the hospital if they needed to.

Medical care (including older people's care)

Are medical care services well-led?

Requires improvement

The strategy for the directorate was to improve the patient journey within the hospital and to improve the seven-day working service across the division. There was a governance structure to manage risk and quality. Staff felt supported by their ward and line managers. Staff were passionate to deliver quality care and an excellent patient experience but said that the visibility of managers in the medical division was poor and that the divisional leads were not always aware of the risks and challenges faced by staff and patients on their wards. Nursing staff did not feel their concerns were acknowledged or addressed by trust management. Medical staff commented on a "tick box" approach by the trust to audit and to seven-day working. Public and staff engagement needed to improve. Innovation was being encouraged and supported but this was being affected by staff shortages.

Vision and strategy for this service

- The trust's vision was well-recognised and owned by staff.
- The division did not have a long-term strategy but priorities were identified around improving the services across the medical division. The medical leads told us their priorities included improving the patient journey and treating patients in the most appropriate area and preventing inappropriate admissions to the AAU. They were also committed to making stronger links with community services to ensure appropriate care was provided on discharge, especially for patients with long-term conditions and complex frail elderly patients. The staff we spoke with were not aware of the division's strategy.
- The medical leads stated they aimed to improve the seven-day working service across the medical division. However, there was uncertainty about level of input needed from consultants to reshape this service.

Governance, risk management and quality measurement

- Some wards had regular team meetings but others did not. The Stroke ward organised 'away days' at which performance issues, concerns and complaints were discussed. Where staff were unable to attend ward meetings, steps were taken to communicate key messages to them.
- The trust clinical governance team collated data and produced reports for the division each quarter. Included in this report was a review of incidents, review of the risk register, general patient safety information, infection control review, and information about clinical and non-clinical claims, training, and morbidity and mortality reviews.
- The division had a quality dashboard for each service and this was available on the trust's intranet. It showed how the services performed against quality and performance targets. Members of staff told us that these were discussed at team meetings. The ward areas did not have any visible information about the quality dashboard, except for the safe staffing levels which were displayed at the entrance of each ward.
- The unit had quarterly clinical governance meetings where the results from clinical audit, incidents, complaints and patient feedback were shared with staff. Staff explained how this had an impact on patient care. For example, nursing staff on the AAU were able to explain about the 'Push Off the Pressure' campaign introduced by the trust in response to higher number of pressure ulcer incidents. However, systems, such as learning from incidents and the clinical audit programme, needed further development.
- The division had a risk register which included areas of risk identified in the medicine directorate. These risks were documented and a record was maintained of the action being taken to reduce the level of risk. Not all mitigating actions were clearly defined or had been taken in response to concerns and the timeliness of action was not clear.

Leadership of service

- Ward staff felt well-supported by their ward sisters and matrons and told us they could raise concerns with them. However, they told us that the divisional nursing and director of nursing were not visible, responsive or always aware of the risks and challenges faced by ward staff. Staff told us they felt unsupported and did not feel their concerns were acknowledged or addressed by the trust management.
- Junior doctors felt well-supported by consultants and senior colleagues. Medical staff felt supported by the

medical leadership in the division and the trust. They had noted, however, that certain actions such as NICE audits and seven-day consultant cover was viewed as a 'tick box' exercise rather than a way of improving the service.

- The student nurses told us they felt supported on the ward and received supervision training from the senior staff. They told us consultants were accessible and approachable.

Culture within the service

- Ward managers and ward sisters were passionate about improving services for patients and providing a high-quality service. However, staff across the division felt the trust's senior managers were not always receptive to the concerns, such as staffing levels, they raised and this sometimes put patient care at risk.
- Staff spoke positively about the high-quality care and services they provided for patients and were proud to work for the trust. They described the trust as a good place to work and as having an open culture.

Public and staff engagement

- Patients were engaged through feedback from the NHS Friends and Family Test and complaints and concerns. Clinical governance meetings showed that patient experience data was reviewed and monitored. There were no other forms of patient and public engagement.
- Staff engagement around the division's intended strategy had not occurred. Staff told us there was not a consistent method of engagement in the division. Some wards had regular team meetings but others did not.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members. Pharmacy staff told us they had developed a pocket guide and electronic tool for VTE assessments which the staff had found beneficial.
- On Nell Gwynne and Edgar Horne wards, a computer programme was introduced for patients living with dementia and other elderly patients. This software was based on reminiscence therapy. Staff told us it could be a good resource for patient engagement but it was currently not being used due to staffing shortages.

Surgery

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

Information about the service

Chelsea and Westminster Hospital provides emergency and elective inpatient surgery services and a range of specialities, including general surgery, trauma and orthopaedic, ophthalmology, plastic surgery and bariatric (weight loss) surgery. There are four surgical wards, a surgical admissions lounge, and day surgical unit. There are seven theatres in the main theatre complex, one of which is specifically for burns patients. The four paediatric theatres are reported on in the section of this report on services for children and young people. The private ward also provides care for patients undergoing surgical procedures.

We visited the four surgical wards, day surgery unit and the private ward, the clinical sterile services department (CSSD), the radiology department, outpatients and theatre and recovery areas. We talked with 21 patients, one relative and 35 members of staff. These included nursing staff, junior and senior doctors and managers. We observed care and treatment and looked at 10 care records. We reviewed other documentation from stakeholders, including performance information provided by the trust.

Summary of findings

The surgery division required better procedures to provide safe, effective and responsive care. The hospital's surgical safety checklist was not fully completed for all patients and needed to be updated to improve compliance with the 'Five steps to safer surgery' procedures. There needed to be better learning from incidents and improved use of the electronic records. Equipment was available and appropriately checked but standards to manage medicines were not met. Infection control practices were followed and overall infection rates were within expected levels. Policies and procedures were accessible to staff on the trust intranet but not all staff were aware of these, and many had not been reviewed to ensure they were in accordance with evidence-based national guidelines. Practice was not appropriately monitored to demonstrate adherence to standards.

Patients received compassionate care and we saw that they were treated with dignity and respect. Patients and relatives we spoke with said they felt involved in their care. National waiting times, however for patients waiting for surgery were not being met and some patients were waiting longer than 18 weeks. There was strong, supportive leadership at ward and matron level but the service did not have an appropriate governance structure to manage risks. Staff reported that the trust

Surgery

had, at times, a 'blame' rather than a learning culture following incidents. Public and staff engagement needed to improve. There was innovation in some areas and outstanding practice in the burns unit.

Are surgery services safe?

Requires improvement

Surgery services required better procedures to support safe care. Medicines were not stored safely. There was access to appropriate equipment to provide safe care and treatment. Surgery staff told us they were encouraged to report any incidents. However, there was no consistent way that feedback and learning from incidents took place. The incidence of pressure ulcers was high but we did not see any local action plans around this or learning from other divisions in the hospital. Infections following fractured neck of femur and following hip replacement were lower than national average. The environment was visibly clean and staff followed the trust policy on infection control.

The hospital's surgical safety checklist – based on the World Health Organization (WHO) checklist – was not fully completed for all patients and needed to be updated to improve compliance with the 'Five steps to safer surgery' procedures. Patients were appropriately escalated if their condition deteriorated. The electronic records systems did not ensure that the safety and wellbeing of patients as agency staff could not use this to access information; information was conveyed at handover or via nurses, which could cause delays or missed actions to care and treatment. Staff did not have sufficient knowledge of the Mental Capacity Act 2005. Medical staffing was appropriate and there was good emergency cover but there was a high number of nurse vacancies. Agency staff were being used but some agency personnel were not given an appropriate induction. Information on patient safety was not displayed in patient areas.

Incidents

- Staff told us they reported incidents via the trust's paper-based incident reporting system. All staff we spoke with said that they were encouraged to report incidents. However, there was no consistent way for staff to receive feedback about incidents. Some staff said they received no feedback about the incidents they reported. Other staff reported that discussions about incidents were held during handover periods.

- Moderate incidents, serious incidents and Never Events (incidents of serious harm that are largely preventable if measures have been implemented by healthcare providers) were reviewed by the surgical quality group which met every three months.
- There were two Never Events in the surgical division between April 2013 and March 2014. The Never Events, (wrong site surgery and a retained swab that related to the paediatric surgery department), are reported in the section of this report on services for children and young people.
- The trust had had a serious near miss event 18 months ago related to the incorrect attachment of an infusion. We were told by the surgical division management team that they were awaiting publication of national guidance prior to implementing any learning. The trust, however, had identified that they were not compliant with the National Patient Safety Alert on Safer spinal (intrathecal), epidural and regional devices (January 2011). The risk was on the trust risk register with control measures whilst further guidance was awaited.
- The frequency of mortality and morbidity meetings varied across the surgical subspecialties but many occur monthly. The meetings are documented but the quality reports for quarter four of 2013/14 identified that documentation had not been submitted for general surgery since January 2011. Ophthalmology had no submissions, the pain team had not submitted since June 2009, plastic surgery since March 2012, and trauma and orthopaedics since September 2013. The division had a recommendation to document these so that suboptimal care was identified, and recommendations agreed, implemented and shared for wider learning.
- Junior doctors told us that monthly mortality and morbidity meetings were used to discuss complications and learning points and where patient care was not up to standard. In anaesthetics, the meeting identified that the WHO surgical safety checklist was modified.

Safety thermometer

- Safety Thermometer analysis showed that, for the surgical division, the rate of falls and urinary tract infections was better (lower) than the English average. However, the prevalence of pressure ulcers was worse (higher) than the English average. There were local action plans in response to the learning from the medical division who had a 'Push Off the Pressure' campaign, however, not all staff were not aware of these.
- Patients, visitors and staff did not have easy access to Safety Thermometer information because it was not displayed with in the wards.

Cleanliness, infection control and hygiene

- The ward areas looked clean and cleaning schedules were clearly displayed on the wards.
- Staff followed the trust policy on infection control. Staff regularly washed their hands and used hand gel between seeing patients, and the 'bare arms below the elbow' policy was adhered to.
- Hand hygiene audits were completed for each area of the surgical division. The quality report for January to March 2014 showed that one ward, Lord Wigram ward (at 36%) was performing below the trust target of 95% compliance with hand hygiene.
- Each clinical area had a nurse who took responsibility for infection control and the completion of hand hygiene audits. We observed one nurse reminding a doctor to remove their wrist watch.
- Patients admitted to the hospital were screened for MRSA. The MRSA screening audit showed that 94.7% of the elective admissions patients and 98.5% of the emergency admissions patients had been screened for MRSA in 2013/14 against the trust's target of 95%.
- For patients who were planned admissions, screening for MRSA was completed prior to admission. Only patients who had a clear MRSA screening were admitted to the planned surgical ward. We were told that sometimes MRSA screening or positive status could be missed, though we were not provided with any figures to corroborate these statements.
- The trust reported that wound infections following hip replacement surgery and for infections following repair of fractured neck of femur were below the national average. The trust detailed that it was responding to this information by continuing to monitor the infection rates.
- Cleaning schedules were displayed on wards and cleaning staff were allocated to specific wards, so they knew the routines of that ward. They received training specific to the cleaning of their area. For example, cleaning staff had training about how to clean the ward's new commodes.

- Patients were very impressed with the cleanliness of the wards. They observed that cleaners moved furniture to clean the floor beneath.

Environment and equipment

- Resuscitation equipment checks in all areas we looked at were mainly completed daily. The resuscitation trolley on Annie Zunz Ward had not been checked in two days. Processes were followed to ensure that other equipment was in working order.
- Equipment was accessible for the care and treatment of bariatric patients (patients being treated for obesity).
- CSSD processes ensured that equipment was cleaned, decontaminated and sterile. The department had implemented an innovative practice of using a metal detector to check waste bags for equipment disposed of incorrectly. This reduced the risk of cross-contamination from equipment incorrectly disposed of.
- Staff said they were always able to access equipment that was needed to deliver care safely to patients.
- One ward reported problems with the supply of linen. The linen supply was insufficient for the turnover of patients which meant there was no linen available first thing in the morning. We were told that linen was supplied promptly when they phoned to report the issue. However, this meant there were delays in providing suitably made-up beds for patients entering the recovery areas after surgery.

Medicines

- Medicines were not stored safely. On Annie Zunz Ward there was an unlocked medicine cupboard. The reason given for this was that the pharmacist had left the ward with the drug cupboard keys. This was rectified promptly, but in the meantime had meant the risk of unauthorised access to medicines, and staff not being able to access medicines that were stored in other areas.
- On David Evans Ward there was a cupboard that held supplies of medicines for patients to take home on discharge. There was no lock on this cupboard and it was being held closed with surgical tape.
- On Chelsea Wing, boxes of medicines were left on the workbench in the treatment room. The treatment room was locked, but the practice of not securing medicines was not in line with the trust's procedures for safe management of medicines.
- The temperature of medication fridges was monitored.
- The trust used an electronic prescription and medication administration record (MAR) chart for all patients on the surgical wards. To use this system, staff had to be allocated a unique user name and password. Agency nurses were not allocated a user name and password which meant they could not access the system to record when they administered medicines. The trust had a system where a medicines chart was manually printed off, which agency nurses signed when they gave medicines; the electronic system was then updated by a member of staff who could sign into the system. There were delays in electronic records being updated and the potential risk to patients could be that patients either missed doses of medicines, received duplicates doses of medicine or did not receive pain relief when they needed it.
- Some patients said they were enabled to manage their own medicines.

Records

- The management of records did not ensure that the safety of patients was protected. The wards used a combination of electronic and paper records. There was a database of care plans stored electronically that could be used for planning patient care. However, care plans were not personalised to patients' needs and could not be accessed by agency staff. Rainsford Mowlam Ward identified these concerns and was in the process of implementing paper care plans which could be held at the patient's bedside and amended as needed.
- Each patient had a comfort round or intentional rounding (where nurses and healthcare assistants regularly checked on patients every two hours). Patients' charts were supposed to show that they had received care and attention in a two-hour period. These were not fully completed and could therefore not provide evidence that care and treatment had been provided.
- Where identified as required, patients' fluid intake and output was recorded. However, on David Evans Ward, the charts were not fully completed. The reason for this, we were told, was that staff completed the charts retrospectively at the end of their shifts. This meant there was a risk that fluid charts would be inaccurate because staff could not remember a patient's fluid intake. One fluid chart detailed that a patient had taken only 100ml of fluid on one day.

- Risk assessments were completed, some for pressure ulcers, risk of malnutrition and risk of falls. There was no system to ensure that risk assessments were reviewed. On Chelsea Wing one patient's assessment for the risk of falls detailed that they were at high risk and so their risk assessment should have been reviewed every day. There was no evidence that this had occurred. The patient had experienced one fall during their stay at the hospital.
- There were no audits of patients' documentation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients reported that their consent was always obtained prior to any procedures being carried out.
- There were two versions of consent form in operation, which had the potential to cause confusion. On 10 July 2014 we looked at consent forms for five patients. Of these, three patients had not been given their copy of the consent form.
- Staff we spoke with had a basic understanding about the Mental Capacity Act 2005. They said it was the role of doctors to complete mental capacity assessments when required. When asked, some staff had not heard of the Act's associated Deprivation of Liberty safeguards.

Safeguarding

- Staff were aware of the safeguarding procedures and protocols. They were able to describe situations where they would raise a safeguarding concern.
- The quarterly quality report for the surgical services provided evidence that allegations of abuse to patients by staff were appropriately investigated. External agencies were involved in such investigations where required.

Mandatory training

- Records provided by the trust showed that training was below the required levels they had set for their mandatory training programme. In 2014 only 72% of staff had completed mandatory training. When these figures were discussed with the surgical management team, they said figures did not accurately reflect the training that had occurred because of a discrepancy caused by the times of the year when figures were collected.
- There was an induction programme for all new staff. Data provided by the trust in June 2014 indicated that 51% of staff had had a local induction. Junior doctors identified that there was often not enough time to complete the online induction training.
- Mandatory training was monitored electronically and by paper. Staff were notified electronically when they were due for mandatory refresher training.
- Staff told us they were notified when they needed to update their mandatory training. One person told us, "Nobody can say I didn't get the training or that training was not available".

Assessing and responding to patient risk

- The hospital's surgical safety checklist (based on the WHO checklist) should be used at each stage of the surgical pathway – from when a patient is transferred to theatre until return to the ward. The trust had conducted a checklist audit in April 2014 and the completion rate in adult theatres was 93%. However, in May 2014 the completion rate was 66%. On 10 July 2014 we checked five checklists and found that three of them had not been fully completed.
- Pre-operative assessments were carried out prior to surgery. As a part of this assessment all patients were measured for antiembolic stockings to reduce the risk of development of deep vein blood clots. We observed, and were told by patients, that the stockings were worn.
- The surgical wards used the national early warning score (NEWS) for assessing acutely ill patients. There were clear directions for actions to take when patients' scores increased, and members of staff were aware of these and we saw these were being used effectively.
- Nursing handovers occurred three times a day. Staffing for the shift was discussed as well as any high-risk patients or potential issues.
- We observed a formal medical handover that included all the on-call surgical junior staff with a list of patients and their details and anticipated problems.

Nursing staffing

- Nursing staffing levels had been reviewed and assessed using the national Safer Nursing Care Tool. The division had carried out an acuity and dependency audit in May 2014. Each ward displayed the planned and actual nursing staffing numbers for that day. Ward sisters said

they had been involved in the development of the planned staffing numbers which had included considering the dependency and flow of patients on the wards.

- The surgical management team said there was a vacancy rate of 15%, which was equivalent to 40 whole time equivalent (WTE) nursing staff on the surgical wards. At the time of the inspection, this shortfall was addressed by using agency nurses. The trust had recruited 60 nurses to commence work across the surgical wards in autumn 2014.
- Agency nurses and healthcare assistants were employed to achieve the required staffing levels. There was a trust procedure for inducting agency staff to the work area. However, not all staff were aware of it. Some staff said there was no induction process for agency staff. Other staff told us there was a paper system to provide evidence of agency staff inductions. On Rainsford Mowlam Ward we observed an agency nurse being inducted into the work area and completing the paper evidence record.
- Agency nurses were not able to access the care plans and risk assessments held on the computers. This meant that agency nurses who were new on the wards did not have access to information on how to care for a patient.
- On both days of our inspection we saw the matron for the surgical wards visiting each ward to assess the staffing levels and assist in resourcing extra staff: this included the use of agency nurses and allocating staff from other wards across the division who were well staffed.
- Patient feedback indicated that they had observed that there was shortage of staff at times. Comments included, "I think there is sometimes a shortage. At night times they work really hard. Some of them don't get their breaks," and, "Staff are pretty scarce at times – but there should always be two nurses to lift me, so sometimes I have to wait".
- There was an emergency care nurse practitioner in general surgery and one surgical appliance officer and one WTE orthopaedic nurse practitioners in trauma and orthopaedics.

Surgical staffing

- There were 6.5wte consultants in general surgery and 27 junior doctors; 9.75 wte Consultants and 13 wte junior Doctors in trauma and orthopaedic surgery; 4 wte consultants in the burns unit and 7.45 wte consultants, and 4 wte junior doctors in plastic surgery. There were consultants when compared to the England average.
- There was 24-hour consultant on call cover for the surgical wards, seven days a week. Staff told us there was good access to a surgical consultant at all hours.
- There were twice-daily medical handovers.
- Medical staff who had undertaken appropriate training in surgery were allocated to the staffing rota.
- There was also 24-hour consultant anaesthetist availability, seven days a week.
- Junior doctors told us that gaps in staffing were filled with locums but this sometimes added to their responsibilities. In plastic surgery there were workload pressures. There were gaps in foundation year 2 doctor's shift rotas for plastic surgery and trauma orthopaedics (but not in general surgery or urology) and middle grade doctors often worked long hours.

Major incident awareness and training

- There was a trust major incident plan that had a review date of April 2014. There was no evidence in the clinical areas that this had happened, and so staff could not be assured the plan was current.

Are surgery services effective?

Requires improvement

The service could not demonstrate that care was provided in accordance with evidence-based national guidelines. Policies and procedures were accessible for staff but many staff were unaware of these. When they were accessed, many of them had not been reviewed or audited to demonstrate compliance. There were few clinical guidelines on best practice. An enhanced recovery pathway was used in orthopaedic care to support patients' quick recovery. However, patient outcomes for procedures varied compared to national averages. Pain management were unnecessarily complicated by assessment-recording procedures which meant that patients' pain might not be effectively monitored and treated. Multidisciplinary working was evident. Overall, staff had access to training

and support but clinical supervision for nursing staff was not embedded into practice. Consultant-led, seven-day services had not developed and were described as "a challenge".

Evidence-based care and treatment

- The surgical directorate could not demonstrate that care was provided in accordance with evidence-based national guidelines, such as National Institute for Health and Care Excellence (NICE) guidelines. Of new guidance issued since January 2014, the directorate confirmed compliance with two. However, responses were outstanding for seven others, including the quality standard for colorectal cancer issues from August 2012.
- There was a lack of guidance for staff to follow to ensure they were providing care and treatment that was following up-to-date national guidance and recommendations. Of the 896 guidelines in the trust, 23 were listed under surgery (the majority in the burns unit) and around half of these (11) needed review.
- Policies and procedures were not all in date. When staff tried to access policies electronically on the ward, some were not available. On one ward area, there was a policies folder; however, the policies in it were not all up to date. On a second ward, staff could not access any policies electronically and there were no paper copies.
- The trust had a pathway for patients with sepsis (a sepsis care bundle) to enable early recognition of the sick person and prompt treatment and clinical stabilisation. This was not being used consistently across all wards.
- Enhanced recovery pathways were used to improve outcomes for patients in bariatric surgery, total hip replacement and knee replacement. This focused on thorough pre-assessment pain relief and the management of fluids and diet, which helped patients to recover quickly postoperatively.
- Local audits were detailed in the quarterly quality report for the surgical directorate. The recent report for quarter four had identified that, although staff were registering new audit projects, there was a lack of evidence to show the audit process was being followed through. There were about 44 audit projects in the clinical audit plan 2013 – 2015. Of these, nine had been completed and 15 were correctly in progress due to continuous data collection or data collection periods. However, 20 were in progress but were outside submission dates, many of these were from 2013, with a few from 2012.
- The quarterly quality report detailed that the surgical directorate was taking part in the required national quality audits to measure their service provision against national standards.

Pain relief

- Two different scales were used for scoring the intensity of pain patients were experiencing. The NEWs charts had a scoring scale of 0 to 10, whereas the comfort round charts had a scoring scale of 0 to 4. Both charts were used for patients, and the information did not always correlate.
- Most patients reported that their pain was well-controlled and staff provided them with pain relief promptly when requested. One person reported excessive pain postoperatively that was due to an underlying medical condition. This had not been considered in their assessment prior to surgery, so the pain was not pre-empted.
- There was a dedicated pain team that could be accessed for support in controlling patients' pain. However, their advice was not always recorded in patients' notes.

Nutrition and hydration

- The trust used a system of coloured lids on patients' jugs and beakers to identify those who needed monitoring of fluid and food intake or who needed assistance to eat and drink. However, the recording of fluid intake did not demonstrate effective monitoring of patients fluid intake.
- Guidance was available on David Evans Ward regarding the dietary requirements for patients with specific conditions. This was displayed in a sensitive manner that ensured patients received a diet that was safe and effective for them.

Patient outcomes

- The hospital's overall mortality rates were lower than expected and there were no mortality outliers (outside the expected range) for this service.
- 82% of patients with a hip fracture received surgery within 48 hours; this was worse than (below) the England average, as was the trust's score for patients receiving a preoperative assessment by a geriatrician.
- The surgical division took part in national audits, for example, the elective surgery Patient Reported Outcome measures (PROM) programme, national hip fracture database and national joint registry.

- PROM scores for improvements in general health and condition-specific indicators after procedures varied. Varicose vein scores were worse than (below) the England average, joint replacement scores were similar to or better than (above) the England average, groin hernia was worse than (below) average for general health indicators but above average for current general health based on patients using a visual analogue scale.
- Data showed the length of stay of patients with hip fracture was above the England average and the relative risk of readmission for non-elective surgery was below the England average.
- Patients considered their outcomes as being good. One patient said the hospital "has a good reputation in the community" and was the patient's first choice of hospital.

Competent staff

- Staff said there was access to regular training and support. We observed nursing staff being assessed for competency in administering intravenous medications. Medical staff told us there was good access to clinical supervisors within the trust.
- Staff told us that supervision was linked with their annual appraisals, but could not describe the process of supervision or what it consisted of. One ward sister confirmed that there was not a process for clinical supervision. However, they told us they were considering how clinical supervision could best be implemented to provide good outcomes for staff and patients.
- The trust had a procedure it was following to achieve revalidation for medical staff.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within surgical specialities had rated their training overall as 'similar to other trusts'. Handover was better than other trusts in anaesthetics and urology but worse than other trusts in ophthalmology. Local induction and feedback was rated as better than other trusts in ophthalmology.

Multidisciplinary working

- Daily ward rounds were undertaken five days a week on all surgical wards. Medical staff and nursing were involved in these. We saw multidisciplinary board rounds were carried out, which included the involvement of a discharge nurse as well as physiotherapists.
- Staff said that they could access medical staff when needed to support patients' medical needs. The surgery quality report for quarter four 2013/14 detailed there had been learning from a failure to work in a multidisciplinary way which had resulted in a patient not receiving their regular medications to reduce the risk of a recurrence.

Seven-day services

- Consultant led seven-day services were indicated as a challenge, particularly consultant-delivered ward rounds on Sundays and access to theatres seven days per week. Access to medical advice at night came from the hospital at-night team. Nurses told us they were very responsive.
- There was on-call physiotherapy support specific to the needs of the patient (for example, chest surgery, plastic surgery and orthopaedic physiotherapy) was available out of hours.
- Radiology services were led by a consultant and were available on weekends until 6pm. The consultant was then on call over the weekend.
- An on-call system for the radiology department across three trusts in London meant that there was availability of a radiologist seven days a week. The system meant that the on-call radiologist travelled to the patient's hospital rather than the patient having to travel to the hospital where the radiologist was based.
- The pharmacy department was open seven days a week but with limited hours on weekends. There were pharmacists on call out of hours to provide advice to staff on duty.

Are surgery services caring?

Good

Patients received compassionate care and we saw that they were treated with dignity and respect. Patients and relatives we spoke with said they felt involved in their care. There was emotional support for vulnerable patients.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. In the x-ray department, we observed a member of the clerical staff managing a difficult situation with a patient with sensitivity, patience and understanding.

Surgery

- The results of the NHS Friends and Family Test were displayed on the wards. Overall, these showed satisfaction with the service provided. However, of five surgical wards, only the burns unit scored better than the England average. The Chelsea Wing, David Evans, Lord Wigram, Annie Zunz and Rainsford Mowlam wards all scored below the England average. The display included the detailed action that wards were taking to address any issues raised from the test results.
- The CQC Adult Inpatient Survey (2013) showed that the trust performed about the same as other trusts for all areas of questioning, except for one inpatient question identified under 'nurses'. For the questions 'Did nurses talk in front of you as if you weren't there?' the trust performed worse (in the bottom 20%) than other trusts.
- Comfort rounds or intentional rounding were undertaken every two hours. However, the documentation for these rounds did not consistently record all aspects of the round.
- We observed a ward round and saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient dignity.
- Patients reported that staff treated them with compassion and empathy. Comments included, "Staff are very friendly, polite, they're absolutely brilliant, I don't know how they do it", "I think the agency staff we've had in my time here have been very good", and, "They are particularly nice to patients – consultants down to cleaners. There is obviously a culture of that here".

Patient understanding and involvement

- Patients and relatives we spoke with said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them. This included being fully involved and aware of their planned discharge arrangements.

Emotional support

- Clinical nurse specialists, including specialist bariatric nurses, were employed to provide support and advice to patients undergoing various types of procedures.
- On Rainsford Mowlem Ward a weekly Alcoholics Anonymous meeting was provided to give support and guidance to patients whose clinical problems were as a result of alcohol addiction.
- For relevant patients on the gynaecological wards, the counselling service could be accessed via the midwifery department.
- There was a bereavement officer available during the week.

Are surgery services responsive?

Requires improvement

Surgical services needed to respond better to patients' needs. Services were developing to improve emergency care and respond to increasing demand but lack of available beds was resulting in patients spending longer times in the theatre recovery areas. The national time of 18 weeks between referral and surgery was not being met Discharge summaries were not written within 48 hours for GPs. Support for people living with dementia was inconsistent. There was support for people with a learning disability and reasonable adjustments were made to the service. However, staff were unsure whether the trust had a learning disability nurse and, if they did, how the person could be contacted. Information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used. Patients reported that they were satisfied with how complaints were dealt with.

Service planning and delivery to meet the needs of local people

- On the day of their surgery, patients with elective (planned) surgery were admitted to the surgical admissions lounge and then proceeded to surgery and to the postoperative ward.
- An emergency surgical consultant had been employed to work Monday to Friday to run a dedicated emergency surgery list. There were plans to appoint a further two surgeons to increase the provision of emergency surgery to meet the needs of the local population.
- X-ray services were being redeveloped to promote better patient privacy for treatment, examination and private consultation.
- The 'Shaping a healthier future' programme outlined the reconfiguration of acute services in North West London. The activity in the division was expected to increase significantly from 2016/17, particularly in terms of emergency general surgery and trauma and orthopaedic work.

Access and flow

- In June 2014 the trust was not achieving the 18-week referral-to-treatment time (RTT) target. Overall, only

75.4% of patients were seen within the target time and this was below the national standard of 90%. There were longer waiting times in general surgery, trauma and orthopaedics, urology and plastic surgery.

- Staff said patients spent longer periods in the theatre recovery areas while waiting for bed availability postoperatively on the wards. Out of the patients admitted into the treatment centre (day case) for surgery, 30% usually needed to be admitted as an inpatient. This added to the pressure on bed availability. No evidence was presented to indicate action was being taken to reduce the number of day cases requiring overnight admissions.
- Staff expressed concerns about bed availability. Bed meetings were held each weekday to address any concerns, but staff felt that their opinions were not always listened to. They gave the view that, if there were not enough beds for patients postoperatively, there would be a push to discharge patients, which they felt increased the risk of patients being discharged too early.
- There were no surgical outliers (patients placed on other wards who should have been in surgery).
- Discharges were commenced on patient admission to hospital. Patients were aware of their planned discharge date and the support they needed when discharged. There was a process to follow to ensure that GPs received discharge information about their patients to ensure continuity of care. Discharge summaries in general surgery, however, were not being written with 48 hours of patient discharge.

Meeting people's individual needs

- Support from the learning disability nurse was available for patients with a learning disability. However, staff on the wards were unclear of what support was available and how they could access it.
- Staff told us about reasonable adjustments made in the provision of care to patients with a learning disability, which included provision of a side room with toilet facilities so parents/carers did not have to leave the patient alone, and the use of the Health Passport (a document which contains key information about the person's behaviours and likes and dislikes). Staff did not know whether there was an easy-to-read consent form to support people with a learning disability to consent to their care and treatment.
- Staff said they had received some training/talks about people living with dementia. Where required, patients living with dementia who were agitated were nursed on a one-to-one basis. The lack of personalised care planning meant there was a risk that patients living with dementia would not receive care and support to promote their wellbeing.
- An interpreting service was available and most staff knew how to access it. We saw one example of this service being used to ensure informed consent was obtained from a patient whose first language was not English.
- Patient information leaflets were available on the hospital website. We did not see information leaflets available on the ward areas, but leaflets were available in the x-ray departments. The leaflets were not available in different languages.
- A protected meal times policy was displayed in each ward area. Staff said the policy was generally adhered to; meaning that patients were able to have their meals with no interruptions.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- Patients were confident that complaints would be managed appropriately by the trust. One patient gave an example where they had made a complaint, and it had been resolved face-to-face on the ward.

Are surgery services well-led?

Requires improvement

The service did not have a specific strategy but there were plans around the increasing demand for services expected under 'Shaping a healthier future' in London. The trust's values were displayed and known by all staff. There was a governance structure but this was not 'owned' by staff. Reports were produced by the trust clinical governance team and many actions on audit, guidelines, risk and incidents remained outstanding. The surgical management team did not have a unified view of what the service provided, or what was considered effective or excellent practice.

Surgery

There was a matron responsible for the surgical wards and staff told us she was visible and approachable. Staff we spoke with worked well together. However, there were concerns that the trust did not have a 'just' culture. Staff reported that there was a culture of 'blame' rather than learning from incidents. Examples were given where nursing staff were blamed and warned over incidents but medical staff, who were involved, were not. Public and staff engagement were underdeveloped. There were examples of innovation and outstanding practice in the burns unit.

Vision and strategy for this service

- The trust's vision and values ('safe, excellent, kind and respectful') were displayed at the entrance to all wards along with the meaning this had for each individual ward. In response to the results of NHS Family and Friends Tests, changes being made to the service provision were aligned to the trust values. All staff were aware of the trust's visions and values.
- At the time of our inspection, the trust was undergoing a restructuring of its services to be in line with the manner in which patients accessed services. Surgical services were being placed in the planned care division which included the surgical wards, theatres and support services.
- There was not a service-specific vision or strategy for the services. 'Shaping a healthier future', outlined the reconfiguration of acute services in North West London and the activity in the division was expected to increase significantly from 2016/17, particularly in terms of emergency general surgery and trauma and orthopaedic work. The trust plans were to improve the emergency care model, increase day case surgery and ambulatory care services and reduce the length of stay in specialties. This strategy was not known to all staff, for example, staff working in ward areas but they did verbalise the need to respond to pressures.

Governance, risk management and quality measurement

- The surgical division had monthly clinical effectiveness meetings in each of the subspecialties for general surgery, trauma and orthopaedics, burns and plastic surgery. The meetings discussed audit, incidents and complaints.
- The trust clinical governance team collated data and produced reports for the division each quarter. Included in this report was a review of incidents, review of the risk register, general patient safety information, infection control review, and information about clinical and non-clinical claims, training, and morbidity and mortality reviews.
- The surgery quality report 2013/14 detailed action that was being taken in relation to any incidents. It also held risk assessments for the surgical directorate. It was not evident from the information in the report that nine out of 10 of those risk assessments had been reviewed in line with the review date detailed on the assessment.
- Of the few clinical guidelines, most required updating; many audits were in progress for some time and some were overdue.
- The surgery quality report detailed that the surgical division had not submitted any mortality and morbidity information since January 2011.
- The divisional risk register identified risks but mitigation actions were not always clear, fully completed or timely. There were also outstanding responses on incidents.

Leadership of service

- There was a clinical director for each subspecialty, lead nurse and senior manager.
- Each ward had a manager who provided day-to-day leadership to members of staff on the ward. Staff told us that the matron with overall responsibility for surgery was approachable and supportive. We saw that they were present on the wards and helped resolve clinical and staffing problems that arose.
- The surgical management team did not present a unified opinion about some aspects of the service provision. During an interview, two members of the management team could not agree on what the service considered to be effective or excellent practice.

Culture within the service

- Staff within the surgical division spoke positively about the service they provided for patients.
- Staff worked well together. However, there were concerns raised by some nurses that, at times, there was a culture of blame rather than learning within the trust. Examples were given where incidents had occurred, with nursing staff held to account or given formal warnings, but not the same treatment for the medical staff involved.

Public and staff engagement

- Patients were engaged through the use of surveys and feedback from the NHS Friends and Family Test. These

results showed that patients were satisfied with the service provided. The results were displayed at the entrance to the wards. There were no other methods of patient and public engagement used.

- There was no consistent method for disseminating information to staff across the wards. Staff reported that, on some wards, regular staff meetings were held. Minutes from these showed that the trust engaged with staff and there was a process for feeding information from the trust to staff working in the surgical division and for staff to voice concerns and issues to the Trust Board. However, on other wards, staff said there were no ward meetings, information about trust issues was provided at handover periods.
- Staff reported mixed views about the visibility of the senior leadership team for the trust. Some staff reported they had seen the director of nursing on the wards; others reported they had not. Staff who had recently commenced work at the trust had met the director of nursing and the chief executive during their induction programme.
- Some staff reported feeling unsupported by the director of nursing.

Innovation, improvement and sustainability

- Innovation was evident in several areas of the surgical division. In CSSD, a metal detector was used to identify surgical equipment that had been incorrectly discarded into rubbish bags. This was to promote staff safety and reduce the cost of lost equipment.
- Some wards had identified that the computerised care planning process was not effective at ensuring patients would receive personalised care. To overcome this, the wards had developed paper-based care plans that were in the process of being implemented.
- On some wards there was a practice of 'away days'. A team of the ward staff had a day away from the ward, structured to include a 'ward meeting', group learning, information about trust initiatives, learning from incidents trust-wide and project work. However, this process was not evident on all wards.
- The burns team had won the chief executive's best clinical service award in 2013/14. The team regularly presented papers and posters at international meetings and published a small but consistent number of papers annually.

Critical care

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

Information about the service

The intensive care unit (ICU) at Chelsea and Westminster Hospital NHS Foundation Trust consists of a critical care unit and a high dependency unit (HDU). The unit provides level 3 care that is for patients requiring one-to-one support (such as those ventilated) and level 2 intensive care beds for high dependency care. The outreach team provides support with the care of critically ill patients who were on other wards. The critical care service had consultant cover 24 hours a day, seven days a week.

The critical care departments include 10 funded adult intensive care/high dependency beds. These beds are used flexibly to provide level 3 (ICU) and level 2 (HDU) care. The regional burns unit with two level 3(ICU) beds. The other beds on the burns unit, two HDU beds and 10 ward beds are managed by the burns service. Between April 2013 and March 2014, there were there were 429 admissions to the ICU/HDU and 28 admissions to burns ICU, totalling 457admissions.

As part of our inspection we visited the ICU and HDU. We spoke with six patients, four relatives and 16 staff. These included nursing staff, junior and senior doctors, a pharmacist, domestic staff and managers. We observed the care and the treatment patients were receiving and viewed four care records. We reviewed performance information about the service.

Summary of findings

The unit had sufficient numbers of nursing and medical staff on duty and there were effective procedures for safe care. The patient Safety Thermometer (a local improvement tool for monitoring harm-free care) was not embedded but there were plans to develop this. Medicines were safely and securely stored. Patients received care and treatment according to national guidelines and there was good multidisciplinary team working to support patients. Patient and performance outcomes were compared across North West London but the trust had re-evaluated this and intended to participate in the Intensive Care National Audit & Research Centre (ICNARC) from July 2014.

Staff cared for patients in a compassionate manner, with dignity and respect. They involved patients and, where appropriate, their relatives in the care. Patients and their relatives were happy with the care provided. Emotional and spiritual support were provided. The leadership on the unit was visible and staff were passionate about providing excellent quality care. Governance arrangements supported assurance around quality, risk and safety. There was a culture that supported staff to develop innovative ways of working. Patients' engagement was well developed through a range of feedback approaches.

Critical care

Are critical care services safe?

Good

The unit had effective processes to protect patients. There were sufficient numbers of nursing and medical staff on duty. The environment was visibly clean and staff followed infection control practices. The patient Safety Thermometer was not well-embedded in the unit and there were plans to use it more often. Equipment was fit for purpose, modern, regularly checked and available. Medicines, including controlled drugs, were safely and securely stored. Patient risks were appropriately identified and escalated.

Incidents

- Clinical staff we spoke with said they were encouraged to report incidents and received direct feedback from the clinical lead of nursing. The department used a paper system to report incidents. Incidents were also recorded electronically centrally. Incidents were discussed at staff meetings. We were shown a copy of the action plans that had been recently developed and saw how the learning was shared across the department.
- The department also monitored incidents of cardiac arrests. A root cause analysis was undertaken for each cardiac arrest and information was shared with clinical staff at morbidity and mortality meetings.
- Mortality and morbidity meetings were held monthly to quarterly and attended by medical, nursing and allied healthcare professional staff. All incidents of death and poor outcomes for patients were reviewed and appropriate action was planned and implemented to improve outcomes for patients.

Safety thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections (UTIs), venous thromboembolism (VTE), and falls.
- The NHS Safety Thermometer information was not displayed on the ICU or the HDU. It was, however, visible on the burns unit. The senior leadership team acknowledged that the safety thermometer was not embedded in the unit and had taken actions such as collating the information that will be placed on the ward. The head of nursing in the ITU told us they were going to start sharing the information with staff on the unit, starting in August 2014.
- Risk assessments for patients for pressure ulcers and VTE were completed on admission and prophylactic therapy initiated for VTE prevention.
- A pathway was used for all patients requiring invasive treatment such as mechanical ventilation.
- The trust reported high numbers of pressure ulcers compared to other trusts in the North West London network. These had been reviewed by the unit and it was concluded that, because the unit also treated patients who had burns, it had a higher rate of patients who had pressure ulcers. The clinical director told us that this was more common in patients in the ICU. The department had investigated this and the senior nurse had taken action ensuring patients received appropriate support to prevent pressure ulcers, including provision of an appropriate mattress. A system of procuring appropriate mattresses out-of-hours had been implemented.

Cleanliness, infection control and hygiene

- Patients were cared for in a visibly clean and hygienic environment.
- Staff followed the trust policy on infection control. The 'bare arms below the elbow' policy was adhered to. There were hand-washing facilities and protective personal equipment, such as gloves and aprons, available. We observed that staff used gloves and aprons and changed these between attending to patients.
- There were effective arrangements for the safe disposal of sharps and contaminated items, including dating of when the sharps box began to be used. All sharps boxes we inspected had their lids closed.
- The latest hand hygiene audits completed in June 2014 in the ICU showed they had achieved 99.8% compliance.
- The trust could not provide data on infection rates in the ICU.

Environment and equipment

- We found equipment was clean, fit for purpose and staff told us there was enough equipment available.
- There were regular safety checks of medical equipment used in the ITU, signed by the individual undertaking the checks.

- The resuscitation equipment was checked daily and records maintained.
- The unit environment was bright and spacious and in good decorative order. There was adequate space between each bed area.
- There was a specific room that was used by relatives to stay in, and there was also a sofa bed for relatives to use.

Medicines

- Medicines, including controlled drugs, were safely and securely stored. The medication records of five people we looked at during our inspection were found to accurately reflect the prescribed and administered medicines for those patients.
- The area used to store medication in the ICU was adequate. The area was locked as per the trust's policy. The medicines and stock records were accurate. We looked at the controlled drugs book for each area and found that the records accurately reflected the supply. The process for reviewing and recording controlled drugs was in line with the Royal Pharmaceutical Society guidelines.
- Fridge temperatures were monitored daily; this ensured medicines were maintained at the recommended temperature and the checks were signed by the individual undertaking these checks.
- There were arrangements for the effective access to medicines out of hours. The ICU had its own allocated pharmacist who visited the units daily and reviewed all medical prescriptions to ensure sufficient stocks were available. Doctors told us that their input as part of the multidisciplinary team worked very well.

Records

- There was standardised nursing documentation kept at the end of each patient's bed. Observations were recorded clearly. The timing and frequency of observations were determined by the acuity of patients.
- All medical records were in paper form and followed the same format which meant information could be found easily. Nursing records were in an electronic format. Some doctors were making notes on the electronic records. There was, therefore, duplication of records.
- There was no electronic prescribing and the unit used paper prescription charts. The number of medication errors was monitored and a recent audit showed it was lower than other similar ITUs.
- There was a formalised recording tool with a protocol for patients who required palliative care. This helped in the provision of care for patients who were at the end of their life. This recording system was only used in the ICU.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were appropriately asked for their consent to treatment and procedures. Staff were able to provide examples of patients who did not have the capacity to consent to treatment. The Mental Capacity Act 2005 was adhered to appropriately.
- The senior sister told us that, during our inspection, there was no one who was receiving care under the Deprivation of Liberty safeguards (DoLs). Staff we spoke with were aware of Mental Capacity Act 2005 and DoLs and could show this related to the patients they cared for.

Safeguarding

- All staff we spoke with confirmed they had completed training for safeguarding vulnerable adults and children as part of mandatory training and updates. Information provided by the department indicated that 100% of staff had completed safeguarding training and 100% had completed children's safeguarding training at level 2.
- Staff demonstrated an understanding of safeguarding procedures and reporting processes.

Mandatory training

- The unit had a training plan for all nursing staff to ensure they met their mandatory training targets. The training plan we saw and staff confirmed, included annual mandatory training. Data provided by the trust indicated in June 2014 that 84% of ICU staff had completed mandatory training.
- Resuscitation officers provided training in basic life support, intermediate life support, paediatric and advanced life support for clinical staff, which was mandatory training for all staff working in the unit.
- There was an induction programme for all new staff. Data provided by the trust in June 2014 indicated that only 11% of staff had not attended local induction.

Assessing and responding to patient risk

- There was an arrangement for the transfer of certain critically ill patients. Cardiac patients were not brought to the unit. They were seen at other hospitals in the area.

- There was an outreach team that provided support seven days a week from 8am to 8pm for the management of critically ill patients in the hospital. Out of these hours there was a 'hospital at night' team that ensured critically ill patients received effective and appropriate care.
- The national early warning score (NEWS) escalation process for the management of acutely unwell adult patients was used to identify patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff.
- Patients were monitored using recognised observational tools. The frequency of observations was dependant on the acuity of the patient's illness. Alarms were set on monitoring equipment to alert staff to any changes in the patients' condition. This meant deteriorating patients would be identified and action taken and escalated to the appropriate team without delay.

Nursing staffing

- The staffing roster was planned and staff worked on a rotational basis on days and nights. All level 3 patients were nursed one-to-one, and level 2 patients one nurse to two patients, but often had one-to-one care. There unit had a senior clinical nurse who had overall responsibility for the service.
- The head nurse of critical care and the clinical director told us they had adequate staff to meet the patients' needs. Where there were shortfalls in staffing levels, they were covered by bank (overtime) staff. The hospital, on some occasions, used agency nurses. However, these nurses were well-known to the unit and their competency to work in the ICU had been previously assessed. The head nurse of critical care had the responsibility to ensure there were always adequate staff with the right skills. Rotas demonstrated adequate staffing levels. On the day of our inspection there were enough staff on duty.
- The unit also used Advanced Healthcare Practitioners across critical care to support the demand for clinical skills, as appropriate. Advanced nurse practitioners also supported the outreach team.

Medical staffing

- Care in the ICU was consultant-led. There were six consultants in intensive care providing cover seven days a week 8am to 8 pm and were available on call at other times.
- The consultants worked in a consecutive three blocks of seven days over a two week period as recommended in national guidelines for intensive care. All admissions to the unit were discussed and admitted under a consultant.

Major incident awareness and training

- The ICU had a comprehensive business continuity plan that outlined in detail how patients' care would continue to be provided in an emergency situation. For example, there was a plan in case the unit's bed capacity was in danger of being overtaken by demand. The unit had an agreed capacity arrangement with its local London Critical Care Network. This ensured that patients' needs were met in an efficient and effective manner.
- There were emergency battery back-up supplies and this ensured that vital medicines and life support systems would continue in the event of an electrical power cut or a disruption to the supply of medical gases.
- There was a clear procedure instructing staff what to do, for example, in the event of a fire. This meant that staff working in the unit were clear of their responsibility in the event of a major incident.

Are critical care services effective?

Good

Patients received care and treatment according to national guidelines. The unit participated in the North West London Acubase system to compare outcome data across nine London trusts. The unit had re-evaluated this decision and had decided to participate in research with ICNARC from July 2014. Patients received appropriate pain relief and their nutrition and hydration needs were appropriately assessed. Staff were well-trained and there was good multidisciplinary team working to support patients.

Evidence-based care and treatment

- The critical care unit used a combination of National Institute for Health and Care Excellence (NICE) and Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment they provided.
- There were clear care protocols and pathways such as the ventilator care bundle which was used to ensure

appropriate and timely care for ventilated patients. The unit had protocols on sedation. These protocols were regularly audited and the results shared within the department.
- The trust pathway for patients with sepsis (sepsis care bundle) was being used.
- The unit did not contribute their patient data and outcomes to ICNARC research. It had not participated with ICNARC because the cost of the system and the data entry requirements were thought to be extensive. The unit contributed to the North West London Acubase system (comprised of nine hospitals in NW London) to compare performance, but this included only nine trusts in London. The trust has now decided to participate in ICNARC and planned to start submitting from July 2014.
- The unit had also its own clinical audit programme. For example, a recent audit on pain relief identified the response times before medicine to control pain was administered. Another audit on physiotherapy rehabilitation undertaken resulted in a protocol that was being developed.

Pain relief
- In ICU, clinical staff followed the unit's protocol on pain control for ventilated patients.
- Patients' pain scores were regularly assessed and documented. Records showed that pain relief was administered promptly and patients' pain reassessed after they had received the medication to control their pain.
- We spoke to two relatives who told us that patients in the ICU received pain control as needed.

Nutrition and hydration
- The unit used the malnutrition universal screening tool (MUST) to assess the nutritional needs of patients. We inspected three records and found the assessment tool had been appropriately recorded.
- In the ICU, staff followed a protocol for hydration and nutrition for ventilated patients and enteral tube nutrition was initiated. Staff told us there was support and guidance available to support patients' needs.

Patient outcomes
- The unit did not contribute to the ICNARC database but were part of the North West London network data collection. There were plans to start working with ICNARC from July 2014.
- Over the past few years, the critical care outreach team had collected a considerable amount of data on the quality of the service. This data had not been fully translated to meaningful information to enable better patient outcomes. For example, there were not comparable rates on mortality, length of stay, or infections.
- The unit also undertook audits of NICE guidance (CG50 on acutely ill patients in hospitals and CG83 rehabilitation after critical illness). As a result of the audit on rehabilitation, the unit was developing a protocol that would be the first of its kind in the country for patients in the ITU.

Competent staff
- In the ICU, 65% of the nursing staff had achieved a post-registration award in critical care nursing.
- All staff received group and one-to-one supervision and appraisals. These processes covered training and development needs and practices. Information provided by the unit showed that, by the end of March 2014, 98% of staff in this directorate had completed their appraisal.
- We spoke with a member of staff who had recently started working in the unit. They told us that an induction programme took place for all new staff and they confirmed it was informative and sufficient at the start of their critical care role. There was a competency programme for new nurses and this included the observation of care being provided.
- Not enough junior doctors had completed the General Medical Council (GMC) National Training Scheme Survey 2014 to produce meaningful results.

Multidisciplinary working
- There was a multidisciplinary team who supported patients and staff in the unit. For example, there was a dedicated critical care pharmacist who provided advice and support to clinical staff in the unit. During our inspection, we met other healthcare staff, such as infection control nurses and dieticians, who regularly visited the unit. Clinical staff told us that the team was also well-supported by physiotherapists.
- Doctors undertook twice-daily ward rounds which had input from nursing, microbiology, pharmacy and physiotherapy. Input from dietitians and speech and language therapist was sought if needed. We were given an example of a recent patient in ITU who required expert dietitian input and how this was accessed.

Critical care

- The unit had an outreach team that was fully integrated and provided valuable support in the care of the critically ill patients.
- There is a specialist nurse for organ donation based at the trust. The unit also had good links with the organ donor team at a nearby hospital. They shared staff and there were links established to ensure there was support for potential donors and for their families.

Seven-day services

- There was consultant cover for patients in the unit during the day from 8am to 8pm and an on-call service out of hours.
- There was 24-hour consultant cover. Consultants carried out twice daily ward rounds and were available for advice and support at other times.
- The critical care outreach team was available seven days week from 8am to 8pm. Out-of-hours care was provided by the 'hospital at night' team. The trust was planning to increase the service to 24 hours.
- At the weekends, support was available on site from the multidisciplinary team, including microbiology, physiotherapy, dieticians and pharmacy. The unit also had access to a radiologist on an on-call basis at weekend.

Are critical care services caring?

Good

Staff cared for patients in a compassionate manner with dignity and respect. They involved patients and their relatives, where appropriate, in care. Patients and their relatives were given appropriate emotional support and were happy with the care provided.

Compassionate care

- We observed staff caring for patients in a kind, compassionate and professional manner. We saw that patients were treated with the utmost respect and dignity throughout their treatment. Nurses were attentive and were always in very close proximity to patients. When they provided care to patients, they always introduced themselves and spoke in a gentle and kind way.

Patient understanding and involvement

- Patients and appropriate members from their families were involved in decisions about their care and treatment. We spoke with a member of a family who told us they had been kept well-informed about the condition of their parent. Because the patient came from a large family, there were many visitors throughout the day. The staff took appropriate measures to ensure patients' needs were managed and the relatives' request to see the patient was balanced.
- Patients' treatments were recorded in patient diaries which were completed by nursing staff and families to improve patient memories of their stay. Patients had access to these diaries after they left the unit. If a patient passed away, the dairies were made available to relatives as part of the bereavement process.

Emotional support

- The trust had a dedicated bereavement service. Bereavement support was offered through the ICU 24 hours a day, seven days a week. Staff provided support and guidance to the family. Access to specialist nurses was also available to support the emotional needs of patients and families. We spoke to a relative who had received similar support a few months earlier and they told us how members of staff spent considerable time with them to help them overcome their loss.
- Patients from all critical care areas could access the multi-faith chaplaincy services for support, including clergy and equivalents from other faith groups. Information on how to access chaplaincy services was available through staff. Staff told us they regularly interacted with the trust's palliative (end of life care) team, who provided support and advice during bereavement.

Are critical care services responsive?

Good

The critical care services were responsive to the needs of patients. Patients were admitted to and discharged from the unit at appropriate times, although discharge could be delayed due to bed availability. Patients that were discharged had follow-up support from the critical care team. Patients with a learning disability were provided with

the necessary support, including the services of a learning disability nurse who shared their expertise with members of staff in the unit. Staff also had access to translation services. Complaints were handled appropriately.

Service planning and delivery to meet the needs of local people

- The unit had 12 critical care beds. Between November 2013 and June 2014, figures showed that the bed occupancy for adult critical care beds across the trust was similar to the national average.
- The unit would transfer patients to a neighbouring trust if they required critical care and there were no available ICU beds available in the trust. The unit monitored the number of patients refused admissions as a result of lack of beds and in 2013/14, no patient was refused admission.
- Due to the 'Shaping a healthier future' programme which outlined the reconfiguration of acute services in North West London, the activity in the department was expected to increase significantly from 2016/17. The trust was investing in the redevelopment of the ICU to increase its size and improve the facilities. This was due to commence in 2016/17.

Access and flow

- Patients were admitted to the unit within the standard four hours from the decision to admit.
- Length of stay on the unit for level 3 patients was 5 to 6 days and 3 to 4 days for level 2. This was similar to the national average.
- Almost all discharges from the unit occurred during the day between 8am and 10pm; this was in line with national guidelines. The unit monitored the number of discharges out of these hours and, for the period April to June 2014, 3% of the discharges were outside these hours. This was better than (lower) than the national average.
- Patients who were discharged to other wards had follow-up visits by the critical care outreach team within five hours of discharge or when required.
- Some patients had their discharge delayed (over 24 hours) from the ICU because of bed availability in the trust. The trust was working with the clinical site team to improve this.
- Length of stay on the unit was above the national average. As a result of an audit on rehabilitation, the unit introduced an intervention tool that helped identify patients who would benefit from more intensive physiotherapy earlier in their stay in ITU. This reduced the length of stay in the ITU.
- Readmissions to the ICU were similar to other trusts.
- Doctors told us there was good support from other specialities, such as surgeons and obstetricians, in the management of the critically ill patients. However, there were difficulties in getting support from the general medical wards. There were always delays and, sometimes patients' discharge beds were taken up with other admissions, and patients were left in the ICU waiting to be discharged.

Meeting people's individual needs

- The unit had processes to support people with a learning disability and staff knew how to access these. For example, there was a learning disability Health Passport and a learning disability nurse who provided support to staff in the unit.
- The unit had flexible visiting hours that allowed relatives to come in when they wanted to. However, relatives were informed that, during certain hours, patients would be provided with intensive support and relatives would be requested to leave the unit. We spoke to two relatives who told us they were well-informed of when they would be asked to leave so that doctors and nurses could continue to provide the necessary care to the patient. They told us they did not mind this because once the care was completed, the nurse would invite them back to visit the patient.
- The unit had access to translation services. Staff could contact the NHS interpretation service by telephone, or request interpreters to visit the unit. However, because relatives were present most of the time, staff were able to use relatives to help patients understand the care being provided. The ICU was a mixed-sex ward. The unit had screens and one side room. However, there were arrangements to care for patients of the same sex in allocated areas. This assisted in maintaining the privacy of male and female patients. We spoke to two relatives from the Black and minority ethnic communities who confirmed that the arrangement maintained the privacy of patients.

Critical care

Learning from complaints and concerns

- Complaints were handled in line with the trust's complaints policy and the new Patient Advice and Liaison Service (PALS) team. Information on how to make a complaint was available for patients and carers.
- Outcomes and actions from complaints were disseminated to staff through formal and informal meetings. We were told that there had been no recent complaints to the unit.

Are critical care services well-led?

Good

The leadership on the unit was visible and there was a strategy and vision for the service that staff understood. Staff were passionate to deliver quality care and an excellent patient experience. Governance arrangements supported assurance around quality and risk and the unit was to start participating in ICNARC research to get better nationally comparative data on patient outcomes. There was a culture that supported staff to develop innovative ways of working. There were quality project teams that enabled greater engagement with staff. Patients' engagement was well developed through a range of feedback approaches.

Vision and strategy for this service

- The senior nurse and the clinical director demonstrated a clear vision for the future of the service. There was a sense of purpose and passion to deliver the vision. Staff we spoke with were clearly passionate about the critical care unit and how it supported the wider hospital and trust. They knew how the trust's values of 'safe', 'kind' "'respectful' and 'excellence' translated into action in their unit.
- Staff we spoke with told us that they felt their workplace was forward-thinking and they knew the aims of the unit. The unit's strategy was described by staff who said the unit would continue to provide excellent services in intensive care therapy by undertaking research in improving patient care.

Governance, risk management and quality measurement

- The unit had monthly clinical governance meetings where the results of various audits and incidents were discussed. The unit had no complaints but feedback from relatives about the care received was discussed at monthly clinical governance meetings.
- The unit had a risk register and, at present, there were no risks identified in critical care.
- There were monthly morbidity and mortality meetings that were an opportunity to discuss unexpected deaths.
- The ICU had a Customer Service Standard award (previously a Charter Mark) and demonstrated a focus on continual improvement on customer service.
- The department met all the London Quality Standards for critical care, with the exception of two, which concerned discharge.

Leadership of service

- The unit was led by a senior clinical nurse and a consultant clinical lead.
- Members of staff told us that the team operated collaboratively. They told us there was strong and visible leadership in the unit.

Culture within the service

- Staff told us that the manager of the service and senior medical staff were visible and approachable on the unit. As a result of feedback from staff, the unit ensured that at least three members of staff attend the trust Schwartz rounds. These rounds are conversations where staff share their unique challenging moments in the provision of care to patients without being judged. Nurses we spoke with valued these opportunities.

Public and staff engagement

- During our inspection we saw a number of cards and letters from patients and their relatives thanking staff for the care they had received in ICU.
- The unit also undertook a relative's satisfaction survey, used patient diaries and has held quarterly focus groups to obtain feedback from patients and their families. Information leaflet had been developed for patients and relatives and there was a board in the ICU entitled YOU said, WE did which demonstrated service changes.
- Staff recommended the trust as a place to work or receive treatment. Staff we spoke with told us there was good communication between senior management and staff.

Critical care

Innovation, improvement and sustainability

- The leadership team had created an environment where all members of staff were part of quality project teams. These teams were given time to undertake research projects to improve the quality of the service. As a result, a number of staff throughout the unit had been nominated for the trust's award for clinical excellence. Staff we spoke with told us how service improvements had been made through these projects.
- The trust had undertaken a project on rehabilitation that resulted in a tool to manage care for patients in intensive care. The tool included a standardised physiotherapy functional score assessment that is now used in over half of ICUs nationally. The tool is being used to improve compliance with NICE guidance CG83 for rehabilitation after a critical illness.
- Research was supported led by an ICU consultant and the physiotherapy team had a research portfolio, for example, they developed an innovative simulation-based physiotherapy course to improve quality and safety of care.
- The ICU was developing the Virtual Intensive Care Healthcare Professional as a way for patients and relatives to access additional information and advice online.

Maternity and gynaecology

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

Information about the service

The maternity department includes two theatres, a nine-bed labour ward and antenatal unit. There are also prenatal and postnatal wards, a high dependency unit, a midwife-led birthing unit and a maternity urgent care centre. There are a total of 68 beds, with 15 antenatal and 27 postnatal beds. The midwife-led birthing unit was newly built in February 2014 and has seven beds with full amenities. The staff working in the private maternity wing, part of the maternity department, are employed by the trust and have NHS contracts and terms and conditions. A neonatal unit is also available at the trust.

The maternity department delivered 4,865 babies in the financial year 2013/14. Home births accounted for 1.3% of all births. There were 758 private patient deliveries and 56,423 antenatal attendances.

Specialist outpatient clinics cover the needs of pregnant women with conditions such as diabetes, obesity and HIV. The antenatal department also provides full screening assessments for antenatal women.

We inspected the antenatal clinic, prenatal and postnatal wards, labour ward and the birthing unit. We held a focus group for midwives and spoke with 40 staff members, including doctors, midwives, managers, and administrators and housekeeping staff. We spoke with eight women and their families who were using the service. We checked eight women's records. We reviewed other documentation from stakeholders, including performance information provided by the trust.

Summary of findings

There were effective procedures that supported safe and effective care for women. Staff were caring and compassionate and treated women with dignity and respect. There were adequate numbers of staff to meet the needs of women. The shortage of midwives had been addressed and vacant posts had recently been recruited to. Staff had relevant training and a good awareness of safeguarding and child protection issues. National guidelines were being used but monitoring compliance needed to improve. Overall, outcomes for women were good, although the caesarean section rate was higher than the England average. There was good multidisciplinary working between hospital and community midwives and GPs and across hospital departments.

Women had choices during birth and were involved in decisions about their care and treatment. Staff on the unit were polite and friendly. We observed women being treated with dignity and privacy. The environment was clean and spacious. The atmosphere in the maternity unit was calm and peaceful. The antenatal department offered a comprehensive screening programme and the maternity urgent care centre had a triage (assessment and prioritising) system for women.

A new governance structure had been implemented in January 2014 and this had improved assurance around quality and safety but there needed to be better monitoring of action plans, and lessons learned from incidents needed to be effectively disseminated to all

Maternity and gynaecology

staff. The monitoring of compliance with guidelines through audit but action plans to address identified issues were not always developed and implemented. The leadership and culture within the department needed to improve to ensure there was effective joint working between doctors and midwives to support women having a reduction in interventions, and so that staff felt supported and listened to. The department demonstrated public engagement, improvements and examples of innovative practice

Are maternity and gynaecology services safe?

Good

There were effective procedures to support women and their babies to have safe care. The maternity ward areas were visibly clean and equipment was regularly checked. Medicines were appropriately stored and managed. Staff understood safeguarding procedures to keep women and babies protected from the risk of abuse.

Medical consultant staff presence exceeded national recommendation. The ratio of midwives to births was 1:32, higher than the recommended 1:28. However, there was no evidence at the time of the inspection indicating these shortages had a significant impact on the quality and safety of care, as temporary staff were being used. Midwives reported, however, that they frequently missed breaks and worked late when they were busy.

The modified early obstetric warning score was used to detect deterioration if women became unwell. Staff we spoke with were aware of what action to take in the event of an emergency. Incidents were investigated thoroughly and learning was used to improve patient outcomes. Serious incidents that occurred were monitored. Consent was appropriately obtained and this included consent for pregnancy terminations.

Incidents

- There were 1,355 incidents reported in the past year within the department, which was lower than the national average for a maternity department.
- There had been eight serious incidents reported by the maternity risk and governance team. These were discussed at multidisciplinary meetings. A full analysis of the events had taken place, and action plans had been implemented for all cases. There had been one Never Event (a retained swab following vaginal delivery), in the private maternity unit, which was staffed by NHS personnel. Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken. The case had been investigated and reported to the relevant external bodies. Following investigation there had been appropriate action taken by the trust to prevent further

incidents and learning was shared with staff in the department. The changes made following this incident were due to be audited in the near future to assess their effectiveness.

- Incidents were reported at departmental, governance and management levels. Doctors and midwives told us that patient handovers were used as a way of presenting information on safety issues developed as a result of incidents.
- Learning from these incidents was disseminated to staff through various ways such as emails, newsletters and multidisciplinary meetings. For example, following the Never Event, staff were reminded that trust policy should always be followed to reduce harm. They were asked to ensure two signatures were on documentation when required.
- There had been some cases of post-partum haemorrhage of more than 4000ml. A root cause analysis and panel review had been done for each incident. The possible reasons for these haemorrhages in the Maternity risk management annual report 2013-2014 were stated to include women's increased age and late induction of labour. There had been an action plan and changes in practice. During December 2013 and April 2014 the incidence of post-partum haemorrhage had decreased. The clinical lead for risk informed us that any further cases would still be investigated. This showed that the department were monitoring incidents so patient outcomes could be improved.
- There were reports of unexpected admissions to maternity. These were women who were not known to the department or had not attended antenatal appointments. These women were risk assessed and given treatment according to their needs.
- Clinical pathways had been updated or introduced following serious incidents to prevent recurrence. For example, an induction of labour integrated care pathway had been introduced to reduce the risk of obstetric haemorrhage.
- A mortality and morbidity meeting was held monthly. Serious incidents were discussed and analysed and decisions made to help reduce risk in the department. All staff were invited to attend the meetings. Lessons learned were disseminated.

Safety thermometer

- The maternity unit was not a pilot site for the national maternity safety thermometer tool but was using a trust safety thermometer which was a local improvement tool for monitoring and analysing patient harm-free care. They used the Maternity Dashboard to record statistics such as the number of normal deliveries, caesarean sections and post-partum haemorrhages occurring each month. Maternity Dashboard information was not displayed in patient areas but some of the information was on display in staff areas such as coffee rooms and offices.

Cleanliness, infection control and hygiene

- All areas were visibly clean, tidy and free from clutter.
- Cleaning staff told us how the units were cleaned: this included cleaning of bathrooms, communal areas, and hand-washing facilities. The CQC Maternity Patient Experience Survey 2013 reported that women felt the units were clean but bathrooms were not clean enough. We observed that the bathroom areas we looked at during our inspection were all visibly clean.
- We saw that staff complied with 'bare below the elbows' best practice. They used appropriate personal protective clothing, such as gloves and aprons and adhered to hand hygiene protocols.
- Hand hygiene audits were carried out monthly which indicated a 97% level of compliance with procedures by staff.
- There was an infection control policy and staff had been trained in infection control. Staff were able to tell us what steps they took to reduce the risk of cross-infection.
- There were no reported cases of MRSA and Clostridium difficile (C. difficile) infections reported for January to June 2014.

Environment and equipment

- There were security arrangements in the department that included locks on all entrance doors, ensuring visitors could only enter with the knowledge of reception or maternity staff. During our unannounced inspection, maternity staff informed us that there were no receptionists at night and they had to answer the door which while did not pose as a security risk, it took midwives away from their clinical duties.
- Staff told us that there was enough equipment for them to carry out their duties. We observed that the

equipment was clean and labelled and had regular service checks. The cardiotocography (CTG) equipment (a machine used to monitor foetal heartbeats) was clean and in working order.

- Emergency equipment was checked daily to ensure it was fit for purpose. The emergency and resuscitation equipment we saw during our inspection was in date and in working order. However, some equipment that needed to be checked on every shift in line with the trust's policy did not have a complete record to indicate that this had been done. For example, the fridge in the postnatal ward had 24 daily check signatures missing for June 2014 and 12 days missing for July 2014. No explanation could be given for this.

Medicines

- All treatment areas and doors to medicine cupboards we checked were locked appropriately. The majority of medicines checked were in date and stored safely.
- The fridge in maternity theatres was left unlocked; however, the door to the treatment room was locked. There had been a risk assessment carried out by the risk team for the management of the risk of leaving the fridge unlocked to ensure easy access to the fridge in an emergency.
- Fridge temperatures in theatres were at the correct level and the medicines in it were in date. All controlled drugs cupboards we checked were locked. The medications in them were identified as the correct amount and were checked and signed appropriately by two members of staff.

Records

- The maternity department used both paper and electronic records. The birthing centre and labour wards had only electronic patient records. Senior staff reported that they were in the process of moving to a solely electronic records system for maternity.
- The eight patient records we looked at all included a range of documentation that was easy to follow. Antenatal and early risk assessments had been completed. Some risk assessments were only available electronically such as those for the prevention of venous thromboembolism (VTE). Two assessments for venothrombotic therapy had not been filed in the notes, but were reported as being done. When we checked the patients, they had been provided with the necessary equipment to prevent the VTE.
- Midwives told us that there was some duplication of records because antenatal, intrapartum and postnatal notes had some of the same documentation. One midwife said: "It's overwhelming" and another said "It takes a long time and you could spend more time with a woman". Senior midwives informed us that changes were being made to reduce unnecessary duplication within records.
- Late gestation terminations were carried out in maternity. The correct procedure was followed. And there was a system for sending the termination of pregnancy (TOP) forms (HSA4) to the Department of Health, (DH). However, there was no record kept by the trust of the forms that had been sent to the DH. Doctors and specialist midwives we spoke were not aware of what happened with these forms following TOP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent had been appropriately obtained from women prior to any treatments being performed. Two of the eight records we checked did not have appropriate consent forms but these had been obtained retrospectively following emergency procedures.
- All the women we spoke with during our inspection had signed consent forms. Records showed that explanations were given for emergency caesareans and procedures that where high risk.
- Records and consent for terminations of pregnancy were done to the required standard of national legal requirements.

Safeguarding

- Risk assessments for safeguarding women and babies were completed for all women using the department. There was a lead midwife for safeguarding, responsible for managing child protection and domestic violence issues. An effective system for safeguarding mothers and their babies had been implemented.
- There was also a vulnerable women's forum meeting held on the first Wednesday of every month, conducted by the lead midwife for safeguarding.
- The trust's training records demonstrated that all midwives had completed safeguarding training to level 3 in 2013, in line with the trust's policy.

- Some staff were aware of how to care for women with a learning disability and referred to what they would do for adults in vulnerable circumstances. There had been a learning disability training day which had included a talk on foetal alcohol syndrome.

Mandatory training

- Staff we spoke with had all received the regular mandatory training which included multidisciplinary obstetric training. They described this training as being very specific to caring for women and children and it helped them to provide safe care.
- The trust mandatory matrix showed that 97% of staff working in maternity had received mandatory training.
- There was an induction programme for all new staff. Data provided by the trust in June 2014 indicated that 37% of staff had had a local induction. Junior doctors identified that there was often not enough time to complete the online induction training.

Assessing and responding to patient risk

- The modified early obstetric warning score MEOWS) was used to record observations and detect clinical deterioration in a mother's condition. We saw this in use in the high dependency unit (HDU) area.
- The HDU provided a higher level of nursing care for women with medical or obstetric complications and post-surgery. Registered nurses with high dependency experience staffed this unit
- There had been 11 patients from maternity who had been transferred to the trust's critical care unit between May 2014 and June 2014. This was slightly higher than the national average.
- Babies needing a higher level of care could be transferred to the hospital's neonatal intensive care unit (NICU).
- Midwives and doctors carried out a handover at the beginning of each of their shifts. These handovers were used to discuss the women in their care. It included the stage of labour, those patients ready to be discharged, safety items such as medications that needed to be given and the number of midwives available on shifts.

Midwifery staffing

- On the day of our inspection, there were enough staff to provide care to mothers. The midwife establishment was 167 whole time equivalent, which meant a midwife to birth ratio of 1:30 in May 2014. This was higher than the national guidance of 1:28. Medical and midwifery staff we spoke with said staffing was a concern and increased pressure on them. Midwives reported that they sometimes had no breaks, and had to stay late after the end of their shift.
- The senior management told us that 22 new midwives had been recruited and they would bring the department to a ratio of 1:29. However, most of these staff would be junior midwives and not due to start in post until later in the year.
- Medical staff also reported that the shortage of midwives had an impact on the prenatal and postnatal wards as the labour ward had to take priority if there were staff shortages. To cover staff shortages such as sickness, specialist midwives were used in the clinical areas to fill these vacant shifts.
- Bank (overtime) staff were used to cover midwife absences. Regular bank staff who knew the department were used. They were given a full induction to the department and attended the trust's mandatory training.
- Medical and midwifery staff participated in shift handovers to maintain the safety of patients and continuity of care. At these handovers, any safety concerns were reported to staff. Doctors' handovers included reporting how many midwives would be working on the shift to ensure patient safety.
- Before our inspection we were told that mothers were concerned with the proportion of midwives of a junior grade. During our inspection we saw that there was a larger proportion of junior midwives, compared to the national average. The department was exploring ways to retain staff after they had been recruited. There was a supervisor of midwives (SOM) who was responsible for overseeing recruitment and retention initiatives, but they were not available during our inspection.
- There were registered nurses employed to manage women in the HDU who had specific training and skills in high dependency nursing. Staff told us that having the HDU team was reassuring for them and their patients.
- During our unannounced visit we spoke to four midwives who reported that they frequently missed breaks and worked late at busy times.

Medical staffing

- There were 20 consultants in total and, of these, nine specialised in both obstetrics and gynaecology. Consultant presence for the labour ward was 110 hours a week. This included elective caesarean section.

Consultant presence in the delivery suite was 84 hours per week. This was above the national minimum required for 40 hours consultant presence on labour wards.
- Consultant cover was from 8am to 8.30pm seven days a week. Handovers took place at 8am and 8pm. There were ward rounds at 5pm.
- There was on call consultant cover was provided when there was no consultant present on the labour ward. There were also 26 trainee doctors with a complex rota providing 24 hour daily cover, seven days a week.
- There were two consultants for anaesthetic cover Monday to Friday between 8am and 5pm on the labour ward. The private wing had a resident consultant anaesthetist at all times. Weekend cover by anaesthetists was provided between 8am and 5pm and there was on-call cover from a registrar.
- There were daily consultant-led clinics. These included HIV and maternity medical antenatal clinics.
- Junior doctors told us that locums were used to fill gaps as much as possible and they were able to balance rotas with their training needs.

Major incident awareness and training
- Staff explained that they followed trust policy in the event of a major incident. This policy was available in the department and on the intranet.

Are maternity and gynaecology services effective?

Good

The maternity service used evidence-based national guidance from the Royal College of Obstetricians and Gynaecologists (RCOG), National Institute for Health and Care Excellence (NICE) and the Royal College of Midwives (RCM). However, the monitoring of compliance with current legislation and guidance needed to improve. There was effective multidisciplinary team working between the hospital and community midwives and GPs. There was a referral system to other specialities for women who were at high risk. Outcomes for women were comparable to hospitals of a similar size, although there was a higher-than-average number of caesarean sections performed, including 32% in May 2014. Staff training was well-supported and midwives were supervised, but there was a shortage of supervisors. There was a recruitment plan to address this.

Evidence-based care and treatment
- Policies were based on guidelines from the RCOG, NICE and RCM. The service was compliant with the majority of NICE guidance and had identified the reason where partial compliance remained for a few.
- Care was provided in line with RCOG guidelines, including Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.
- In October 2103 the clinical governance report identified that 128 out of 267 (48%) of guidelines required review. Most policies we saw had been reviewed and updated and were available on the trust's intranet. Staff we spoke to were aware of guidelines such as how to manage sepsis and third and fourth degree tears.
- We saw evidence of the department's audit programme. Although some audits had been undertaken, such as audits for caesarean section and post-partum haemorrhage, the programme was still being completed. Of 12 audits identified under maternity in the quality report for quarter four 2013/14, nine (75%) were still in progress, (despite the data collection period ending in 2013), one was correctly in progress and two had been completed. The lead clinician for governance and clinical audit told us that efforts were being made to implement an effective audit plan so the department could reduce the risk of harm to patients.

Pain relief
- Women reported that they received pain relief when they needed it. They told us that they were given a choice in different stages of their labour. One woman said, "pain relief was not a problem – I got it when I needed it".
- The birthing unit provided had a clear protocol for provision of a range of pain relief such as pethidine. Further pain relief was available including epidurals which were provided on the labour ward.
- Staff were competent in providing pain relief. Although there were incidents of medication errors, the number of these incidents was similar to the national average. Pain relief audits assessed that the pain relief given to women was effective.

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Nutrition and hydration

- People told us that the hospital food tasted good. Drinks and snacks were available throughout the day.
- Women who had surgery were given a strict intravenous fluid regime. Nurses on the HDU were able to explain fluid balance regimes and how they administered intravenous fluids and medications.

Patient outcomes

- The rate for caesarean sections ranged from 28–38% per month between May 2013 and May 2014. The rate for emergency caesarean sections was decreasing but the rate for elective caesarean sections was increasing. Audits had been undertaken to look at the root cause and analysis of what could be done to reduce the rate. The rate was slowly declining but remained at 32% during May 2014.
- A stillbirth review had been undertaken between September 2013 and February 2014. Results showed that, of the 15 cases, no evidence was found relating to poor care or service delivery within the maternity department.
- All serious incidents were monitored and were at a rate comparable to other trusts. There were no maternal deaths reported for 2013/14.
- The rate of third and fourth degree tears was lower than 5% which is the threshold expected by RCOG.
- There were 11 unplanned admissions to the intensive care unit (ICU) between July 2013 and July 2014. These women had been assessed using the modified early obstetric warning score and safely transferred. The department treated a high number of high-risk women compared to some other trusts, as they took referrals from other hospitals. Midwives and obstetricians visited the ICU regularly while these women were there to provide the necessary care. We saw that outcomes were good for women following ICU care. For example, women who suffered massive obstetric haemorrhage were cared for in the ICU then transferred back to maternity once their condition had stabilised.
- New mothers were encouraged to breastfeed but were shown a range of options and supported to feed their babies however they chose. Information was available about techniques such as how to make up artificial milk. Specialist breastfeeding midwives were available to assist women with feeding their babies. Most women we spoke with had opted to breastfeed. Those who chose not to breastfeed said they were given other options, which they had discussed at various stages of their pregnancies. We saw an audit from October 2013 that showed the rate of women leaving maternity breastfeeding was above 90%. This was better than the national average of 70%. We also saw breastfeeding guidance that was given to mothers to support them with their breastfeeding.
- The unit had full accreditation under the UNICEF Baby Friendly scheme.

Competent staff

- Junior doctors reported that there were training opportunities and teaching took place every Friday. They were well-supported by consultants.
- There was a higher-than-average number of junior midwives in the department. Women using the service had reported this as an issue of concern in the CQC Survey of Women's Experience of Maternity Care (2013). We found that junior midwives spent a year on induction and completing professional competencies. Those we spoke with said they had been supported throughout this time.
- All staff we spoke with had appraisals and regular continuing professional development.
- All midwives we spoke with had a SOM who performed their annual review. The ratio of SOMs to general midwives was 1:17 which was higher than the recommendation of the local supervisory association. The head of midwifery told us that there were plans to recruit a head of SOM within the next year.
- Staff told us that mandatory multidisciplinary obstetric training included practical sessions on CTG monitoring, and basic life support and what to do in the event of an emergency. There was a 100% attendance rate for this training.
- 95% of midwives and registered nurses in HDU had completed adult life support training. Staff had been trained in CTG interpretation. There was a "buddy system" for hourly CTG reviews by midwives.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within obstetrics and gynaecology rated their overall satisfaction with training as similar to other trusts. However, local induction was rated as worse than other trusts.

Multidisciplinary working

- There were clinics for high-risk women with medical problems such as diabetes, HIV, and female genital

mutilation (FGM). Women with cardiac problems had shared care with another local trust. Any referrals to members of the multidisciplinary team and other specialities were followed up by midwives.

- Community midwives liaised between GPs and hospital staff to provide care for women. They informed us there was a good continuity of care for women between the community and the hospital staff. There was, however, an issue about the lack of IT support in one community area. This had been raised as an incident but had not been rectified. We were told that this resulted in some community midwives taking longer to receive some blood test results. While this did not impact on women's care, it was time-consuming for midwives.
- Staff could access medical support from other specialities during the mother's stay on the maternity ward. We were told of medical staff visiting their patients regularly. If a mother was transferred to the ICU, maternity staff would visit them to provide check-ups and care and visit their baby in the NICU if they were admitted to that unit.

Seven-day services

- There was obstetric consultant presence between 8am and 8.30 pm seven days a week. Junior and middle grade doctors were present 24 hours a day and seven days a week. There was anaesthetic presence available 24 hours a day, seven days a week.
- The maternity urgent care centre was available 24 hours a day and seven days a week.
- Radiology services were led by a consultant and were available on weekends until 6pm. The consultant was then on call over the weekend.
- The pharmacy department was open seven days a week but with limited hours on the weekend. There were pharmacists on call out of hours to provide advice to staff on duty.

Are maternity and gynaecology services caring?

Good

Women told us that they were treated with dignity and respect. Staff were polite and caring and provided emotional support for women who had complications in labour and birth. Women were encouraged to discuss and make birth plans. Feedback from surveys showed an overall satisfaction with care. An NHS doula (a person who helps a mother through the birthing process) service was available. This service was not common to maternity services, but had been requested by women. Women had appropriate support. For example, women who had a termination of pregnancy for foetal abnormalities were offered support from specialist midwives.

Compassionate care

- All women we spoke with said staff had been caring and they felt the staff listened to them. We observed staff speaking to mothers in a polite and respectful way. Fathers we spoke with said they had been involved with the birthing process.
- The NHS Friends and Family Test showed that, overall, 87% of patients felt highly satisfied with the maternity wards. The scores were better than the England average for the postnatal questions within the test but antenatal care and birth scores were worse than the England average. The trust's own survey results showed that women and their families were happy with the care provided.
- The CQC Survey of Women's Experiences of Maternity Care 2013 showed that the trust was performing about the same as other trusts on all questions on care, treatment and information during labour, birth and care after birth. There were two questions where the trust performed better (in the top 20% of trusts) and these were for staff introducing themselves and the length of stay on the unit. There was one question where the trust performed worse (in the bottom 20% of trusts) and this was for the cleanliness of bathrooms and toilets.
- During our inspection we saw women being treated with dignity and respect. We saw staff giving assistance and providing regular comfort rounds (where staff check on patients every two hours).

Patient understanding and involvement

- The antenatal team provided women with information about childbirth. Women we spoke with in the antenatal unit said they had received enough information to make good choices. Women were involved in their birth plan and advice and explanations were provided by staff. One woman said, "All my options were explained to me and then I was allowed to make a choice," and another said, "This is much better than the hospital I had my first child in – everything was explained to me and I felt like I was in control of labour".

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- Women told us that they had been given clear information about the treatments they had received. One said, "I have been involved in all aspects of my care".
- Women were provided with a named midwife. This meant they had a contact person they could call if they had any queries. Midwives told us this helped women who were anxious about the birthing process. There was online information about the service and explanations were provided about the different birth settings that were available.

Emotional support

- We observed midwives giving emotional support to women post-delivery. We were told that women who had complications during labour where offered follow-up care.
- There were clinical nurse specialists for breastfeeding, mental health, and HIV.
- There was a midwife for mental health who helped women with previous postnatal depression or anxiety. Risk assessments were carried out on women to reduce the risk of postnatal depression. One woman who had postnatal depression after a previous pregnancy had been referred to the midwife and she said, "It had been a great help".
- There was a bereavement counsellor who supported women who had experienced the unexpected death of a new-born baby.
- Late gestation terminations of pregnancies were carried out on the unit, follow-up support was given to women if they needed it.

Are maternity and gynaecology services responsive?

Good

The maternity services and family planning services were responsive to people's needs. Antenatal risk assessments were carried out for women and there was a range of high-risk clinics, such as cardiac, endocrine, haematology and HIV. There was also a specialist midwife for mental health. Women were able to choose where they would have their babies and had access to the full range of options for birth, subject to the appropriate risk assessment. Social assessments were carried out to support vulnerable women. The department was open and transparent when things went wrong. We saw that complaints were handled effectively.

Service planning and delivery to meet the needs of local people

- The birthing unit had capacity to care for women who were considered to have low-risk births. During our inspection the unit was full and this was escalated to the appropriate hospital team.
- There was a midwife who dealt with the flow of patients to the department, and liaised with the bed management team within the trust. They were also responsible for ensuring that all areas had the appropriate number of midwives needed to provide care according to the demand of the labour ward. For instance, midwives were taken from the birthing unit to the labour ward if they were needed.
- The maternity urgent care centre was introduced in February 2013 and used a telephone triage system. Following triage assessment, women were sent to appropriate areas of the department or sent home. For example, women who were in established labour would be sent to the labour ward.
- Birthing partners were encouraged to stay with their partners during labour and be involved in aspects of the delivery process.
- An early pregnancy assessment unit service was available on weekdays from 9am to 5pm. Referrals could be made from GPs, midwives or the women themselves.
- A midwife-led vaginal birth after previous caesarean service was re-launched in 2014.
- A new bereavement suite was opened in March 2014. There was ongoing work to strengthen the bereavement team.
- The SOMs had organised a natural birth open day in April 2013, to encourage women to feel involved in the birthing process and to provide information about the different types of deliveries.

Access and flow

- Women in labour were admitted through the maternity urgent care centre, labour ward or directly to the birthing unit.
- Bed occupancy was 57%; this was below the national average of 58.6%.

Maternity and gynaecology

- Women were offered birth plans according to their level of risk; these ensured that they were cared for in the most appropriate area during labour.
- During labour 100% of women were seen by a midwife within 30 minutes.
- Women could be admitted via the maternity urgent care centre following triage, where they were assessed by a midwife and transferred to labour ward if needed.
- Women were given their baby's 'red book' (showing records of routine tests and vaccinations) before discharge. Midwives completed a discharge checklist before discharging women.
- Records showed that women's antenatal, labour and postnatal needs were assessed and provided according to their need. Plans for follow-up clinics were made for women who had third and fourth degree trauma.
- During our unannounced inspection the labour ward was very busy and there were four women waiting in a holding bay. Staff told us that this was a capacity issue.

Meeting people's individual needs

- The atmosphere in the maternity unit was calm and peaceful.
- There was adequate space in the clinical areas. Women we spoke with said they found the environment spacious. However, staff said they would like more space as they felt the areas were very cramped. Rooms in the birthing unit were large and modern, with enough room for partners to stay. One partner told us "they offered me the chance to stay".
- Women were provided with antenatal assessments and screening. Medical histories were taken and any referrals to other specialist teams were made.
- There were specialist midwives for breastfeeding, mental health, and HIV to support women.
- A social assessment was undertaken by midwives in the antenatal clinic. This identified language issues, housing problems or where a social care package was already in place.
- Staff informed us that there were information leaflets available in different languages for women; however, no one could show us these. An interpreter service was available for women who needed it. Family members were not used as interpreters.
- Staff were able to deal with complex care needs. There was a range of high-risk clinics for women such as cardiac, endocrine, haematology and HIV. There was also a specialist midwife for women with mental health conditions.
- Partners were able to stay with women 24 hours a day. There was a bathroom and shower facilities provided for them. Those we spoke with were happy with this arrangement.
- We were told that the doula service available was especially helpful for women who needed induction of labour.

Learning from complaints and concerns

- Complaints handled at local level were done so in a timely manner. Complaints were handled by the shift coordinator or matron for inpatients. Staff told us that complaints were handled as soon as they were received. If a complaint was received from a discharged patient, the complainant would be called back if necessary. This sometimes resolved the complaint and avoided a formal complaint being made. The calls made to complainants had made a difference to the number of complaints being escalated.
- We saw that the number of formal complaints were low. Formal complaints were logged and the one complaint we looked at included a record of the actions staff had taken and the timescales for responding. It was noted that the timescales in the trust's policy had been adhered to.
- Some complaints came directly from the trust's governance system and were handled according to trust policy. An audit of complaints had been undertaken and management had attempted to reduce the number of complaints by changing the policy so more could be handled by the department first.
- In response to complaints of previously restrictive visiting hours, most of the department was open for visitors 24 hours each day.

Are maternity and gynaecology services well-led?

Good

The service had a three-year strategy to improve governance, safety and capacity. Work was ongoing on

each of these issues and staff were aware of the strategy. Governance arrangements had greatly improved assurance around quality, risk and safety, although action plans for improvement needed to be formally completed and the dissemination of learning including around the most serious risks need to be more effective.

Most staff enjoyed working in the department but some indicated that the leadership and culture of department needed to improve. The service did not have a clinical director and the midwifery leadership needed strengthening. Working relationships between midwives and doctors needed to improve: midwives were concerned about the erosion of their autonomy by medical interventions, and medical staff about the need to supervise junior midwives. Staff shortages and the lack of supervisors of midwives were having an impact and, for some, contributing to low morale. Actions were being taken, for example, recruitment had occurred and a review of issues was planned for staff who were under stress on the postnatal ward. Public engagement and support for women was good and the department was innovative and had made improvements in many areas. Further improvements in staff engagement were required.

Vision and strategy for this service

- There was a three-year strategy for the women's service, for 2013–2016. This included plans to improve the governance of the department and safety of the service and manage capacity issues.
- The 'Shaping a healthier future programme, outlines the reconfiguration of acute services in North West London, and the activity in the department was expected to increase significantly, with an expected 500 more births in 2014/15.
- Staff were aware of the strategy. The clinical leads of the departments said they were aware that "there was still work to do".

Governance, risk management and quality measurement

- There was a new governance structure for maternity which started in January 2014, and new meetings had been implemented by the clinical lead for risk and governance to give cohesion to the structure. Monthly multidisciplinary team meetings, maternity safety and maternity committee meetings were held. The risk register was discussed three times a year. The results of these meetings were fed back to the hospital governance team. This had enabled the service to make links between the incidents they had and provide action plans to improve care given to women.
- A new audit plan was now being implemented by the risk and governance team. This included audit topics identified by the clinical risk management lead doctor. The team were aware that some more work was required to consolidate the programme. On the audit matrix in the Maternity risk management annual report 2013–2014, action plans had not always been completed following audit. For example, post-partum haemorrhage cases had been audited between January and November 2013. The action plan had not been completed but a new guideline had been implemented to manage post-partum haemorrhages, there had been three of these haemorrhages between December 2013 and April 2014. The aim of the team was to ensure the quality of the service was maintained during the transition period of the new structure being implemented.
- Similarly, learning from the meetings that discussed risk was adequate even though action plans were not completed. For example, a risk around baby tagging remained on the register and was due to be completed in May 2014. During our inspection we found this had still not been completed. A new completion date was set for September 2014.
- The risk register was used to identify risks, provide action plans and update guidelines and procedures in the department. Risks were identified and reported by staff in the department. Following investigation, these risks would be reported at the multidisciplinary team meeting, mortality and morbidity meetings and maternity safety committee meeting. However, this dissemination of learning was not always effective and some of the junior members of staff we spoke with were not always aware of the more serious risks that women could face within the department.
- The clinical audit programme did not demonstrate compliance with guidelines, with nine out of 12 (75%) audits still in progress.
- A Maternity dashboard was used to record activity and management data, as well as clinical and trust indicators, and provide a monthly record of performance against targets. It was a tool to monitor trends and risks especially relating to safety and helped to identify potential harm to patients

Maternity and gynaecology

- The maternity dashboard used within the department monitored safety and effectiveness. Outcomes for women had improved since the new governance structure had been put in place. For example, elective caesareans sections were declining. The high number of caesarean sections and shortage of staff was a risk identified by the management team. In the maternity services meeting May 2014, there was a small overspend reported for April 2014 due to the number of bank staff needed to maintain midwife numbers at a safe level.
- The maternity dashboard was completed monthly and included performance indicators to maintain safety such as the number of readmissions, serious incidents, unit closures and level of one-to-one care for women.
- Reports of babies falling out of bed due to co-sleeping with mothers on wards were on the risk register from 2013. This was being monitored as a potential risk so midwives could inform mothers of the dangers of co-sleeping with their babies in a bed. No new incidents had been reported and appropriate action had been taken.

Leadership of service

- The service did not have a clinical director at the time of our inspection. There was a lead midwife.
- All midwives we spoke with had a SOM who performed their annual review. The ratio of SOMs to general midwives was 1:17 which was higher than the recommendation of the local supervisory association. The head of midwifery told us that there were plans to recruit a head of SOM within the next year.
- Some midwives reported that the department did not have a consultant midwife and felt that this role would allow them to be more "proactive" with their roles, and give them a chance to increase their autonomy, which they reported had been eroded. We discussed this with the lead midwife who informed us that there were no plans to employ a consultant midwife.

Culture within the service

- Some staff spoke of a culture where they could approach and challenge doctors to improve the outcomes for women. Junior and some senior midwives told us that staff were very supportive. They said they could approach any member of staff for help and would receive it.
- Most senior members of the medical and midwifery staff told us that they actively encouraged women to have normal deliveries where possible.
- A few senior midwives, however, said they sometimes found the service was very consultant-led. Midwives expressed concern with the level of medical intervention and said they felt it difficult to change ideas and practice within the department. We were told of examples such as a room in the birthing unit being used by consultants, without prior discussion with midwives. We were also informed of medical decisions for caesarean sections and third stage labour overriding midwives when they felt the woman was progressing well and could have a normal delivery. Staff also informed us that women wanted a medical approach to delivery and they had high proportion of women requested caesarean sections.
- Some medical staff told us that have many junior midwives who lacked experience did mean that they had to be monitored and supported all the time.
- Attendance at multidisciplinary team meetings was encouraged for all levels of staff so they could hear cases of women that were high risk or complex. Staff attended, but midwives reported that sometimes the lack of staff on the wards made it hard to attend.
- Most midwives and doctors told us they enjoyed working for the trust. One said, "I love working here," and another said, "people are very supportive". However, a few midwives told us that their morale was low due to shortages of staff, having so many junior midwives and the medical model of care. Staff including management told us that they felt some areas of the department were too small to meet the numbers of women presenting in the department. More midwives had been recruited but many were junior and the lack of experience would be a concern.

Public and staff engagement

- Women were engaged through feedback from the NHS Friends and Family Test and complaints and concerns. The Friends and Family Tests reported that most women were happy with the service.
- The supervisors had analysed complaints received in the department and the annual report 2013/14 reported on the major themes of complaints. Comment cards were also given to people using the service to give any feedback they had.
- There were follow-up clinics where women could report on the service they had been given. These were provided by midwives and doctors and included 'after

thoughts' which was introduced to be more supportive to women who have dramatic births and be more responsive to patient complaints. Women could make referrals to this clinic themselves.
- Some midwives told us that sometimes there were changes made that affected them but they were not consulted.
- The service held a monthly maternity experience committee which looked at information on patient experiences and staff experiences. In the last meeting in June 2014, for example, posters on staffing levels had been produced for display on wards, and action was being taken to review the stress levels of staff on the postnatal inpatient wards and to recruit a Black and minority ethnic midwife to lead on a project to reduce discrimination in the workplace. This was in response to the RCM report, which showed that, in London, a disproportionate number of midwives who were disciplined or dismissed, were of Black and minority ethnic origins.

Innovation, improvement and sustainability

- The department was innovative and had made improvements in many areas. For example, the department had received an award for the FGM service they provided. The mandatory multidisciplinary obstetric training the trust used had also achieved an award. This training was effective and helped staff to care for patients. The use of NHS doulas was seen as innovation and the service had breastfeeding rates of over 90%. The support from breastfeeding midwives had improved on this figure.
- Staff were working to reduce the rates of caesarean section such as encouraging a vaginal birth after previous caesarean. However, the rates for elective caesarean were increasing.
- The CQC had concerns around the high rates of postnatal infection and had informed the trust in April 2013. The trust had worked to reduce the number of these infections and during our visit we saw these numbers had declined.
- The trust had a cost improvement programme which had an impact on maternity services. The maternity department had looked at ways to provide a model of shared antenatal care with GPs to reduce hospital visits.
- At the request of the directorate leads, a stocktake of the service had been carried out by a team from the trust in August 2013. This was done to provide an independent assessment of the way the department addressed key issues of concern such as infection rates, stillbirths and complaints which affected the department. Results showed there had been improvements in these areas.

Services for children and young people

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

Information about the service

Chelsea and Westminster Hospital NHS Trust provides services to children and young people via Chelsea Children's Hospital which was officially re-opened, following refurbishment and rebranding, on 18 March 2014. The hospital provides a range of paediatric services, including general surgery, medicine and neonatal intensive care.

Most services are based on the first floor of the main hospital and managed by the Neonatal, Children's & Young People's directorate. The directorate comprises a children's outpatients department, a 16-bed medical ward (Neptune), 24-bed surgical and gastroenterology ward (Mercury), 12-bed adolescent ward (Jupiter), 12-bed day care unit (Saturn), a 12-bed paediatric high dependency unit (PHDU), of which eight are funded and a level 3 medical and surgical neonatal intensive care unit (NICU) which also provides extended recovery for up to three infants aged 0–6 months who may have been admitted from home with a surgical problem.

There were six paediatric wards throughout the hospital. Private patients are seen in some paediatric areas There was also a six-bed burns unit (Mars) and four paediatric operating theatres, which were managed by other divisions within the trust. The NICU provided facilities to care for up to 37 babies, including intensive care cots, high dependency cots and special care facilities. The unit is designated as a level 3 neonatal unit. The dedicated paediatric outpatients department had 22 consulting rooms which were permanently allocated to individual paediatric consultants. There was also a range of outpatient clinics covering all specialties.

The service sees over 75,000 children a year as inpatients, outpatients, in children's A&E and as day cases. At the children's hospital in 2012/13, there were 41,840 follow-up appointments and 24,940 new outpatient appointments in clinics.

During our inspections of services for children and young people at Chelsea Children's Hospital, we spoke with nine parents/carers, two children and 29 members of staff. The staff included medical, nursing, management and ancillary staff. We visited the children's outpatient department, Neptune, Mercury, Saturn and Jupiter wards, the HDU and NICU. We spoke with people, observed care and reviewed records and documentation. We reviewed other documentation from stakeholders, including performance information provided by the trust.

Services for children and young people

Summary of findings

The Chelsea Children's Hospital needed better procedures to provide effective and safe care for children. There was 24-hour resident paediatric medical cover at all levels, including consultants for paediatrics and the neonatal intensive care unit (NICU). However, nurse staffing levels needed to be monitored so that levels and skills mix were appropriate and in line with Royal College of Nursing guidelines. Incident reporting needed to improve and lessons learned shared more effectively. Staff mandatory training also needed to improve Clinical practice guidelines needed to be updated and monitored to ensure compliance with national standards. Staff were caring and child-centred and we received positive feedback from the majority of children, young people and parents that we spoke with about their caring attitude of staff. The Chelsea Children's Hospital had excellent modern, spacious dedicated and child-friendly facilities. Services were responsive to children's needs and there was good support for children with a learning disability or mental health needs, although out-of-hours support for mental health needed to improve. The service needed to develop clear strategies. Governance structures did not provide the assurance around quality, safety and risk and were described as "haphazard" by staff.

The leadership team in the department and the trust was described as "not visible or fully supportive of staff". The culture in the service overall was described as "good" but staff identified a culture of bullying in neonatal care that needed to be addressed. The trust was taking action to improve the service. Public engagement was good but staff engagement needed to improve. There was innovation in the service in neonatal care, for example, there was outstanding practice in neonatal end of life care, although there was less evidence of improvement in other areas of the service.

Are services for children and young people safe?

Requires improvement

Procedures to keep children and young people safe from avoidable harm required improvement. Staff were encouraged to report incidents but there was an inconsistent approach to feedback and learning. Infection control practices were followed but some staff did not observe the 'bare below the elbow' policy for ensuring good hygiene practices. Equipment was regularly checked and most medicines were stored appropriately. Medical staffing met national recommendations but there was a shortage of nursing staff. There was a high use of agency staff and not all ward areas had appropriate levels of skilled staff. During our inspection we identified a healthcare assistant who had not worked on the ward before monitoring a child in the HDU. Staff had not completed mandatory training to appropriate levels and this included safeguarding and basic life support.

Incidents

- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There had been two Never Events reported between January 2013 and March 2014 in the service, both of which occurred in theatre. One was for wrong site surgery and the other was a retained oral swab. These investigations were carried out by senior staff within the surgical division. Actions included: an update to the swab, needle and instrument policy to reflect the additional controls; an audit of this practice; amendments to the hospital's surgical safety checklist – based on the World Health Organization (WHO) checklist – in October 2013. The action plan was confirmed as completed in March 2014. The surgical safety checklist was audited in paediatric theatres in April 2014 and was 100% compliant; there had not been any further audits.
- There were six serious incidents reported between April 2013 and March 2014, all of which had been investigated. Two further serious incidents had occurred since April 2014, and initial analysis had taken place, though the investigations were not completed at the time of our inspection.

- Root cause analysis investigations were undertaken when serious incidents or Never Events occurred. However, some senior staff who were responsible for undertaking these investigations had not received specialist training in these methods, to ensure that investigations were appropriate.
- Staff told us they reported incidents via the trust's paper-based incident reporting system. Staff, including those responsible for investigating incidents, were concerned that the reporting system was not robust as the paper forms sometimes went missing, which led to delays in the investigation process.
- Ward-based staff told us they were clear about the need to report incidents and said they discussed outcomes of incident investigations during weekly meetings led by the nurse in charge.
- The nurse in charge of the ward told us they were responsible for investigating incidents relating to nursing staff and healthcare assistants. They were also responsible for coordinating investigations of all incidents that occurred within their ward, including those that involved medical, therapy and pharmacy staff. We were told this sometimes delayed the investigation process and that learning from incidents was not always shared across the other groups of staff.
- The trust expected staff in each ward area to keep a daily record of whether a drug error, incident or fall had occurred. We identified that there were three drug errors in July 2014 at the time of the inspection. Senior staff we spoke with told us they were unaware of the impact or any learning from these incidents as they were awaiting investigation.
- Feedback from incident investigations was shared with staff via the clinical effectiveness newsletters which highlighted the top five incidents on a quarterly basis. For example, in July 2014, medication error was the most reported incident type. Actions stated did not address root causes. For example, in response to the high number of medication errors, learning reported in the newsletter was that staff should "check prescriptions"; the root cause for why this may not be happening were not shared.
- Moderate incidents, serious incidents and Never Events were reviewed by the clinical effectiveness sub-committee which met monthly.
- Neonatal morbidity and mortality review meetings had happened in the department at least bimonthly in the last 12 months. Cases were discussed with anaesthetists and obstetricians. Actions from meetings, however, were not always recorded.
- We were shown a presentation of a review of three patients from morbidity and mortality meetings. All reviews stated the actions that were required. Evidence to demonstrate how lessons were learned from these reviews was not provided.

Safety thermometer

- NHS Safety Thermometer data was collected within the directorate monthly.

Cleanliness, infection control and hygiene

- All of the areas we visited were visibly clean and we observed cleaning taking place on the wards. There were up-to-date cleaning schedules in these areas.
- Hand sanitisers and hand-washing facilities were available for use within all the inpatient areas we visited. Automatic antiseptic hand gel containers were also situated at the entrance to and at other locations on wards.
- However, we witnessed a doctor who was not bare below the elbows in the outpatients department. A member of staff told us that it was difficult to challenge some medical staff regarding infection control practice. They said that when they escalated concerns to senior medical staff, they were not dealt with effectively.
- We observed that most staff observed the infection control policies, including hand hygiene and using protective personal equipment appropriately.
- Regular infection control audits took place. The trust provided data from its most recent infection control audit dated March 2014. This showed that wards were fully compliant and effective with regards to infection prevention.
- There were infection control nurses in most ward areas we visited, who had received specialist training to provide advice to staff.
- In the NICU we were advised that single-use pacifiers (dummies) were discarded after use.

Environment and equipment

- Ward areas were bright and airy, and many were designed to be child-friendly. Some areas were undergoing refurbishment which meant that wards were located in temporary facilities.

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- In the refurbished ward areas, bays were clean and comfortable. There were also side rooms which were used for babies, or when children or young people needed isolation.
- Children and young people with more complex needs were often cared for in one bay, which was closest to the nurse's station, ensuring they could be easily observed by staff.
- There was a system for checking resuscitation and other equipment in ward areas and in the outpatients department. We looked at 10 pieces of equipment and found they were fit for purpose, regularly checked and in working order.
- We looked at four resuscitation trolleys and found specialist equipment available for all age ranges that was easily accessible and was fit for purpose.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary.
- Paediatric pharmacists provided regular daily support to the wards and reviewed medications.
- Fridge temperatures were checked and steps were taken to ensure they were maintained at the correct levels.
- The medicines refrigerator temperatures on Jupiter Ward had been recorded and these were sometimes in excess of expected levels. The temperature in the medication room exceeded 30 degrees in May 2014 which staff told us resulted in medication having to be discarded. Ventilation systems had been installed to maintain temperatures within the appropriate range.
- One gas cylinder of nitrous oxide gas had expired in 2013.

Consent

- Staff we spoke with confirmed that children's or their parent's consent would be appropriately sought prior to any procedures or tests being undertaken. Children were involved in giving consent as appropriate
- Parents/carers we spoke with told us that they had been involved in decisions relating to the treatment offered.

Safeguarding

- A named nurse, named doctor and designated doctor for safeguarding children were available for assessment, advice and to ensure the trust fulfilled its legal obligations. Staff we spoke with were clear that there was a named safeguarding contact who they could call if there were any concerns.
- Ward-based staff told us that the service remained involved in any referrals made and that feedback and support was provided to staff involved in these situations.
- A safeguarding committee, attended by the named professionals, managers and senior ward staff, met quarterly to look at issues surrounding safeguarding within the service.
- Three serious case reviews were investigated in partnership with local authorities between April 2013 and March 2014. Recommendations for the trust from each review had been implemented.
- All children who are subject to a child protection plan in local authorities were highlighted by the safeguarding team on the electronic patient record system.
- Evidence provided by the trust demonstrated that 90% of staff had attended level 1 training for awareness in safeguarding children, and 87% of staff had attended level 2 training.
- Staff working predominantly with children, young people and parents were required to complete level 3 safeguarding children training. In May 2014, only 69% of relevant staff had received this training; this had increased to 78% in June 2014. Concerns regarding the level of uptake were stated in the 2014 General Medical Council (GMC) National Training Scheme Survey for trusts which showed that not all trainee doctors had attended mandatory child safeguarding training.
- Domestic abuse was the third leading safeguarding concern within directorates. Domestic abuse awareness had been incorporated into all levels of safeguarding children training sessions.

Mandatory training

- Managers told us the trust database for mandatory training records was sometimes out of date as it was based on data that was up to two months old. They felt that their own records were more accurate.
- Ward-based staff told us that they had received specialist paediatric life support training. Evidence to confirm completion was requested but had not been provided by the trust.
- Staff who worked with neonates (newborn infants) told us they had received neonatal life support training. Monthly simulation training sessions were held and all staff were allocated to attend. This included staff who were managed by different clinical service units.

- The June 2014 mandatory training dashboard showed that, overall, 72% had completed mandatory training. However, some medical staff had not attended basic life support training. Only 18% of paediatric surgical staff had attended this training, and there was less than 60% attendance from paediatric emergency, craniofacial surgery, paediatric dentistry and play specialists staff.
- There was an induction programme for all new staff. Data provided by the trust in June 2014 indicated that 40% of staff had had a local induction. Junior doctors identified that there was often not enough time to complete the online induction training.

Assessing and responding to patient risk

- The department used a Paediatric Early Warning Score (PEWS) system which had been developed by nursing staff to provide an alert if a child's clinical condition deteriorates.
- Nursing staff we spoke with were aware of the appropriate action to be taken if patients scored higher than expected.
- The two completed PEWS charts we looked at showed that staff had escalated correctly, and repeat observations were taken within the necessary timeframes.
- An audit of the PEWS was undertaken in 2013 but results were not available at the time of our inspection. The audit found the PEWS tool used by the trust did not provide clear directions for escalation on the observation charts. We were told that the national standardised PEWS chart would be implemented later in 2014.
- A trust-wide policy for the prevention and management of the deteriorating patient was implemented, though this had not been updated since 2011.

Records

- Nursing and medical records, including risk assessments, we reviewed were completed appropriately.
- All patient records on the HDU were electronic, linking with laboratory results and prescriptions.
- Senior staff told us that a documentation week event was held in May 2014, which included audits of nutrition, hydration, PEWS and care plans. Although, staff we spoke with did not know of or attend this event. We saw that audit results were shared with the matron and nurse coordinators.
- A tool specifically designed for use with children and young people in assessing risks to pressure areas, the modified Braden Q scale, was in use to help predict paediatric pressure ulcer risk.

Nursing staffing

- Nursing staff told us nurse staffing levels has not been assessed and that no acuity tools had been used to determine ward staffing. Nurse coordinators were responsible for ensuring skills mix and staffing levels were suitable for their ward area, and used their clinical judgement. However, following our inspection the trust told us an acuity tool was in use daily on NICU and an acuity and dependency audit was undertaken in May 2014 across the three general paediatric areas
- Royal College of Nursing 2013 standards recommended that the staffing ratio of registered nurse to patient should be two-to-one in high dependency care and one-to-one in intensive care. There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas and access to a senior children's nurse for advice at all times, 24 hours a day. At least one nurse per shift in each clinical area (ward/ department) should be trained.
- Planned and actual staffing numbers were displayed on every ward. Staff told us that the registered nurse to patient ratio on HDU should be two-to-one. On the first day of our inspection, the display on HDU showed inaccurate staffing numbers and the required staff ratio was not being met, but the information was also out of date by one day. We raised this with the nurse in charge, but when we returned later in day we found it had not been changed.
- We saw one healthcare assistant, who had not previously worked in children's services at the trust, was allocated to provide one-to-one support to a child who required ventilation on the HDU, with oversight from the nurse in charge, who was identified as being supernumerary (or additional to normal staff numbers) on the rota. This showed there were times when staff with the right level of experience were not on duty to ensure patient safety.
- There was a 26% vacancy rate in the NICU. Senior staff told us this was a London-wide problem and agency staff were used to fill posts. The NICU did provide one-to-one nursing care, by using bank and agency staff, but there were no further plans to address the number of vacancies.

- Senior staff told us there was a staffing shortfall with 247.63 whole time equivalent (WTE) budgeted nursing posts and 199.95 WTE actually in post. Staff reported that they were often understaffed on shifts and vacancies were filled with agency staff where possible. Senior staff reported that up to 30% of agency nursing staff and healthcare assistants.
- Agency use had to be approved by the matron and site management team due to the cost pressure. There were no concerns raised from nursing staff about use of agency staff when required. Senior staff told us they were expected to use agency staff from a select number of approved organisations. This list of approved organisations had changed in March 2014, which meant that agency staff who were familiar with the services were now not available. Staff reported that due to the use of bank and agency staff, the skill mix was sometimes inappropriate for individual shifts.
- At least one nurse per shift in each clinical area was trained. Senior staff told us a rotation programme had commenced to increase the flexibility of the workforce.
- At night and during the weekends, nursing coordinators were not supernumerary and carried a clinical caseload on some wards of up to five patients. There was access to a senior children's nurse for advice at all times.
- The senior nurse in charge was not always supernumerary. This was not happening in practice in two areas within children's services. We found instances where the nurse in charge was assigned to patients for certain shifts were they were deemed supernumerary. These occasions were not always escalated as incidents. Senior staff we spoke with told us they were unaware of these occurrences.
- There were twice-daily nursing handovers.
- We heard no concerns regarding the numbers of student nurses deployed on clinical shifts and this did not exceed the number agreed with the university for individual clinical areas.
- During our unannounced inspection we visited the NICU; there were 25 babies on the unit and 15 staff. The nurse coordinator confirmed they were within required staffing ratios but no acuity tool had been used. They had raised staffing concerns with the matron but no action had been taken to address these yet.
- During our unannounced inspection there were no staffing issues of concern on Neptune Ward but there were issues on Jupiter Ward. Healthcare assistance and agency staff were not sufficiently skilled to care for patients that needed ventilation, oncology and other specialist care. The nurse coordinator should have been supernumerary but was carrying a caseload of five children as well as the emergency bleep.
- The trust told us that Saturn ward coordinators were not supernumerary. During our inspection we noted that the nurse coordinator was manning the ward and supervising four patients.

Medical staffing

- There was 24-hour consultant cover for the paediatric and neonatal wards, seven days a week. The Royal College of Paediatrics and Child Health standards were met for consultant cover regarding medical staffing for acute paediatric services.
- Out-of-hours, specialist paediatric medical advice was provided or escalated to the required consultant by the paediatrician or neonatologist on call.
- There was also 24-hour consultant anaesthetist availability, seven days a week.
- Daily ward rounds were carried out by a consultant so that patients' needs could be assessed and acted on appropriately.
- There were twice-daily medical handovers during which all patients and their treatment plans were discussed.
- Medical staff who had undertaken training in paediatrics were allocated to the staffing rota for June 2014. Senior management staff told us that gaps on the rota were covered by locum registrar grade doctors with paediatric experience. However, when we reviewed rotas for the NICU between January 2014 and June 2014 we could see there were three gaps at middle grade level. Recruitment to address these gaps had not taken place and locums were not always used.

Major incident awareness and training

- There was a major Incident plan and service continuity plans for paediatrics and NICU. Ward staff told us there was an escalation procedure which identified the action staff would take for obtaining additional staff in the case of a major incident or when the hospital had reached capacity.
- There was an up-to-date directorate major incident policy and service plans for the NICU and paediatric wards. These described winter management plans and service continuity.

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Are services for children and young people effective?

Requires improvement

Clinical guidelines were available for use but many were not up to date and did not always take into account of National Institute for Health and Care Excellence (NICE) guidance. Clinical audit was not being used effectively to monitor compliance to evidence-based national guidelines and best practice, or to ensure that practice improved. Information on outcomes was not widely shared between staff. Pain was assessed promptly and staff used age-appropriate tools. Multidisciplinary working was evident and the department was part of local London networks to liaise on specialist care. There were seven-day, consultant-led services.

Evidence-based care and treatment

- The clinical effectiveness committee monitored the use of up-to-date guidance in clinical policies and procedures, and disseminated relevant NICE guidance to specialists within the directorate for consideration.
- The clinical effectiveness committee paper for quarter four, January 2014 to March 2014, showed that 50 out of 150 policies had not been updated since 2010 or 2011. Some policies failed to take into account NICE guidance that had been published, including an epilepsy policy.
- Local audit activity was reported in the quarterly clinical effectiveness committee meeting papers. We saw that the trust's internal clinical audit programme highlighted which local audits were ongoing. It included audits that the trust recommended as 'must do' or 'should do', such as audits against NICE guidance.
- The clinical audit plan 2013–2015 identified 86 audits in paediatrics and neonatal intensive care. Of these, only 10 (11%) had been completed; the majority were still in progress despite the data collection period ending in 2013. Only three of 16 local audits were completed. Evidence of completed audits, actions and learning identified were requested but not provided. Progress updates for the audits that were not yet completed, some of which had commenced in 2012, was requested but not provided.
- Senior staff within the neonatal, children's and young people's services directorate told us it was difficult to make even small amendments to update clinical policies and procedures as the trust's processes were onerous.
- The neonatal service was working to standards set within the Department of Health's Toolkit for High-Quality Neonatal Services.

Pain relief

- The trust told us that there was a paediatric specialist nurse for pain in post. However, paediatric pain provision was also delivered by nurses who were not trained in paediatric care within the inpatient pain management service.
- Paediatric pain charts were in use in the nursing documentation we reviewed.
- Medication records showed clear prescribing of pain relief and the time, route and dose of the medication administered.
- Monthly medication audits undertaken by the pharmacist team included measures of the provision and effectiveness of pain relief and results showed this worked.
- Following advice from the ward play specialist, staff used techniques to distract children and young people who were experiencing pain or due to have procedures involving the use of needles.

Nutrition and hydration

- Each nursing record we reviewed held a copy of the Screening Tool for the Assessment of Malnutrition in Paediatrics (PYMS), as well as a tool developed internally by dieticians. Those we reviewed were appropriately completed.
- We saw that staff presented menus with simple descriptions of the food available for lunch and dinner.
- In the records we reviewed, we saw that food and fluid charts were maintained when required.

Patient outcomes

- Mortality rates were lower than expected and there were no mortality outliers (outside the expected range) within this service.
- The department participated in national audits for which it was eligible, including the National Paediatric

Diabetes Audit, Child Health Reviews, Inflammatory Bowel Disease Audit, Moderate and Severe Asthma in Children Audit and the National Neonatal Audit Programme.

- The most recent National Diabetes Inpatient Audit results demonstrated that the trust performed in line with, or better than, the national average. One learning outcome from the audit was for increased dietician input, but there were no formals plans to address this.
- Evidence to show how findings from national audits were being used to drive change and improvement in the service was provided for some audits. We saw an action plan for the Child Health Reviews national audit and the Inflammatory Bowel Disease Audit where most actions were completed. Progress of actions following the National Neonatal Audit Programme 2012 (where four out of five measures were below national standards) was monitored.
- We were provided with results from some audits, including an audit of oesophageal atresia (a rare birth defect in which a baby is born without part of the tube that connects the mouth to the stomach) identified a mortality rate of 14% which was higher than the national average of 2.6%. The report stated this was due to the fact that the national figure only captured a one-year period. There was no further learning identified from this audit.
- Positive results showing low complication rates were reported in audits of artificial urinary sphincter (a device made of silicone rubber that is used to treat urinary incontinence) and percutaneous endoscopic gastrostomy insertion when a tube is placed directly into the stomach for food, fluids, and medications.
- Further evidence of how outcome data was monitored was not available and we were told by the trust that these records were kept individually by consultants and not reviewed within the directorate. There were no outcome measures reported for non-specialty areas.
- Figures provided from the trust's patient information database showed that, overall, reports of complications, revision and readmission rates, were lower than the national average. These rates were not reported or reviewed by the directorate's committees or groups.

Competent staff

- A training room located near the paediatric theatres was regularly used to provide interactive support for clinical procedures.
- Medical staff told us there was access to clinical supervisors within the trust.
- Only 67% of staff had received an appraisal within the last year.
- Junior doctors received weekly training. Doctors in training posts received ongoing departmental and ward teaching and consultants were entitled to up to 30 days specialist training every three years.
- In the GMC National Training Scheme Survey 2014, the trainee doctors within paediatrics rated overall satisfaction with training as similar to other trusts. Local induction, adequate experience and feedback in paediatric surgery was better than other trusts. In neonatal medicine, overall satisfaction was worse than expected when compared to other trusts; workload, educational supervision, access to education resources, feedback and study leave were all worse than other trusts and were in the lowest ranked 5% of trusts for these ratings. Handover and induction were low outliers and clinical supervision, adequate experience and local teaching were similar to other trusts.

Multidisciplinary working

- Wards were supported by paediatric physiotherapists and occupational therapists but there were no multidisciplinary ward rounds.
- Ward staff and the specialist palliative care team worked together where children came to the ward to receive care and treatment.
- Staff told us they worked closely with other health partners to support children and young people, for example, the patient's GP or health visitor and children's community nursing teams.
- There were regular multidisciplinary team meetings in some areas, namely paediatric dermatology, the HDU and paediatric medical oncology. We were unable to establish whether allied health professionals, including physiotherapists and occupational therapists, were regularly involved in these meetings.
- The service was involved in local and national networks of experts within the specialist areas. This included the North West Thames Regional Genetics Service and North West London Perinatal Network' the North Central London Epilepsy Network, Paediatric High Dependency Care Network with Great Ormond Street Hospital,

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London and South East of England Burns Network and a number of networks across North West London for perinatal care, cancer, diabetes, high dependency care and surgical care.

- Specialty areas, including paediatric gastroenterology, had transition clinics with regional service to facilitate the transfer of paediatric care to adult services. The neonatal unit had a specialist nurse who provided support for post-surgical neonates transferred back to other trusts.

Seven-day services

- There was consultant presence out-of-hours and seven days a week with residents in paediatrics and neonates.
- Children and young people had access to occupational therapy and physiotherapy services during the weekdays between 8am and 7pm. There was no access to therapy services out of hours or weekends.
- Routine radiology ran at the weekends with an on-call radiologist on site from 9am to 5pm. Magnetic resonance imaging was available.
- Pharmacists were in the hospital from 9am until 5pm on both Saturday and Sunday. Out of those hours, there was an on-call pharmacist available on the phone.

Are services for children and young people caring?

Good

Children and their parents or carers were treated with dignity, respect and compassion. Staff involved children and their parents or carers in decisions about their care and treatment, and they were supported and reassured if they were anxious or concerned. The feedback from children and young people following surveys needed to be actioned more formally.

Compassionate care

- Parents/carers and children and young people we spoke with on a number of wards, on the NICU, the HDU and in the outpatients department, told us that they had been kept well-informed and that staff demonstrated positive attitudes. One parent commented, “I really could not have asked for more from the staff. My child has long-term healthcare needs and they have been repeatedly marvellous”.
- Parents on the NICU reported that staff demonstrated compassion and understanding. One said, “Staff are caring and always on hand”.
- However, we did receive one negative comment where one parent was left waiting for 15 minutes after they pressed the call bell on a children’s ward after they pressed the emergency call bell.
- The children we spoke with in the outpatients department were all complimentary about the care they had received from the doctors and nurses. One child commented, “I like them, they are nice”.
- The service participated in the Picker Institute Young Outpatient and Inpatient Surveys in 2013. The results showed that parents/carers were positive about how friendly doctors were and that they satisfied with how doctors explained side effects of treatment. However, improvements were needed in supplying contact information after the initial outpatient appointment, with hospital food, the discharge process and child involvement in their care. Senior managers told us that they were aware of required actions, though these had not been formally addressed.
- We asked for evidence which would demonstrate that the trust did gather feedback for children and young people by other means. This information was not provided to us.

Patient understanding and involvement

- Parents/carers we spoke with felt that they had received sufficient information about the care and treatment of their child.
- The nursing records we reviewed showed that staff had asked the parents or patients for their opinion.

Emotional support

- A specialist neonatal palliative nurse was part of the multidisciplinary team and provided advice to staff as well as directly supporting parents/carers of neonates with long-term or life-limiting conditions.
- The neonatal unit also had regular input from a psychologist to support parents.
- The hospital chaplain team took part in monthly cremation services for foetuses who had died aged from under 12 weeks and had a separate service for those babies over 12 weeks; they also attended weekly meetings on the NICU to identify families who would benefit from chaplain support.

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- The records we reviewed on Jupiter ward contained evidence of assessments for anxiety or emotional wellbeing for adolescents who used the service.
- Internet access was available across the trust and details for use were displayed prominently in ward areas, so children and young people could communicate with their friends and family throughout their hospital stay.

Are services for children and young people responsive?

Good

The hospital had dedicated facilities for children and young people. These were modern, bright, spacious and child-friendly. Children and young people had good access to specialist care, and education facilities within the department were rated as 'outstanding' by Ofsted. Children were seen within national waiting times for surgery or outpatient appointments, although some clinics could be cancelled at short notice. There was good support for children with a learning disability and mental health needs, although the support provided out of hours was not consistent for these patients. Information leaflets that were child-friendly or easy to read were not available. Parents had facilities so that they could stay with their child. Complaints response times needed to improve.

Service planning and delivery to meet the needs of local people

- The trust opened the Chelsea Children's Hospital on 18 March 2014. These new paediatric facilities for children included the Saturn Ward for day case surgery, paediatric theatres, Mercury Ward for inpatients and the Chelsea Community Hospital School. The facilities were bright, spacious, and child-friendly, with sensory lighting on ceilings, art and design features and break-out areas for young people and their parents and carers. Some areas were undergoing refurbishment which meant that wards were located in temporary facilities
- Children and young people would be admitted via accident and emergency (A&E) or children with long-term health needs could go straight to the ward where they would be triaged (assessed and prioritised). Children could also be referred to the service from community teams or their GP.
- The trust's policy/staff told us they gave patients between the age of 14 and 17 years a choice of where they wanted to be cared for. However, one young person we spoke with said they had to attend the children's outpatient department, where babies and very young children are seen, even though this was not their preferred choice.
- Guidelines for admission to the adolescent ward, Jupiter, had specific criteria for children under 11 and over 16 years and those with mental health needs.
- There were four dedicated paediatric theatres for neonates and children and young people, which operated Monday to Saturday between 8am and 5.30pm for elective and emergency cases. They were staffed by paediatric anaesthetic consultants and a paediatric theatre nursing team. Operations could be carried out on the NICU in emergency situations.
- The trust was the lead centre for specialist paediatric and neonatal surgery in North West London and carried out complex surgery on babies and children.
- The service followed the trust's escalation policy to alert the bed managers about times when the ward became busy. In emergency situations, staff referred children to and received clinical advice from Children's Acute Transport Service. Details about the numbers of transfers to this service within the last year were requested from the trust but we did not receive this information.

Access and flow

- Admissions to theatres was at 7.15am. Staff told us that, between 10am and 12pm, admissions were not staggered, though children and young people with complex needs were routinely first on the list. We saw evidence of this. Out of hours, the service was provided in main theatres but clinically managed by the paediatric clinicians.
- Staff told us that children and young people being treated in the paediatric theatres were not always pre-assessed which led to delays in surgery.
- For the period March 2013 to March 2014, the trust was achieving the 18-week referral to treatment, and diagnostic waiting times were within expected targets. There was, however, a backlog of patients for paediatric dental surgery and the paediatric department had submitted a business case for further resources to deal with this.

- A number of surgical areas had been increasing activity and performing more operations in order to reduce the length of waiting lists. However, not all teams caring for children and young people who required these operations were involved in decisions to increase activity, such as neurophysiotherapists. A member of staff raised some concerns with us during the inspection about the impact of increased orthopaedic activity on staff time.
- There were 7,755 outpatient appointments that were not attended by children and young people between April 2013 and July 2014. The minutes of the most recent outpatient department meeting in February 2014 identified that that the reasons for this was not being monitored.
- During our inspection, a specialist outpatient clinic had to be cancelled and patients sent home on the day. We were told this was because the medical staff were away; some were on leave. Senior staff told us this was a rare occurrence. However, in a letter from April 2014 to consultant teams about leave requirements, it was acknowledged that a number of specialist areas were cancelling more frequently. Steps to address this had not been successful.
- Discharge meetings took place with parents and senior medical grade staff.
- The NICU was well-designed and met the needs of the babies who received care and treatment. The trust had taken steps to ensure there was adequate space between cots, though identified that this did not meet British Association of Perinatal Medicine neonatal standards and had assessed the risks and impact. Babies requiring immediate intervention after birth had direct access to the NICU services through the maternity unit.

Meeting people's individual needs

- Most children and young people were seen in appropriate environments for children or young people. Staff told us that a small number of specialist outpatient clinics were held in adult environments. There were allocated areas for older children to relax or spend time in the children's and young people's ward areas and in paediatric theatres.
- The environment within Saturn Day Unit was appropriate for the children being cared for. It was well-maintained, colourful and had posters on display. In the recovery ward, there was a noticeable lack of child-friendly displays and the appearance of the area was very clinical. Staff told us this was their own preference, rather than that of children or parents/ carers.
- Ward areas had a supply of play and specialist sensory equipment for children and young people. There was a chill-out room for adolescents.
- Children or young people with complex needs would be cared for within the paediatric service for longer than other children. For example, a person with a learning disability could still access this service at age 19 years.
- There was support for children with a learning disability. We saw that, for one child with a learning disability, the learning disability specialist nurse was involved and a Health Passport – a document which contains key information about the person's behaviours, likes and dislikes – was reviewed by all staff involved in that person's care.
- Parents were able to accompany their children to theatres and recovery areas.
- There were no child-friendly or easy-to-read leaflets available throughout the Chelsea Children's Hospital and leaflets were not available in different languages.
- Some staff were aware of available translation services. There was a telephone-only service but staff told us this was difficult to use and they preferred face-to-face translation for more complex cases.
- A joint guideline was in use for with children and young people with mental health issues who were admitted to the paediatric unit. Records we reviewed showed young people had a paediatric mental health management plan required by the guideline. However, there was a lack of mental health input for children on the wards, particularly for out-of-hours care provided by other local trusts. This put additional strain on the service where a patient required one-to-one support due to a risk of self-harm.
- An audit of the use of registered mental health nurses on Jupiter Ward was undertaken in 2013. It showed a high number of agency nurses were used. The only recommendation from the audit was for a reduction in the number of registered mental health nurses to save the trust money. There were no considerations or actions in relation to patient safety.
- Education services were provided by teachers from the Chelsea Community Hospital School. There was a

flexible attitude towards the curriculum and to personalised learning which meant that children and young people could be taught in a place they chose, including by their bedside in the ward or on the HDU.
- There was an infant feeding team who provided advice and support to women.
- Parent facilities, including fold-out beds and parent rooms, were available on each ward we visited. There was also trust accommodation available.
- One parent told us that ward staff arranged parking permits free of charge as their child used the service frequently.

Learning from complaints and concerns

- Information on how to make a complaint was available for patients and carers.
- Complaints were handled in line with the trust's complaints policy and the new Patient Advice and Liaison Service team.
- There were 26 complaints reported between April 2013 and March 2014. Most complaints were about medical staff communication, delays in treatment and misdiagnoses. Only 65% of complaints were responded to within the expected 25-day timeframe.
- Complaints were discussed at the quarterly clinical effectiveness sub-committee meeting. Evidence to demonstrate how learning was shared was not provided to us.
- Complaints data for 2014 had not been analysed at the time of the inspection. There was no breakdown of complaints or feedback by age of patient.

Are services for children and young people well-led?

Requires improvement

The leadership at the Chelsea Children's Hospital required improvement. The services had not developed a strategy or quality improvement plans. Governance structures did not provide the necessary assurance around quality, safety and risk and staff described these as "haphazard". The leadership team in the department and the trust was described as not visible and supportive of staff. The culture in the service overall was described as good but staff identified a culture of intimidation and bullying in the neonatal care unit that needed to be addressed. The trust was taking action to improve the service. Public engagement was good but staff engagement needed to improve. There was innovation in the service in neonatal care, for example, there was outstanding practice in neonatal end of life care, although there was less evidence of improvement in other areas of the service.

Vision and strategy for this service

- The service had been rebranded as the Chelsea Children's Hospital. The service had yet to develop a strategy or quality improvement plans to identify its long-term aims. Staff could not verbalise the strategic intentions of the service but wanted to provide a quality service.
- Guidance from the National Centre for Excellence in Child Care was being followed, though this was discontinued in December 2013.
- The paediatric services were currently working in conjunction with local commissioners to develop the out-of-hospital care strategy, with an aim of reducing unnecessary attendances in paediatric outpatients and A&E, and reduce admissions.
- Staff on Jupiter Ward told us they had been moved to a temporary ward two years ago and had not received an update from the senior management team about when a permanent move would occur.
- There was no children's champion on the trust board.

Governance, risk management and quality measurement

- There were separate committee structures for the paediatric service and the neonatal service, and both described meetings to review incidents, audit, guidelines and clinical governance reporting to clinical effectiveness committees. Paediatric incident reports were submitted to an incident review sub-committee. However, this committee had not met within the previous 12 months.
- Governance and risk management was neither integrated nor proactive within the directorate.
- Senior management told us the governance and risk reporting system to the board for the directorate was "haphazard" and said the information captured was "weak". They told us that all governance, quality and risk management information was monitored by the clinical governance support team, and that this team was accountable for the accuracy of the data and providing updates.

- The clinical governance support team provided collated data and produced reports for the directorate on all matters related to quality. Senior management staff did not recognise some of risks described on the most recent risk register.
- There was no dashboard presented to the board for monitoring safety for the directorate.
- Senior staff told us that the risks described in the paediatric and neonatal risk register presented in the quarter four clinical effectiveness committee paper were not up to date or reflective of the current risks to the department.
- Risks included the safeguarding processes and security on the ward areas. There was insufficient assurance that action to mitigate risks had been followed up.
- The paediatric and neonatal risk registers lacked depth and did not fully address and reflect the risks highlighted in the various reports, data and quality measurements available in relation to this service. There were no dates of entry, action or completion. We were told that some items had been on the register for over four years and had not yet been adequately resolved.
- The leadership team in the paediatric department could not provide evidence that clinical policies and procedures were kept up to date or that they had undertaken sufficient steps to ensure the safety of children, young people.
- Senior staff were unable to provide us with details of the exact rate of agency use per staff group within the directorate. We were provided with the July 2014 performance board human resources (HR) report which identified a vacancy rate of 5.73% within the directorate in May 2014. The report showed there had been a reduction in the use of agency staff but the use of bank (overtime) staff remained high. The action taken about this at board level was not noted. Staff on the wards informed us that beds were regularly closed due to staff shortages but nothing was being done to make changes.

Leadership of service

- The service had a clinical director, lead nurse and senior manager.
- Staff told us that the senior management team of the children's service was not visible in the department or supportive of staff. Staff identified that some of their concerns, such as staffing issues, were not addressed effectively and there was a lack of "ownership" of the issues identified.

Culture within the service

- Staff we spoke with told us that morale within the service was generally good and they received support from their line managers regularly. Staff did not feel they had support from divisional nurses and the director of nursing. We were informed that a senior nurse had briefed staff to not to tell us about nurse staffing level issues.
- Some staff described a sub optimal culture in the neonatal unit. Some medical staff within the NICU spoke of long-established intimidation and bullying behaviour by the senior staff when dealing with junior doctors, trainees and some nursing staff. Some actions had been taken by the trust to address these concerns, such as antii-bullying workshops, but staff we spoke with told us they were not effective as they could not see a culture change. The trust identified to us the series of measures it was taking to investigate and resolve the situation and support staff.
- We observed a consultant pull a nurse's card access tag to open a door from children's outpatients. The consultant did not ask beforehand and simply pulled the tag which was around the nurse's neck, causing the nurse to lean forward. The consultant did not say 'thank you' but simply walked on through the door.
- A clinical psychologist was available to provide staff with emotional support, and they held regular drop-in sessions which staff spoke highly of.
- The staff sickness absence rate was reported in the July 2014 performance board HR report as 3.56% in May 2014. However, in the April 2014 Neonatal, Children's and Young People's directorate board meeting minutes, the reported sickness rates was stated as 'high especially in NICU at 6.35%' and 2.49% within paediatrics. It was felt that this was due to under-reporting. Further updates regarding progress around this were not reported in the most recent meeting.

Public and staff engagement

- A youth forum was recently set up and had met once at the time of the inspection. Some changes suggested by members of the forum had already been made.

Services for children and young people

- There was patient participation in the transition group and a parents' group. Both were involved in food tasting, menu planning and design and planning meetings when the children's and young people's services areas were being rebuilt in 2013.
- A directorate newsletter was sent to staff, but the last edition was circulated in December 2013.
- A monthly bulletin was circulated to NICU staff and was on display on the noticeboard at the entrance to the ward.
- There were trust-led clinical governance half days. Staff we spoke with during the inspection had not attended these sessions.
- Staff told us that the chief executive was visible, though this was not the case for other members of the executive team. Also, some staff did not feel their concerns were listened to.

Innovation, improvement and sustainability

- The neonatal palliative care nurse had developed national standards on caring for very young babies with life-limiting conditions who needed palliative or end of life care on neonatal units. These standards had recently been shared with medical royal colleges and other hospitals for national use.
- The specialist nurse for neonatal surgery provided outreach services to parents, neonates and staff in neonatal units and the community.
- The operational leadership for the Neonatal, Children's and Young People's directorate at the hospital was an established team and spoke about the impact of recent changes across the North West London health network and the trust's cost improvement plan. They told us that the directorate had to deliver £6.9 million in cost savings. The paediatric department had not confirmed cost improvement projects as yet.

End of life care

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

Information about the service

Chelsea and Westminster Hospital provides end of life care to patients with progressive, life-limiting illnesses. Conditions include cancer, advanced organ (heart and kidney) failure, neurological conditions, respiratory failure, dementia and HIV related illness. The specialist palliative care team provides support to patients and staff at all wards within the hospital. This team also provides training to staff on the wards in various aspects of palliative care. Between April 2013 and March 2014, the hospital reported 440 patient deaths which took place in the hospital. This figure does not include those patients who were able to be transferred to their place of choice. There were approximately 400 inpatient referrals to the specialist palliative care team and 244 patients in outpatient clinics in 2013/14.

During our inspection we spoke with eight patients and three of their relatives, We also spoke with 28 members of staff, including the specialist palliative care team, bereavement services, mortuary staff, chaplaincy, nursing, medical staff, allied health professionals, and porters. We reviewed other documentation from stakeholders, including performance information provided by the trust.

Summary of findings

The services required better procedures to support safe care, particularly when do not attempt cardio-pulmonary resuscitation (DNACPR) orders are used. The trust had introduced a new toolkit to replace the Liverpool Care Pathway for end of life care and, overall, there was effective care and good practice observed against national audit standards. More staff, however, needed to be aware of and use the new toolkit. Patients had appropriate pain relief, and staff were caring and compassionate and treated patients with dignity and respect. There was multidisciplinary working towards patient-centred care. Patients spoke positively about the way they were being supported with their care requirements.

There was no system to identify access to specialist palliative care team support and not all patients were appropriately referred. It was not appropriately documented that patients and/or their relatives were communicated with over the decisions not to resuscitate, and the trust needed to update local policies in line with a recent Court of Appeal judgement on the need for this action. Patients did not always have a clear care plan which specified their wishes regarding end of life care and staff were not always aware of their wishes for the preferred place of death. Some patients and their relatives were not being told in a timely way about dying. The leadership of the service was effective.

End of life care

Public and staff engagement were being used to improve the service, although methods for patient feedback needed further development. The service had good plans for improvement and sustainability.

Are end of life care services safe?

Requires Improvement

Procedures to support safe care for patients required improvement. Some equipment was not appropriately checked and there were not enough hospital wheelchairs and this could lead to delays when transferring patients between wards and the department. Medicines were stored safely and prescribed and administered appropriately but the method of recording caused risks in their administration to patients. DNACPR forms were not appropriately completed for the decision and consultant sign-off. Patients' mental capacity to consent was recorded but this was not monitored. The majority of patients in their last days of life had been assessed within their last 24 hours of life as requiring end of life care; this assessment was lower than the England average. Nurse Staffing levels in the specialist palliative care team had recently been reviewed and recruitment was ongoing to ensure they met national minimum standards. Medical staffing levels did not meet national recommendations.

Incidents

- Staff told us that there had been no serious incidents reported relating to end of life care in the hospital within the past 12 months.
- Staff were aware of how to report an incident or raise a concern.
- Junior doctors identified that Monday meetings were used to discuss every patient who had died and how they had been treated. The learning and staff feelings were discussed. Meetings were multidisciplinary and included counselling staff, the chaplaincy and the bereavement nurse.

Cleanliness, infection control and hygiene

- The mortuary was visibly clean and well-ventilated. It was cleaned Monday to Friday by a designated, trained cleaner.
- Mortuary staff had limited awareness of infection control policy or procedures. They did not adhere to the trust's infection control and hand hygiene policies. We observed that mortuary staff wore rings and one member of staff had long fingernails. Staff were not wearing uniforms.

- The mortuary had been licenced by the Human Tissue Authority in March 2013 to allow post-mortem examination and storage of bodies. At the time of our inspection, the post-mortem room was not in use due to problems with ventilation. The trust had planned to refurbish these facilities by the end of 2014. Post-mortem examinations were carried out in two other local hospitals.

Environment and equipment

- Porters told us that occasionally there was a shortage of hospital wheelchairs which led to delays in transferring patients between wards and departments.
- The mortuary was unsuitable to store the bodies of bariatric (obese) patients as there were no specific trollies or large refrigerator to accommodate this need. Staff told us that, if required, bodies would be kept in the post-mortem room until suitable facilities were arranged off-site.
- There were specific facilities available in the mortuary to store bodies long term. Staff told us that, due to increasing demand, these facilities were not always sufficient. They told us that plans were underway to refurbish the mortuary to increase storage capacity.
- Equipment used in the mortuary was maintained and checked regularly. This included suitably certified and checked trollies and refrigeration system which were maintained by external contractors. However, some small portable electrical equipment such as kettle, microwave, printers and computers used in the mortuary office were not checked by a qualified technician.
- Equipment such as commodes, bedpans and urinals was readily available in ward areas.
- Staff told us that syringe drivers used to give a continuous dose of painkiller and other medicines were available to help with symptom control in a timely manner.
- Patients were equipped with call bells to attract the attention of a member of staff when necessary.

Medicines

- Controlled drugs were managed appropriately.
- Medications were delivered via continuous subcutaneous (just under the skin) infusion devices; syringe drivers, were prescribed on paper charts separate from the patient's electronic medicines record. This had the potential to result in inappropriate or unsafe prescribing as the full information about the patient and the medicines in use was not available at the time of prescribing. Although the electronic system prompted the prescriber to look at the patient's paper drug chart and there was pharmacy advice, the prescriber had no access to information to support their decision at the bedside, such as formulary, default doses, or drug-to-drug interaction information.

Records

- We reviewed 19 DNACPR forms. Only four of these were fully completed in line with the trust's policy. Those that were incomplete did not contain information such as a review by the consultant; they lacked evidence of who had approved the decision and some were illegible.
- The trust carried out an annual audit of DNACPR forms. The last audit in September 2013 looked at 33 forms. The forms included information such as the individual's clinical history and the reason for the decision not to provide CPR in the event of an emergency. Only 58% had been signed by a consultant or specialist training year 3 doctor indicating their involvement, and15% did not include a review date. An action plan had been developed by a risk manager and a clinical governance coordinator in response to these findings and was due to be completed by December 2013. Only 58% of forms were filed in the patients' notes and we observed this during inspection, where some forms were only loosely attached to the notes.
- The mortuary records, which included body release forms, were accurate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In most cases, patients' capacity to consent was recorded on the DNACPR forms.
- Staff were aware of the Mental Capacity Act 2005 and were provided with appropriate guidance on the actions they should take if they were unclear if a patient had the capacity to consent. This included best interest assessments, contacting relatives or friends and checking whether patients had made lasting power of attorney related to health and welfare.
- The trust did not routinely monitor whether patients' capacity to make and communicate decisions had been assessed and indicated on the DNACPR forms.

Mandatory training

- The specialist palliative care team members said that they had completed mandatory training which included

fire safety, basic life support, moving and handling and safeguarding adults and children. Training summary records were not kept to indicate how many of them had completed this training and when.
- Mandatory training in end of life care was not provided to staff outside of the palliative care team despite this being a national recommendation for all staff involved in caring for dying patients.
- Porters involved in the transfer of bodies between the ward and mortuary had all been trained in the trust's procedures for transporting bodies to the mortuary and the use of equipment.

Assessing and responding to patient risk

- The trust's electronic system flagged those patients who were receiving end of life care. However, staff told us this system was not always effective due to some access restrictions. Temporary staff were unable to access the system and some of the permanent staff often did not use it appropriately. The trust told us they were rolling out training for staff on use of an electronic palliative care coordination system, which is currently being used across London.
- The results of the National Care of the Dying Audit 2012/13 showed that 71% of patients were identified for end of life care when they were dying. This was better than the England average of 61%. However, the trust scored worse than the national average for those patients who had been assessed within their last 24 hours, with 74% compared to the England average of 82%.

Nursing staffing

- The hospital specialist palliative care team consisted of a lead nurse for end of life and two palliative care (band 8a) clinical nurse specialists. One of the nurses was on long-term leave and their post was being covered by a junior (band 6) specialist nurse. There was also an end of life discharge coordinating nurse. This post was currently vacant but there were plans to recruit to this post.
- The lead nurse told us that the trust had agreed to fund additional posts in the team: one band 7 nurse (Macmillan funded) and two band 6 nursing posts in order to deliver a seven-day service, commencing October 2014. These new posts had not been recruited to at the time of our inspection.

Medical staffing

- The team had only one palliative care consultant, who was working part-time – 0.35 whole time equivalent (WTE). This was not in line with the Association for Palliative Medicine of Great Britain and Ireland recommendations, and the National Council for Palliative Care which states there should be a minimum of one consultant per 250 beds. The consultant was supported by a middle grade doctor on specialist training and a junior doctor and a part-time (0.4 WTE) staff grade doctor.
- The specialist palliative care team had recognised that there was a need to increase medical staffing to improve services and this was documented in the team's strategy. Although no deadline was given, there were plans to present a business case for further consultant sessions.
- There was weekend and out-of-hours, on-call advice provided by a medical team employed by the local Trinity Hospice.

Security

- Access to the mortuary was controlled by the mortuary staff, security team and porters office. There was also a set of keys kept off-site, available to technicians from another hospital working in partnership with the trust.
- There was no record of visitors or staff visiting the mortuary. Staff were not required to sign in or out and there was no other monitoring system to ensure that only authorised people accessed the hospital mortuary. Health and Safety Guidance, Safe working and the prevention of infection in the mortuary and post-mortem room, 2003 identified the needs to assess risk and have authorised access only, particularly out of hours.

Are end of life care services effective?

Good

There were current, evidence-based guidelines and standards for staff to follow, although not all staff were aware of the end of life care guidance that the trust had introduced to replace the Liverpool Care Pathway. The trust had performed well in the National Care of the Dying Audit. Patients had appropriate access to pain relief. The specialist palliative care and ward end of life care team

End of life care

members were competent and knowledgeable and there were good examples of the multidisciplinary team working to centre care around the patient. Ward staff required better understanding and training to support end of life care on the ward. Patients had access to seven-day services and out-of-hours and weekend support was provided by the local hospice.

Evidence-based care and treatment

- The specialist palliative care team told us that, following the withdrawal of the Liverpool Care Pathway, guidance on the principles of care for dying patients, along with an end of life toolkit had been introduced. However, not all ward staff we spoke to were aware of this toolkit and ward staff and medical staff told us that since the loss of the Liverpool Care Pathway framework ward doctors could be hesitant to make end of life decisions because there was no guidance.
- The trust had developed an action plan in response to the More Care, Less Pathway: A Review of the Liverpool Care Pathway report published in July 2013, and were currently implementing this.
- The end of life care strategy was based on national guidance such as on the National Institute for Health and Care Excellence (NICE) quality standard 13, which defines clinical best practice in end of life care for adults and the Department of Health's National End of Life Care Strategy.
- The trust used quality markers and measures for end of life care to monitor performance against four local quality improvement goals set by the commissioning team. They were aiming to increase the number of patients who were identified as being in the last year of life on the acute assessment unit and increase the number of patients entered onto the end of life care register.

Pain relief and symptom control

- The trust's results from the National Care of the Dying Audit showed that, at the time of the patient's death, there was documented evidence that 'use when required' medication had been prescribed for 54% of patients; this is better than the England average of 51%.
- There was an operational guide on how to manage key symptoms of dying patients. It provided advice on managing pain, restlessness and agitation, breathing difficulties and nausea and vomiting. The staff we spoke to were aware of this guidance and used it.
- Nurses we spoke with had knowledge of the treatments and symptom management to address pain appropriately.
- The lead nurse for palliative care was an independent non-medical prescriber but the specialist palliative care team nurses, despite being Band 8a, were not. The palliative care team members did not prescribe pain relief and therefore all medications were prescribed by one of the doctors.
- The specialist palliative care team told us that they planned to participate in the National Pain Audit in 2014. This audit had not commenced at the time of our inspection.

Nutrition and hydration

- Most patients we spoke with were happy with the food and drink provided by the hospital.
- We observed that all patients had access to drinks that were within their reach.
- The National Care of the Dying Audit found that 45% of patients had a review of their nutritional requirements. This was similar to the England average; while only 42% of patients' hydration requirements had been reviewed, which was worse that the England average of 50%.

Patient outcomes

- The trust scored similar to or better than other England trusts in six out of seven organisational key performance indicators and six out of 10 clinical key performance indicators (such as spiritual needs, assessment and symptom care) related to patients' outcomes. The hospital was in the process of preparing an action plan in response to the National Care of the Dying audit 2012/13.
- The trust had undertaken a survey of bereaved families in October 2013. They had sent out 47 questionnaires to relatives of some of the 76 patients who died at the hospital in June and July 2013. Only eight responses had been received, which was a low response and unrepresentative. However, the survey found that most family members who responded were satisfied or very satisfied with the service provided and all respondents felt that staff were respectful.

End of life care

Competent staff

- The specialist palliative care and end of life team members were competent and knowledgeable. They were aware of the most recent developments within their specialities, including changes in national guidance.
- The consultant in palliative medicine told us that all members of the specialist palliative care team had been appraised. This was confirmed by the staff we spoke to. However, staff in the specialist palliative care team and staff on the wards supporting people at their end of life were not provided with clinical supervision. They told us there were limited opportunities to identify areas for improvements.
- The consultant in palliative care medicine had given presentations and teaching sessions to staff working on end of life care. However, formal training was not in place.
- Ward managers were appointed as end of life care team leads for their clinical areas. Staff told us that end of life teaching sessions had been provided to senior ward nurses and that they were responsible for cascading the training to others. There was no monitoring system to ensure this took place and some ward staff were not clear about changes introduced.
- The consultant in palliative medicine told us that they had teaching sessions with all junior doctors annually and there was an ongoing programme of teaching sessions for nurses and allied health professionals. We were unable to confirm this, as no record of training was kept. Some nurses and allied health professionals told us that they have not completed this training.
- Members of the specialist palliative care team had attended training relevant to their role. The trust currently did not provide a formal training programme but was undertaking a training needs analysis to develop an educational package for the care of the dying. Specific training called 'I can make a difference' was being planned for staff (band 1 – 5) in acute, community and hospice settings.
- In the GMC National Training Scheme Survey 2014, the trainee doctors within palliative medicine had rated overall satisfaction with training as better than other similar trusts. Clinical supervision, workload and access to educational resources was better than other trusts, but local teaching was worse.

Multidisciplinary working

- In the National Care of the Dying Audit, the trust was above the England average for the recognition of the multidisciplinary team recognising signs that the patient was dying.
- The specialist palliative care team was supported by a part-time (0.5 WTE) physiotherapist and occupational therapists who worked in the oncology department. There was also support from a clinical psychologist and Macmillan counsellor/support officer (shared with oncology).
- There was not an effective system to monitor the palliative care needs of patients who were transferred between different providers such as hospices or nursing homes.
- The team had established close links with other providers of end of life care, including hospices, charitable organisations, primary care providers and community nurses. These were used to establish an educational initiative network with an aim to improve patients experience while they moved across care settings.
- The trust had an end of life steering group chaired by the clinical director for medicine and included patient representatives, complaints manager, divisional matron for medicine and surgery, a pharmacist and staff working in transport services, among others. This group met regularly with an aim to improve the end of life care for patients dying in the hospital.
- Staff organised weekly multidisciplinary team meetings to discuss individual patients' pathways and their clinical needs. A member of staff told us that a holistic approach to care was taken and that issues discussed at those meetings included meeting patients' physical, psychological, social and spiritual needs.
- Palliative care and end of life team members did not routinely attend multidisciplinary team meetings on other wards.

Seven-day services

- The specialist palliative care team was available Monday to Friday from 9am to 5pm. Out-of-hours support was provided by on-call staff at the local Trinity Hospice. The specialist palliative care team had secured funding and was planning to recruit additional staff with an aim to provide a six-days-a-week service by December 2014.
- The bereavement officer was only available Monday to Friday.

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- The pastoral care team provided daily support to patients and relatives to ensure that the spiritual needs of dying patients and their relatives were met.
- Mortuary staff were available Monday to Friday between 8.30am to 4pm. There were arrangements to allow bodies to be released out of hours and during the weekend.

Are end of life care services caring?

Good

Patients said staff were caring and compassionate. They felt involved in planning their own care and making decisions. We observed staff being respectful and maintaining patients' dignity, and there was strong patient-centred culture. Patients were given emotional support from trained staff, and volunteers working with hospital staff also supported patients who did not have regular visits from relatives or friends. Bereavement support was good but was minimal when the bereavement officer was absent.

Compassionate care

- Most patients told us staff were caring and that they had no complaints or concerns.
- One patient who was receiving support from the specialist palliative care team told us they were cared for "better than where they were before", however, they thought there were not enough staff during the night as staff looked very busy. Another patient said it was a "very good service" but staff did not dim the lights at night. They also said that they had been consulted by groups of up to six doctors at a time which felt intimidating.
- We observed that staff were compassionate and caring to patients and their relatives. All the staff we spoke to were very clear about their role in ensuring that people received appropriate support.
- The trust had done a survey of bereaved families in July 2013. We noted that only eight of the 47 surveys had been returned. Of those family members who responded most were satisfied or very satisfied with the service provided and all respondents felt that staff were respectful. They also reported that they felt involved in the care planning process.
- We observed that staff handled bodies in a professional and respectful way. For example, when transferring from a ward to the hospital mortuary.
- Porters told us they had no concerns regarding staff handling bodies and thought they were respectful and maintained patients' dignity.
- Patients' records and nursing care plans demonstrated that regular half-hourly comfort ward rounds (where nursing and healthcare assistant staff regularly check on patients) were undertaken to ensure patients were comfortable.

Patient understanding and involvement

- Staff provided patients with information on how to contact the specialist palliative care team and where to obtain additional support and information.
- Nurses were very friendly when explaining to patients about their medicines and encouraging them to take them.
- We observed that staff made efforts to contact family members after their relative had died and they involved them in the decision-making process.
- Not all patients had care plans which specified their wishes regarding end of life care.

Emotional support

- Staff said that families were not always invited back to the ward to speak with the clinicians who provided care to their relative at the end of their life. They thought that this should be a routine procedure that would benefit bereaved families.
- There was one bereavement officer and she was passionate and proud of the support delivered to comfort relatives and making sure people left knowledgeable about what to do following a death. When the officer was on leave then there was minimal cover provided by the complaints team. The team were often not able to go on wards to ensure death certificates were done in a timely way.
- The chaplaincy held a regular ecumenical memorial services for adults and children who died in the hospital. The chaplaincy were available daily to provide spiritual and emotional support when appropriate.
- Patients could see the clinical psychologist who worked with an oncology and cancer support officer.
- Staff who had been supporting patients at their end of life were not routinely offered psychological support or supervision.

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- A group of volunteers worked specifically with the multi-faith chaplaincy team to offer spiritual support to patients of all or no faiths. Volunteers also supported patients who had no or very few relatives or friends, by providing a 'by your side' service.

Are end of life care services responsive?

Requires Improvement

The specialist palliative care team was visible on all wards and nursing staff knew how to contact them. A partnership had been formed with the local Trinity Hospice to ensure that support was available 24 hours a day. However, not all patients were appropriately referred to the specialist palliative care team and there was not an effective system to identify patients who should have access to palliative care. The trust had identified the need for the earlier identification of those who are moving towards end of life in order to address patient and family choice.

Not all patients had a care plan which specified their wishes regarding end of life care and staff were not always aware of patients' wishes about their preferred place of death. Patient discharge was not monitored. There were delays with sending discharge summaries to patients' GPs. The hospital did not have an effective operational procedure for managing the belongings of deceased patients. It was not appropriately documented that patients and/or their relatives were communicated with over the decisions not to resuscitate, and the trust needed to update local policies in line with a recent Court of Appeal judgement on the need for this action. There was support for people with a learning disability or living with dementia, although this was not consistent. There was support for people from different cultural, religious and spiritual backgrounds. Patients' complaints were responded to promptly and appropriate actions were taken in response.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team worked in partnership with a local Trinity Hospice to ensure support was available 24 hours a day.
- The trust had an end of life register that was used to store patient information relating to those patients at the end of life. The specialist palliative care team told us they were encouraging the use of this register by providing training to staff on individual wards. This register was used to communicate patients' preferences and needs to staff and other organisations responsible for their care. The use of the register was monitored as one of the end of life targets for the Commissioning for Quality and Innovation (CQUIN) framework.
- Patients who required end of life care were mostly referred to the specialist palliative care team. There was a system for highlighting patients who were already recognised as receiving end of life care but it was not always used by staff on the wards. The specialist palliative care team and chaplaincy team members told us that occasionally patients were not flagged on this system which meant they were not provided with adequate support. The trust had identified the need for the earlier identification of those who are moving towards end of life care in order to address patient and family choice.
- There was no routine audit of referrals to establish which specialities and wards accessed palliative care and therefore it was not possible for the team to raise awareness of their service with specific clinical teams. Staff told us they were unable to run reports on patient referrals using the hospital's electronic system.

Access and flow

- Specialist palliative care team members were visible on all wards and nursing staff knew how to contact them. There was no routine audit of the specialist palliative care team's response times and we were unable to establish how quickly following referral patients were seen by the team members.
- The National Care of the Dying Audit did identify that access to specialist care in the last hours of life was similar to the England average.
- We observed that, in one case when a patient died, their body was kept in one of the bays on the ward for approximately three hours, while other patients were in this bay. A member of staff told us that this was because they were trying to contact the relative. We also observed that it took over an hour to move another body from the A&E to the hospital mortuary. The porters told us that this was because they were required to prioritise when allocating jobs.
- There was a rapid discharge system to ensure that patients who were in the last days and hours of life

could die in their preferred place. However, the trust did not monitor this to identify if there were any obstacles to discharge for patients and the rapidity of response could not be demonstrated.

- Not all patients had care plans which specified their wishes regarding end of life care. Nurses we spoke to were not always aware of patients' wishes. For example they could not tell us the preferred place the patient wished to die. Staff were unaware of how they performed in relation to respecting patients' wishes regarding their preferred place of death. Staff were also not always aware of relatives' own views about how well hospital staff responded to the physical, emotional and spiritual needs of people in their final days of life.
- The end of life discharge coordinator post was vacant, and it was not clear from the evidence provided what impact this was having on ensuring timely patient discharges.
- Patient discharge summaries were not completed and sent to their GPs within 24 hours of discharge; this was not in line with the trust's policy. An audit carried out by the trust in November 2013 found that only 1.7% of all summaries were completed and sent out within the set timeframe. The trust aims to achieve 80% compliance with this target as the average length of time for completion was 7.23 days. Following our inspection the trust provided evidence that they had prepared an action plan in response to the audit to improve discharge summaries completion. We were told that improvement had been noted in the subsequent audit and 80% compliance with this target had been achieved.

Meeting people's individual needs

- The trust carried out an annual audit of DNACPR forms. The last audit in September 2013 looked at 33 forms. Communication with the patient was documented in 91% of cases and communication with the patient's relatives was documented in 61% of the forms. In the National Care of the Dying Audit, the trust was below the England average for discussions with the patient and their relatives or friends regarding their recognition that the patient was dying. We looked at 19 DNACPR forms and care plans. In most cases, there had not been any documented meaningful conversation with patients or their relatives or carers.
- The trust's DNACPR policy updated in July 2013, had been developed in line with the Resuscitation Council's framework and guidance from the Association of Anaesthetists of Great Britain and Ireland and General Medical Council (GMC). This guidance had not been reviewed or updated following the Tracey Judgement on 17 June 2014. The Court of Appeal in England ruled that doctors now have a legal duty to consult with and inform patients if they want to place a Do Not Resuscitate (DNR) order on medical notes and that there would need to be convincing reasons not to involve the patient.
- Staff told us there was a shortage of single rooms and they were frequently unable to provide a single room to patients which would allow privacy in the final days and hours of their life. There was one dedicated room – the Butterfly Room on the David Erskine Ward – to provide a peaceful environment for patients in the last days and hours of their life. It included facilities such as a sofa bed and a kitchenette so that relatives were able to spend time with the patient. Many patients were transferred to this room but most patients at the end of their life were cared for in the main ward areas.
- There was support for people with a learning disability or people living with dementia but this was not used consistently by ward staff.
- There were various printed information leaflets available to patients and their relatives, including leaflets on what needed to be done when someone was dying or on services provided by the chaplaincy multi-faith team. This information was only available in English. We did not see any information in an easy-to-read format.
- Staff told us that translation services where available and there were generally no delays in accessing these services when needed.
- The National Care of the Dying Audit for hospitals in England found that 37% of patients had a spiritual needs assessment at the trust; this was similar to the England average.
- The Chaplaincy's multi-faith team visited wards regularly and they were informed of those patients who were at the end of their life so they could provide appropriate support. However, staff did not always routinely record whether they had discussed the patient's spiritual requirements with them.

End of life care

- Mortuary viewing facilities were appropriate and allowed relatives privacy. Staff told us that they had applied for funding for the viewing areas to be redecorated, but this funding had not been approved at the time of our inspection.
- There was no operational procedure for the management of deceased patients' belongings. We observed that, on one occasion, the patient's belongings were left behind on the ward without being adequately secured or accounted for. On another occasion, nursing staff were unaware of what belonged to a deceased patient after their body had been removed from the ward. There was no record of the patient's belongings. Staff told us that belongings were kept secure in the hospital's cashier office.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy.
- The specialist palliative care team had received four complaints since December 2013. All had been responded to promptly and appropriate actions were taken.
- When required, the lead nurse had met with complainants to discuss their concerns. Those meetings were recorded and response letters were sent in each case. Action plans were developed when learning was required.
- The hospital's end of life steering group was involved with reviewing complaints reports and clinical incidents.

Are end of life care services well-led?

Good

The end of life care strategy was recently developed and the specialist palliative care team was implementing and developing knowledge and understanding across the hospital. Services were being developed in line with national guidance and there was participation in national audit. The end of life care steering group was further developing systems for governance and risk and monitoring quality against national standards. There was awareness of the actions that were needed to improve the service but risks were not appropriately identified and monitored and local audit and monitoring of end of life care standards improved.

The leadership of the service was effective and the specialist palliative care staff were a small, supportive and dedicated team. The dissemination of standards across the wider hospital needed to improve. Public and staff engagement were being used to improve the services, although methods for patient feedback needed further development. The service had good plans for future improvement and sustainability.

Vision and strategy for this service

- There was an end of life strategy developed in March 2014 which was guided by the Department of Health's National End of Life Care Strategy and other documents such as NICE guidance.
- In 2013 the trust had allocated additional funds to assess the training needs of all staff. The team were committed to this work and were in a process of analysing training needs across the trust. The end of life team had organised focus groups to support this project.
- There was a three-year strategy for the specialist palliative care team developed in June 2014. This document highlighted goals, required actions, timescales and individuals responsible for achieving them. The specialist palliative care team members were aware of this strategy and the progress of implementation.
- Although staff told us that end of life care awareness across the hospital had recently improved among staff, they felt that there was no "sense of ownership" on individual wards.

Governance, risk management and quality measurement

- Senior managers were involved with the trust's end of life steering group which met regularly. Outcomes of those meetings were reported directly to the trust's quality committee through the lead for end of life care.
- There was accountability at board level for the quality of end of life care. Staff were clear about the role of the senior responsible clinician in end of life care and their involvement in decision making.
- There was a designated lay member with specific responsibility for care of the dying.
- There were no specific risks indicated on the trust's risk register or local risk registers relating to end of life care or the specialist palliative care team. There were risks, however, linked to the team that should have been mitigated to minimise impact on patients' care. These

included the team being short-staffed, staff awareness of changing guidelines, potential gaps in referrals received by the team, and staff caring for dying patients without completing suitable training.
- Systems to monitor the quality of the service needed further development – for example, to identify patients who were not offered palliative care in their last days and hours of life, and to ensure that action plans had been implemented effectively, such as in response to findings of the DNACPR forms audit or discharge summaries audits. There should also be a local audit on the care of the dying.
- The end of life care steering group had been formed at the end of 2013 to address governance issues. The group met every two months with an aim to support the implementation of quality markers and to review the service using benchmarking tools and national audits.

Leadership of service

- The palliative medicine and clinical lead and end of life lead were aware of issues relating to their specialities and had developed appropriate strategies and objectives to ensure continual service improvements. However, there were no systems to ensure that this was communicated to all staff caring for patients at the end of their life. The consultant lead was only 0.35 wte in the hospital.
- There was limited coordination across all divisions to ensure consistency of approach or to make sure that training was cascaded to all appropriate staff. The trust had started addressing this issue through the end of life steering group.

Culture within the service

- Staff on the wards and members of the specialist palliative care team we spoke to were focused on providing a good experience for patients. They were patient-focused and aimed to provide the best possible care.
- Staff said they were encouraged by their immediate line managers to report any concerns they had. They told us they could discuss any issues with their manager.
- Specialist palliative care team members felt well supported in their work.
- Staff in the specialist palliative care team worked well together. They spoke about supporting each other and helping out whenever required.

Public and staff engagement

- The hospital organised an annual open day; the last event took place in June 2014. The palliative care and end of life teams had participated in this event and had display stands where patients and members of the local community could approach them if they had questions. This event was also attended by the local hospice working in partnership with the specialist palliative care team.
- There was a patient representative on the end of life steering group to help champion patient and public engagement and share the patients' perspective.
- The trust organised a bereaved families survey in October 2013 to gather relatives' views related to end of life care received by the patients who had died at the hospital. However, the response rate to this survey was low so no conclusions could be drawn.
- Staff engagement with end of life care had improved in the months leading up to our inspection. Nurses we spoke to were aware of the end of life steering group and that the trust was undertaking an end of life training needs analysis.

Innovation, improvement and sustainability

- The trust had long-term strategies for palliative and end of life care to ensure service sustainability.
- The specialist palliative care team had agreed to recruit additional members to improve the level of care provided to patients at their end of life and promote training delivery.
- The mortuary staff told us that there was an agreement to redevelop mortuary facilities by the end of the year. The trust planned to increase capacity and provide suitable facilities for bariatric patients.
- The neonatal palliative care nurse had developed national standards on caring for very young babies with life-limiting conditions who needed palliative or end of life care on neonatal units. These standards had recently been shared with the medical royal colleges and other hospitals for national use.
- The trust had a funded fellowship from the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care, to implement a clinical leadership training programme in end of life care.
- The trust was planning for trust-wide implementation of Coordinate My Care. This is a clinical service for patients where they agree to share their information

electronically between healthcare providers to coordinate their care, and record their wishes of how they would like to be cared for. The record can be accessed by GPs, community nurses, the hospital team, out-of-hours doctors, specialist nurses, the London Ambulance Service and the NHS 111 telephone service for medical help that is not a 999 emergency.

Outpatients and diagnostic imaging

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

Information about the service

The Chelsea and Westminster outpatient department provides clinics for a range of specialities including patients with surgical, medical and therapy needs. It provides specialist clinics in bariatric (weight loss) surgery and burns care as the trust is a regional centre for burns and has a high number of patients for stroke and bariatric surgery.
The Trust also provides a wide range of diagnostic tests including echocardiogram (ECG), phlebotomy and pre-operative assessment as well as all imaging services including magnetic resonance imaging (MRI), CT scanning, ultrasound and x-rays. Outpatient appointments are available Monday to Friday between 9am and 5pm with some clinics held Mondays, Wednesdays and Fridays until 8pm to provide access for patients who cannot attend during the day. In 2013/14 the adult outpatient department provided 83,495 new appointments and 184,537 follow-up appointments.

We inspected dermatology, ophthalmology, preoperative assessment, trauma/orthopaedics, phlebotomy, diabetes, plastic surgery, endocrinology, therapies including physiotherapy outpatients and hand therapy and also neurology, and oncology clinics including chemotherapy. We spoke with 35 members of staff, including nurses, doctors, therapists (such as physiotherapists), ward clerks, porters, receptionists and managers and 24 patients. We looked at 16 patients' records. We also looked at a variety of other staff and trust records such as policies and procedures, training records, meeting minutes and performance indicators. We observed care being provided, tracked patients through their care pathways and observed the care environment. We reviewed other documentation from stakeholders, including performance information provided by the trust.

Outpatients and diagnostic imaging

Summary of findings

The department did not follow appropriate safety procedures for incident reporting and learning; equipment checks, safeguarding and mandatory training and local best practice guidelines were not up to date; and multidisciplinary working needed to improve. Staffing levels in the department had been assessed as appropriate.

National waiting times for appointments were being met but some clinics had short-notice cancellations. Patients were positive about their care but they were not always kept informed, for example, about delays in clinics. People with a learning or physical disability required better support to access services. The service had innovative plans for development but local and trust leadership needed to improve during its implementation. Governance and risk arrangements were fragmented and there was not always single responsibility for a programme or target. Staff and public engagement needed to improve.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Outpatient safety procedures were not always followed. Incident reporting and feedback on incidents needed to improve, although when incidents were reported, this resulted in learning across the department. The outpatient clinics were visibly clean and medicines and prescription pads were stored securely. Equipment checks were completed appropriately but the number of resuscitation trolleys for the space covered was a concern.

The fracture clinic had a high number of missing patient notes which caused delays or cancelled appointments. Missing records were not regularly audited. Some staff were not aware of safeguarding procedures and mandatory training was not up to date. Staffing levels were assessed by the department as appropriate.

Incidents

- There had been two serious incidents reported in 2013/14 in outpatients: one incident was a pressure ulcer and one a safeguarding alert. Root cause analysis for these incidents had been completed by outpatient staff such as the department nursing lead and management. We were not provided a copy of the analysis so we were unable to determine if learning had occurred. Evidence provided by the trust demonstrated that other themes in incidents reporting between January and March 2014 related to letters being sent to the incorrect GP, over-exposure of radiation during imaging and poor or lack of communication between departments or clinicians. We requested copies of investigations into some of these incidents, but these were not provided to us by the trust.
- There were 276 incidents reported as being within phlebotomy between October and December 2013. Some of these were in outpatients but the clinical areas were not named. Most of these incidents related to patients bleeding after an insertion of a cannula (tube inserted into the vein) and also sampling and labelling errors.
- Incident reporting did not always follow trust policy. Senior staff told us that staff could report incidents to the governance team by completing an incident form.

However, many staff (including nurses and receptionists) told us they had reported incidents to their line manager rather than completing an incident form themselves as they had been told this was the process to follow.

- Nurses in the fracture clinic were able to describe to us the process of reporting incidents but told us they had never reported an incident despite being with the trust a number of years. The last quarter showed no incidents had been reported in the fracture clinic, yet we had identified issues, for example, with missing patient notes.
- None of the outpatient-based staff we spoke with said they received feedback on incidents they had reported. However, staff were able to provide examples of learning from incidents. These included an incident where a patient who was neutropenic (susceptible to infections) was not identified at their preoperative assessment because there was no mechanism to pick up their results. The trust had responded to this incident by increasing the length of preoperative assessment appointments from 30 minutes to 60 minutes so there was enough time for paperwork to be completed.
- Staff told us that, in response to a security incident when a staff member was assaulted, panic alarms had been provided in rooms in the department.

Cleanliness, infection control and hygiene

- All clinical and non-clinical areas we observed were visibly clean. Patients we spoke with told us they found the outpatient areas clean and tidy.
- The trust outpatient survey, undertaken in January to March 2014 reported that the majority of patients who used the toilets considered them to be clean.
- A whiteboard in the reception area showed the daily cleaning for the clinic rooms, sluice rooms and toilets. However, there was no record of the previous day's cleaning schedule or evidence that this cleaning had been completed.
- During our inspection we observed that all waste bins were emptied regularly and were not overflowing.
- There were weekly cleaning audits every Thursday and these found that areas were clean.
- Staff followed the hospital's infection control policy. We observed staff washing their hands or using hand hygiene gel and using protective personal equipment, such as aprons and gloves, appropriately. However, not all staff were bare below the elbow – mainly medical staff.
- We observed that hand gel was available in all areas we visited, including at the department's entrances and in clinic rooms, two of which were at a height accessible for wheelchair users. Hand hygiene posters and guidance were displayed in each clinic we visited to remind people of the importance of washing their hands.
- Only 75% of staff in the outpatient department had had infection control training in March 2014.
- The infection control audit for April 2014 showed good compliance with infection control guidance in outpatients at over 95% including MRSA screening. However, there was lower than 90% compliance in the eye clinic, the ECG suite and therapies rooms. Senior staff were aware of what was causing the low compliance and had actions in place to address this.
- Fifteen of the 20 pieces of equipment we looked at either did not have a clean sticker or the clean sticker was out of date.
- Some of the waiting area seats were torn, particularly in the fracture clinic, which was an infection risk.

Environment and equipment

- The chairs in the dermatology and endocrinology clinics were low and we observed that people with poor mobility needed support to get up from the chair. The reception desk for the preoperative assessment area was not accessible for people using wheelchairs as it was too high. We saw that the door between the waiting area and the clinic rooms was too small to fit a wide wheelchair and there was limited space in clinic rooms. We were told by the preoperative staff that issues relating to the unsuitable environment had been raised with senior staff within the trust during the planning stages of the redesign of the outpatients and preoperative areas, but changes were not made to address the issues raised.
- The fracture clinic had two rooms and these were particularly small with difficult access for wheelchairs. The clinic rooms in phlebotomy were divided into two by a curtain but these did not fully divide the room and meant the rooms were very small and gave little room to move.

Outpatients and diagnostic imaging

- The assessment for the current premises configuration of the outpatients department provided by the trust was dated 2011 and documented the financial implications of moving dermatology and plastic surgery, gynaecology and paediatric outpatients, but there was no risk assessment. There was no evidence of risk assessments regarding the current locations of phlebotomy, preoperative assessment or trauma/ orthopaedics outpatients.
- Some outpatient areas, such as the eye and fracture clinics, were in need of redecoration as there were black tyre marks on the floor and marks and dents on the walls.
- The fracture clinic electric doors at its entrance were malfunctioning as they opened and closed very quickly without the sensor being activated. Staff and patients we spoke with agreed the doors did not function properly but none of the staff said they had reported it and we saw no report to maintenance about it.
- Staff told us that their requests for repair or replacement of equipment were completed in a timely manner. However, during our inspection we observed that several pieces of equipment needed repair and had not been identified or monitored by staff.
- The portable appliance testing on five out of 20 items of equipment we looked at were out of date, including one from 2011. These included computers, electric cooling fans and kitchen equipment such as kettles and microwaves.
- We observed fire doors propped open and staff did not know why this was the case.
- Daily checks of the resuscitation trolleys were completed and all medical gases we saw were in date.
- We found equipment in stock, including scopes, gloves and bottles for samples. Staff told us they never had issues with running out of equipment.

Medicines

- All medicine cupboards and fridges we checked were locked and fridge temperatures were checked daily in line with national guidance.
- Prescription pads were kept securely and were appropriately managed.
- Controlled drugs were stored in appropriate fixed, locked cabinets and were checked and signed for appropriately.

Records

- All the patient records we checked had information filed securely with no loose sheets.
- The outpatients department audited the number of temporary records created; in the last 12 months, 0.8% of records were temporary which was better than their target.
- There were no audits undertaken on the number of records not available in clinic. The fracture clinic staff told us that up to 15 of 80 records were regularly unavailable in clinics and patient appointments were therefore either delayed or cancelled. Staff stated that this was due to a lack of training of non-ward clerk staff in record tracking.
- Staff stated that patient notes were sometimes missing from preoperative assessments due to delays from other hospitals, but this was rare. The trust had responded to this by employing a case manager which staff said had reduced the number of delayed or missing patient notes.
- To prevent patient records arriving at clinics late, outpatient therapies had their own patient notes which were kept in the department. Although, general patient information such as comorbidities (two or more diseases existing at the same time in the body), contact details and allergies were held electronically.
- Records were stored appropriately to maintain confidentiality, either electronically or in paper files.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All the records we reviewed included evidence of the discussions that had taken place prior to the patient consenting to the procedure.
- We observed that reception staff and clinicians confirmed the patient's details when they checked into the clinic or before they treated patients.
- Patients told us they were always asked by their clinician if they wanted their treatment discussed before proceeding.
- Names of patients attending the clinic were displayed on TV screens in two clinics which compromised their confidentiality.
- When we spoke with staff, they showed they were aware of their responsibilities under the Mental Capacity Act

2005 such as ensuring patients either had a best interest assessment or had persons appointed to act on their behalf involved in their care if a patient did not have appropriate capacity.

Safeguarding

- Safeguarding information was displayed in six of the10 clinics we checked, which included information for both patients and staff. These showed how they should report any concerns they had and stated staff's responsibilities for reporting safeguarding concerns.
- Records of staff attendances at safeguarding training demonstrated that 100% of outpatient staff were up to date with this training. However, only 10 of the 31 staff we spoke with were aware of the adult safeguarding lead in the trust and knew how to report a safeguarding concern.

Mandatory training

- The outpatient department's mandatory training compliance was 77%. Training records showed that attendance at some mandatory training was below the expected level; this included only 11% of staff completing a local induction, 60% attending fire training, 56% vaccinations ,74% basic life support and 74% of staff completing records training.
- Records showed that only 11% of staff had a local induction. Staff told us they were inducted well when they started, including having a two-week supervision period.
- The diagnostics manager identified poor attendance of mandatory training by staff in the diagnostics department. However, this department's attendance at training was reported separately from outpatients and showed they had a better compliance with mandatory training at 80%.
- The diagnostics and outpatients managers told us there was an ongoing discussion with the trust's human resource staff to negotiate which areas of mandatory training were required for non-medical staff, as they stated that topics such as venous thromboembolism (VTE) and medicines management were not appropriate for this group. However, central training records reported their non-attendance at training, which reflected on the department's overall compliance rate. Some specialities such as reception/administration staff had agreed that this training was not required for all staff and training reports had been amended to reflect this.
- Staff told us they were reminded by their line management if their mandatory training was out of date and their pay increment was delayed until they had completed all necessary mandatory training.

Assessing and responding to patient risk

- Posters displayed in all outpatient areas informed staff of the action they should take if a patient needed urgent medical attention. All staff we spoke with were aware of the action they should take if a patient collapsed or became acutely unwell in the department.
- There were two resuscitation trolleys for the four outpatient clinics, which were located over two floors, including the preoperative assessment unit and phlebotomy on the lower ground floor. There were only two resuscitation trolleys covering the outpatient area over two floors for all the patients seen in clinics. The trust identified that a risk assessment to check if this was sufficient had been done but we had not received a copy of this.
- Trained staff were not within sight of the waiting area in the diabetes clinic and would not see patients if they became unwell.

Nursing staffing

- Staffing records showed the outpatient areas were staffed to establishment with eight registered nurses and two senior nurses. Nursing staffing levels had been assessed based on the acuity and dependency of patients in the clinics as appropriate.

Medical staffing

- The medical staff rota showed consultants were not required to conduct ward rounds while they were providing outpatient clinics. However, we were told that consultants were sometimes late for their clinics, at times due to ward duties running late.
- Chemotherapy staff had raised concerns that a consultant haematologist was not always available when they needed one. A meeting was due to take place after our inspection to resolve the concern.

Major incident awareness and training

- Staff were aware of what their roles and responsibilities were in the event of a major incident.
- There had only been one fire drill in outpatients in the last two years and records did not show how often these should occur.

Outpatients and diagnostic imaging

- Staff told us that back-up generators were in place to ensure imaging could continue in the event of a power failure and all imaging equipment had a long battery life.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the outpatient departments.

There was evidence of the use of national guidance but local guidelines were not kept up to date. The imaging department was nationally accredited. Staff had access to training but this was not always completed and we did not see evidence of appraisal and supervision. There was multidisciplinary working in teams, for example, the cancer teams, but this was not effective in diabetes care. Seven-day services were not fully developed, despite the capacity constraints in some clinics.

Evidence-based care and treatment

- Staff told us and showed that they followed appropriate national guidance in their clinical practice such as National Institute for Health and Care Excellence (NICE) technology appraisals for cancer.
- Clinic leads told us staff kept up to date with current national guidelines either through their professional registration or were updated by their line manager via email or in team meetings. There had been emails from clinical leads in the last two months showing changes to clinical guidelines. However, the outpatient-based staff we spoke with could not remember when they were last updated about a change in clinical practice other than medical equipment. This meant the way this information was conveyed to staff was not always effective.
- Governance meeting minutes showed that 47 out of 897 guidelines in clinical support services, (part of which is outpatients), had been due to be reviewed in December 2013 and this action had not been completed at the time of our inspection.
- The imaging service was accredited by the Imaging Services Accreditation Scheme and the equipment had met national quality standards.

Patient outcomes

- The ratio for how many patients who have a first appointment who also have a follow-up appointment was 1:18, which was better than the England average. Therefore the trust had fewer patients than average requiring a follow-up appointment. The trust monitored individual consultant's first appointment to follow-up ratio to identify issues with clinical capacity. However, there was no evidence that high ratios were followed up or actioned.
- Patients reported issues with continuity of care as they saw different nurses or doctors at their follow-up appointments and this meant they were sometimes given different advice or treatment from the prior clinician.
- The National Cancer Peer Reviews undertaken in 2013 found that the trust met the majority of the national requirements. The areas for improvement were to ensure that a colorectal consultant was always available for colorectal stenting and the histopathologist should always attend the multidisciplinary team meetings. We did not receive an action plan from the trust to address this.

Competent staff

- Nursing and support staff we spoke with told us they had an annual appraisal and access to training as well as regular supervision with their line management to discuss their performance. However, we were not provided with information to demonstrate how many staff had received an annual appraisal in the last 12 months.
- Chemotherapy staff had specific training courses at other trusts that specialised in chemotherapy and HIV care to ensure they were up to date with current clinical practice.
- To meet the needs of people with learning disabilities, specific training was arranged monthly which we were told therapists (physiotherapy, occupational therapy, and so on) always sent at least two staff to attend each session, but this was often cancelled due to low numbers.

Outpatients and diagnostic imaging

Multidisciplinary working

- There were 11 multidisciplinary teams for cancer, with 11 clinical nurse specialists, four multidisciplinary team coordinators and three consultants. These ensured that different patients with different forms of cancer could be appropriately cared for by a range of professionals.
- Staff we spoke to in most clinics felt they worked effectively with other members of the multidisciplinary team to provide appropriate care for patients' needs. However, they felt that, as the diabetes team were located in several parts of the hospital, this resulted in the team not working cohesively to deliver care.

Seven-day services

- Outpatient appointments were available Monday to Friday between 9am and 5pm, with some clinics held on Mondays, Wednesday and Fridays until 8pm to meet patient demand.
- The preoperative assessment clinic provided appointments at the weekend and up to 8pm on a Thursday.
- MRI scans and ultrasound scan were available seven days a week and between 8am and 8pm. Other imaging services were available for inpatients and urgent requests 24 hours per day, seven days per week. An on-call radiologist was on site 24 hours per day.
- Weekend appointments were not available in outpatients and we were told there had not been feedback from patients wanting weekend appointments, despite capacity issues in some clinics such as trauma/orthopaedics and plastic surgery.

Are outpatient and diagnostic imaging services caring?

Good

Patients were treated with privacy and dignity by friendly staff. However, in some clinics, there were issues with the hospital environment that compromised confidentiality and privacy and dignity. Patients told us they were informed about their treatment and involved in their care. Staff provided emotional support to patients who were vulnerable, confused or distressed.

Compassionate care

- We spoke to patients and the majority were happy with the care and treatment they had received and felt the services had tried to accommodate their needs. One patient scored the service "12 out of 10". We observed that staff interacted positively with patients and supported them and treated them with dignity and respect when communicating.
- The CQC last produced an outpatient survey in 2011 which reported that 93% of those who responded would recommend the trust's outpatients department as a place to be treated. The trust had continued this type of survey on a quarterly and yearly basis. In the 2013 survey, 87.8% of patients liked their visit to outpatients. Nearly all patients found reception staff helpful and friendly. The outpatient survey showed that 83.7% of patients were able to discuss any problems with their clinician and 95.6% felt they were treated with privacy and dignity. The survey had shown improvements in the overall rating and improvements since the previous year in ratings for appointments starting on time and having the side effects of medicines explained.
- Patient feedback on the NHS Choices website gave outpatients 3.5 out of 5 stars. There was varied feedback on dermatology, cardiology, imaging and orthopaedics. There was poor feedback on elderly care and good feedback on general surgery, general medicine, gastroenterology, plastic surgery, pain management and haematology. Issues raised included rude staff, not being listened to, lack of information, lost patient records and calls not being answered.
- Most clinic rooms were private and people could not be overheard from outside, although the preoperative assessment waiting area was in the corridor next to the reception desk where it was possible to overhear discussions as people were booking in. When we spoke with a lead for this service, they said this had not been a concern but they would now look at this issue.

Patient understanding and involvement

- Patients told us that any procedures or treatment were explained to them by their treating clinician in a way they could understand; clinicians also ensured that patients were happy to proceed before progressing any treatment or tests.
- We observed, and patients told us, that patients were advised on their treatment after they left the clinic, including if they needed a new appointment, when their test results would be available and who to contact if they had a concern.

Outpatients and diagnostic imaging

- In therapies such as physiotherapy and occupational therapy, some of the patients we spoke with said they had not been given or asked what goals they had following the therapy or how long the therapy would need to last.

Emotional support

- Patients commented that staff supported them if they became distressed.
- We observed, and were told by patients, that staff attended to patients quickly if they were confused or vulnerable.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Services did not always respond to patients' needs. The outpatient environment was not always well planned to make the appropriate use of space and respond to capacity issues and patients could end up waiting in crowded areas with limited seating. Patients were being seen within national waiting times and this had improved. There could be delays in clinics which were not always explained. The trust was reducing its rates of patient non-attendance which were above the London average. Some clinics were cancelled at short notice at a rate that was worse than national levels. Patients and staff reported on how difficult it was to access the service by phone to check or change appointments and some patients said they had attended unnecessary appointments or had missed appointments because of this.

There was support for people with a learning disability but this was used inconsistently by staff and some outpatient environments did not support access for people with poor mobility or who used a wheelchair. There was support for people living with dementia. Complaints were handled appropriately and action was taken to improve the service. Some complaint responses that we viewed were very technical and would have been difficult for patients to understand.

Service planning and delivery to meet the needs of local people

- The trust had commissioned an external demand and capacity modelling review of the departments to explore how they could increase efficiency and meet people's needs. This review had made seven recommendations in 2014 which the trust had developed into an action plan which they had started to implement.
- The ground floor outpatient area had been redeveloped in the last two years to improve patient flow and experience. We observed, and staff expressed their concerns, that the current configuration was not appropriate for patient needs, such as the lack of space in the fracture clinic and phlebotomy area. Staff told us that the redevelopment had been discussed with them, but they felt their concerns had been ignored.
- There had been no audit of the use of the outpatients department clinic rooms and we found one outpatient clinic area had been closed, leaving over 20 clinic rooms empty. This was despite the pressure on other areas of the facility.
- The appointments centre was open from 8.30am to 5.30pm. However, patients we spoke with reported difficulties accessing this service as the telephone lines were frequently busy. Three patients told us they had attended appointments that were unnecessary and that it was difficult to contact the appointments team. Some patients had missed appointments particularly where a follow-up some months later or an annual appointment had to be arranged but was not confirmed. There were only two phone lines for the outpatients department and the trust was planning to call patients to arrange appointments instead, to prevent patients being kept waiting.
- To meet the needs of those patients with comorbidities that could affect their surgery, a second preoperative assessment was arranged to ensure they were fit for surgery.
- One-stop clinics were available, such as nerve conduction tests, and drop-in appointments were available for the triage (assessment and prioritising) of preoperative patients which meant it was easier for patients to access these clinics.

Access and flow

- The percentage of appointments where patients had used the NHS Choose and Book national electronic appointment system was 40%, which is worse than the national average. The June 2014 appointment slot issue

report showed that 14 patients were unable to use Choose and Book for an appointment between 2 and 8 June 2014, mainly for the eye clinic and trauma and orthopaedics clinics.

- The patient non-attendance rate was more than 10% in June 2014, which was above the national average but below the London average. Clinics with non-attendance rates of above 15% included anaesthetics, bariatric surgery, diabetes, elderly medicine, general medicine, hepatology, and TB care.
- To reduce the non-attendance rates, the trust sent a text message and letter reminders to patients. This was followed up by a phone call when either the clinic or the demographic area had a high rate of non-attendance. This approach had made an impact on the non-attendance rate as it had reduced from 12% in 2012/13 to 10.1% in 2013/14.
- Patients were risk-assessed by their consultant to decide if patients who did not attend should be referred back to their GP or rebooked for another appointment. If a vulnerable or clinically urgent patient did not attend, they were offered a further appointment rather than being referred back to their GP.
- In 2013/14, the trust had been fined for not meeting the 18-week referral to treatment times (RTT) target for plastic surgery, trauma and orthopaedics, and general surgery. The trust acknowledged that these areas had a lack of capacity and it was recruiting additional consultants. In June 2014, the trust was achieving the target overall for 96.4% of outpatient appointments, which was better than the national average (90%).
- The figure for incomplete care pathways (patients on the waiting list that are within 18 weeks) in June 2014 was 92.1% which was better than the national average. All the patients we spoke with told us they were seen for their initial appointment within 18 weeks and their patient records confirmed this.
- Compliance with the two-week wait for cancer appointments target was worse than the national average in January to March 2014 at below 95% but had historically been better than average. Both the 31-day and 62-day waiting time targets for cancer appointments had improved in January to March 2014 to better than the national average at 100% and 85% respectively.
- The six-week waiting time for diagnostics was significantly better than the national average. At the time of the inspection, all patients were seen within this target.
- Cancelled appointments by the hospital were 9.2% and those cancelled within six weeks was at a rate of 4.6% for 2013/14 which was worse than the national figure. Evidence showed that services with high cancellations rates included bariatric surgery, dermatology, endocrinology, gastroenterology, general medicine, hepatology, neurology, pain management, TB care and urology. There was a rota for consultants to book leave six weeks in advance of clinics being booked but we were told by clinic staff that consultants cancelled appointments due to leave or other commitments. Staff and patients told us that a high number of appointments were rescheduled. However, the trust did not collect data to monitor this at the time of our inspection. None of the action plans we received included a strategy for reducing hospital cancellations.
- The patient feedback report had noted concerns with blood tests having to be reordered due to issues with samples not being large enough to be tested, which meant patients were having to re-attend to give further samples, delaying their treatment.
- The late running of clinics was not monitored or reported. In the trust outpatient survey 2013 only 58% of patients said they were accurately told how long their appointment would be delayed. Some patients told us they had waits of up to 30 minutes beyond their booked appointment time. The last quarter outpatient survey showed that 15.4% of patients reported waiting over 30 minutes for their appointment and most negative comments in the survey were about the waits in the waiting areas. Staff we spoke with stated that, on average, clinics ran late at least once a week. Instead, the outpatients department measured the length of outpatient sessions; these averaged over two hours, seeing fewer than 5.5 patients a session, but there were no targets for these sessions.
- Some patients told us they were not informed of any delays when they were waiting to attend clinics and some areas, such as the fracture clinic, did not have delay times displayed. We spoke with one patient who was still waiting 35 minutes after their scheduled appointment and had not been told about a delay.
- The hospital had a dedicated outpatient pharmacy open 9am to 6pm. Monitoring reports we examined

during our inspection showed that the pharmacy was not meeting its performance targets for dispensing prescriptions within 15, 30 or 45 minutes which meant patients were being delayed leaving the hospital after their appointment. There was not always information available to explain delays. Key performance indicators for the pharmacy department showed that the average waiting time for an outpatient prescription was 34 minutes, which was within the target.

- The latest trust outpatient survey 2013 showed that 85% of patients considered they had enough time to discuss their health problems at their appointments. Patients were offered a choice of appointments and could book follow-up appointments as soon as their initial appointment had finished.
- Chemotherapy had access to 10 patient beds/chairs of which seven were being used at the time we inspected. Staff told us there was an issue about once a month where they did not have enough beds/chairs, but they were looking at increasing their capacity.
- All the patient records we reviewed showed that GP letters were sent within seven days of the patient's appointment. However, a trust report for January to March 2014 showed that the trust was not meeting its own target of sending 90% of letters to GP within seven days.
- Information provided by the trust prior to our inspection (and confirmed by patients we spoke with) reported that outpatient GP letters lacked information about ongoing care. GPs also did not receive information after follow-up physiotherapy appointments which meant they were not always aware of their ongoing progress with their patient's care. The outpatient department was aware of this and said that the number of words was limited by the software used. They currently had to dictate letters but said that new IT software planned for the future would prevent issues with GP letters.

Meeting people's individual needs

- Most clinics, except for the fracture clinic, had a number of leaflets available to help patients understand their conditions. However, they were only available in English and staff said they would have to be individually interpreted for patients by an interpreting team to make them available in another language. Staff we spoke with were unaware if the trust had any easy-to-read information available for those patients with a learning disability.
- Some patients told us they did not always get written information to summarise the oral advice given by a clinician, such as a leaflet or treatment plan.
- A translator line was available for clinics and translators could be booked to attend in person, but we were told that the translator line often cut off during the clinic appointment; none of the action plans we received included ways to address this.
- Psychological support was available to patients who wanted it. This included Macmillan and counselling support for those patients who received a poor diagnosis such as terminal cancer. Their services included psychologist support, massage and aromatherapy.
- Patient records showed if a patient had a learning disability but the electronic patient system did not have a system for highlighting these patients, or a record of their specific disability, to ensure that appropriate support could be provided. One patient with a learning disability had been attending the outpatient clinic with their parent for several years. The parent did not know the trust had a Hospital Passport (which documented key information about how the individual should be supported) and this had not been used. The parent told us that this would have saved so much time and would have avoided treatment delays as they constantly had to re-explain and go over the history of their child's condition.
- Therapy services ensured sessions with people with learning disabilities and people living with dementia had one-to-one sessions so that the risk of an incident was reduced and patients could be fully supported. Patients with multiple needs had at least 45-minute sessions, whereas other patients were seen for 30 minutes. Patients told us that staff were flexible about what therapy exercises patients participated in, depending on what the patient was comfortable with.
- Patients were screened and assessed preoperatively for dementia to determine if they needed additional support when they attended for surgery.
- We observed that the phlebotomy facility's waiting area was unable to seat all patients using it, resulting in patients often having to stand. Some of the complaints in the 2013 trust outpatient survey were about the lack of seating in the waiting areas but the trust did not distinguish which clinics these comments came from.
- Mobile imaging equipment was available for patients, particularly for those with mobility issues that meant

they could not attend the imaging department. Staff told us transport was available for people who needed mobility support and patients told us they were able to access this if they needed it.

- Some outpatient facilities were not meeting the needs of people with a physical disability. There was no disability accessible toilet in the preoperative assessment area and the reception area was too high for wheelchair users. There was also a lack of waiting space for wheelchairs in waiting areas. Clinic rooms in the fracture clinic and phlebotomy area had limited space for wheelchair users and chairs in the dermatology and endocrinology clinics were low and did not support people with limited mobility.
- Patients reported that appointment letters contained enough information, including contact details, directions to the clinic and the name of the doctor they would be seeing. However, patients were not provided with a map of the hospital when they received their appointment letters and we observed that these were not available when the patient arrived. We could not find, and were not provided with, a leaflet with a map of the hospital.
- Some staff (but no patients) told us that signage to the appointment clinics did not always help patients find the relevant clinic. The signage we observed clearly identified each clinic other than where patients receive chemotherapy. When we asked a volunteer where the chemotherapy area was, they were unable to answer this. Volunteers were available to assist patients to their appointment at the main entrance of the hospital and they could be booked in advance for patients who needed additional support.
- The trust helped patients to prepare for their appointment by asking them to consider the questions they would like answered, and also to complete a diary of their symptoms. This meant the patient would have a reference guide available to ensure they had understood what they were told at the appointment and that they were aware of what would happen after their appointment.
- To ensure that all patients arrived at the clinic, including those who may require additional support, an alert system was used to identify patients who had checked in at the main outpatient reception but not arrived at their clinic. When alerted, staff would locate the individual onsite. However, this system would not identify those patients who had used the department's self-check in using the electronic system.
- Chaperones were available to patients who wanted and needed them.
- One toilet in preoperative assessment had a hatch available to deposit urine samples through. However, due to the size of the room, the hatch meant that people could see into the toilet, which compromised their privacy and dignity

Learning from complaints and concerns

- Staff were aware of the trust's complaints policy and knew how to direct patients to it if required.
- Complaints information and Patient Advice and Liaison Service (PALS) leaflets were only displayed in three of the 10 clinics we visited; these explained how patients could raise a concern or complaint.
- The staff told us that, if they felt they could not deal with a patient's complaint face-to-face in the clinic, they were able to page a manager to attend to help and resolve the informal complaint before a formal complaint was made. However, there was no record maintained of the number and type of informal complaints patients made, therefore we could not confirm how many complaints had been resolved before the patient made a formal complaint.
- Trends of formal complaints made to PALS were analysed, and during January to March 2014 the highest numbers of complaints related to appointment delays and cancellations. An outpatient improvement programme was in place to address the long-term issues regarding outpatients but this did not specifically look at actions relating to cancellations.
- The two responses to complaints we looked at were written using clinical terminology, which would be difficult for some patients to understand. Also, these letters did not always include the actions the trust planned to take to reduce the risk of a similar issue recurring.
- We saw evidence that the department learned from complaints. Staff we spoke with were able to give examples of changes that had been made in response to patients' complaints. These included therapies extending their clinic times to 8pm and revising the wording of appointment and clinic letters to patients to make them more understandable.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Requires improvement

The outpatient service had a vision and strategy to improve access and performance, and better manage patient demand. The service monitored its own performance but governance arrangements were fragmented as these were the responsibility of staff in other divisions and there was not a coordinated approach to managing performance and risk. Staff felt supported by their line managers but told us that leadership within the service was not visible. There were good plans for service innovation and improvement and patients were surveyed to provide feedback. However, staff and the public were not always effectively engaged with how the service could improve.

Vision and strategy for this service

- All staff were aware that the outpatient department had a strategy and vision. The department's strategy included aligning resources for integrated care pathways, enhancement of the referral process, improving patient flow, reducing unnecessary patient travel, matching activity with capacity, reducing the outpatient attendance at secondary care, improving capacity, and ensuring patients were seen in the correct care setting. There was a target for initial improvements to be made within two years, with yearly monitoring.
- The trust had implemented a planned care pathway for patients, which aimed to reduce the number of patient visits, improve transfer and communication between health services, increase telephone consultations, and redesign the administrative structure. The impact of this pathway had been risk-assessed by senior staff and actions to mitigate identified risks had been implemented.
- There was a clear vision in the therapies department to increase their community work in the next 12 months, which staff were aware of.

Governance, risk management and quality measurement

- Performance data was available to monitor the department's progress. The outpatient department had a dashboard showing how the department was performing against key performance indicators. This showed that the department was not meeting many of its targets, including hospital cancellations of appointments, referral to treatment compliance, average length of sessions and 'first to follow-up' appointment ratio. This was monitored on a weekly basis and rated depending on whether it was meeting the set targets.
- The outpatient department did not have a department-specific risk register. Any risks identified in the department were included on the related clinical specialities register or on the divisional risk register, which was not up to date.
- Outpatient risks were escalated appropriately and we saw that issues such as the 18-week RTT target not being met had been discussed by the executive team at their January 2014 team meeting, but no action to address this was minuted. Other issues, such as short-notice cancellations were also not being appropriately addressed.
- Under the new trust structure, the therapies and outpatient departments were not in the same division but there were still direct links between their staff leads. This meant that risks the departments shared could still be discussed.
- The therapies service had struggled to meet its key performance indicators for its community service contract but had been able to recruit additional staff to start the process.
- Before our inspection we received information about issues such as the use of the NHS Choose and Book system, waiting within the outpatient department, meeting cancer RTTs and translators not turning up when booked. The trust was aware of these issues and was due to address them as part of their overall improvement programme. However, this programme had only recently commenced.

Leadership of service

- There was an identified lead manager and nurse for outpatients. However, at least five staff reported they had not seen the outpatient nursing lead.
- Most staff said they felt supported by their line manager.
- Senior staff reported that they felt the trust gave outpatients and therapies its due importance so that priority risks or requests for additional staff were approved or addressed.
- Although the outpatient senior staff could address issues within its department, there were issues that

affected its performance that it could only influence, such as availability of consultants at clinics. This meant the accountability for the performance of the department was fragmented between different governance structures.
- At least 15 members of staff at all levels within outpatients said the executive leadership of the trust was not visible as they had never seen them in the service.

Culture within the service

- Staff reported feeling supported by their colleagues and their direct line management which meant the trust was a good environment to work in.
- Administrative staff were rotated between the different clinics but some of these staff members told us they were not comfortable with this system and felt this had been imposed on them by the service management.
- Staff sickness was better than the national average of 4.5%, with a 2% rate in diagnostics, 4% in dermatology, and 4% in therapies.

Public and staff engagement

- Quarterly patient surveys were undertaken by the outpatients department. Patients attending the department could complete a survey and these were available at reception desks. However, none of the patients we spoke with said they had completed one or knew about the survey, and we did not observe staff proactively asking patients to complete this.
- Some of the clinics did not have noticeboards completed in the patient waiting areas showing how the department was performing.
- Department meetings took place where all staff were invited to discuss issues that had occurred in the department, such as the unavailability of patient notes or issues with booking in patients. These were used as a reminder for staff to be vigilant in areas such as tracking notes. Records showed that chemotherapy team meetings had only taken place twice in the last 12 months. The clinical nurse specialist told us they had just changed the shift patterns so that a meeting could occur once a week before patients arrived.
- Administration staff said they were unaware of how the department was restructuring under the new governance structure, and had not been consulted fully on changes to how GPs would refer to the trust becoming outsourced.
- Staff in the preoperative assessment clinic did not feel part of the trust team as they felt issues they had raised regarding the location of the clinic had not been listened to.

Innovation, improvement and sustainability

- The outpatient department had a programme for improvement which included increasing the compliance with the RTT targets, and improving the access to the department such as phone lines, Choose and Book service, virtual clinics and introducing an electronic referral triage system to direct referrals to the most appropriate point of care.
- Managers and leads told us cost improvement programmes were due to be implemented to ensure that the service was sustainable. This included aligning grade bands with trusts across London, reviewing staff skills mix, and reviewing weekend pay rates. They were also reviewing the administrative workforce to establish how the team could work more efficiently and centralise the processes for clinic preparation to improve efficacy and efficiency.
- The trust was to introduce electronic patient records and online appointment booking systems to improve patient access to the outpatient department. These systems were still in development when we inspected and no final implementation date had been set.
- The trust intended to roll out a customer service training programme to help staff improve patients' experience when they attended clinics.

HIV and sexual health services

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

Information about the service

The trust is the largest sexual health clinic in Europe and the European lead for HIV and sexual health, providing a wide range of services across London. The five sexual health clinics are the Kobler Clinic and John Hunter Clinic for Sexual Health, located in the St Stephen's Centre next to Chelsea and Westminster Hospital; the West London Centre for Sexual Health (WLCSH) which is located at Charing Cross Hospital in Hammersmith; 56 Dean Street and Dean Street Express (at no. 34), which are both located in Soho, central London.

The clinics offer: diagnostic testing; a results and treatment service for sexually transmitted infections, which includes HIV tests; contraceptives, including long acting methods as well as oral and intrauterine emergency contraception; pregnancy testing; hepatitis A and B vaccinations; and safer sex education, support, counselling and patient forums. They provide patients directly with the results of their diagnostic tests. Young people can also access these services.

The department provides outreach sexual health clinics in the community. For example, at NHS walk-in centres, other specialist sexual health clinics, a local prison and community amenities such as nightclubs and centres for the homeless.

The service diagnoses one in three HIV men in London and one in six over the whole country. They support over 8,000 people who have been diagnosed HIV positive. In the period from April 2014 to June 2014, the clinics across all three locations had seen a total of 168,000 patients for sexual health needs and HIV.

We visited the clinics and observed staff interaction with people using the service. We spoke with 13 patients, two representatives from patient groups, the lead consultant for the service, the lead nurse for HIV, lead nurse for the genitourinary medicine, the general manager for sexual health services, the substance use lead, five doctors and 21 staff, including nurses, health workers, administration and call centre staff. We reviewed other documentation from stakeholders, including performance information provided by the trust

HIV and sexual health services

Summary of findings

There were effective procedures to support a safe and effective service for patients. Clinical standards were adhered to and patients were appropriately involved in research and drug trials. The environment at clinics was visibly clean and uncluttered. The clinics at 56 Dean Street and Dean Street Express were trendy, modern and bright. One patient representative told us the team had brought "sexual health and HIV services into the 21 century". Patients described the service offered at each of the clinics as "exceptional", "caring", "confidential" and "quick". Staff were highly trained and were compassionate and caring. They treated patients with dignity and respect and "normalised" conversations about sexual health. Staff worked in a multidisciplinary way to centre care around the patient.

Each location had identified the demographic of the people using their service and provided speciality clinics, outreach, community engagement and counsellors suited to the people using the service. The team constantly explored new and innovative ways to deliver the service. National guidelines were being used and most patients could access services at one of the locations within 48 hours. The service reviewed its performance through patient surveys and the patient champions. There was clear governance and strong leadership and staff at all levels felt involved in decisions and ideas that could help the division and individual locations run well. The service was well-recognised at local and national levels.

Are HIV and sexual health services safe?

Good

The HIV and sexual health outpatient services had a clear process for reporting incidents and any learning was shared with staff. Staff had appropriate safeguarding and child protection knowledge but some staff required specific training in safeguarding procedures for children and young people. Patient records were kept appropriately and confidentiality was maintained. Records were not accessible to anyone other than appropriate staff.

The clinic areas we visited were visibly clean, tidy and uncluttered. Staff followed infection control procedures and these were regularly audited. Emergency medical equipment was checked and errors were reported. Staff were aware of how to respond to a medical emergency, violent incident or evacuation procedure. Medicines were stored appropriately and pharmacy staff provided a separate counselling service for patients starting a new medication regime. The staff numbers and skills mix varied according to the types and number of clinics at each location. Numbers were appropriate but staff were having to work longer hours to deal with increasing service demands. This had been recognised as a service risk.

Incidents

- There was a clear process for reporting incidents. Staff felt confident about reporting incidents to their manager and using the paper reporting system. Staff were able to describe the types of incidents they were expected to report, such as system or process failures, falls and medication errors. We looked at an incident reported on the day of our inspection at 56 Dean Street and saw it was fully completed and the facts were easy to read and understand.
- Between March and December 2013 there were eight incidents relating to the HIV and sexual health outpatient services. One incident related to a patient's distress immediately after care by a member of staff. This was due to the staff member's lack of communication and lack of awareness with regard to neglect and possible abuse, one fall incident; two medication errors, resulting in patients receiving an

incorrect dose; and four incidents in regard to record-keeping, resulting in patients not receiving test results. Actions taken were clear. There were no serious incidents reported between January and March 2014.
- The lead nurses for sexual health and HIV reviewed all reported incidents in order to identify any patterns or themes. The outcome, learning and any changes in policies or procedure relating to incidents was communicated back to staff through monthly meetings or on an individual basis.
- Junior doctors identified that clinics had monthly meetings to discuss incidents and learning from them.

Cleanliness, infection control and hygiene

- The outpatient clinics we visited were visibly clean, tidy and uncluttered.
- We observed that all staff followed the 'bare below the elbow' best practice guidance. Staff attended hand hygiene training as stipulated by the trust's statutory and mandatory training. The table below identifies the percentage of staff who had attended the training. It shows that, for three locations (in yellow and red), the number of staff who have not attended training is outside of an acceptable level as identified by the trust's targets.

56 Dean Street /Dean Street Express: 73%

WLCSH (Charing Cross Hospital): 90%

John Hunter Clinic: 87%

Kobler Clinic: 38%

St Stephen's Centre Management /call centre: 63%

- Hand hygiene gel was readily available for staff and visitors to use in all the departments we visited.
- We observed staff following the trust's policies for hand hygiene and wearing personal protective equipment. The infection control link nurse was responsible for monthly hand hygiene audits. We checked a sample of hand hygiene audits and saw they were completed regularly and accurately. There were rarely any concerns, and any issues were raised with staff on a one-to-one basis or through meetings and reminders.
- Cleaning was provided by external contractors. Nursing staff and healthcare assistants were responsible for cleaning clinical areas and any spillages. A weekly matron's audit identified any environmental issues, such as deep cleaning of the floors. We checked a sample of cleaning audits and schedules and saw they were completed regularly and accurately. Any issues were raised with the cleaning contractors or the nursing staff responsible. The nursing directorate was informed and they were responsible for reporting issues to the hospital board. Cleanliness, infection control and hygiene was a standing item on the agenda at board meetings.

Environment and equipment

- The WLCSH, Kobler and John Hunter clinics were based in hospital environments. The two clinics based in Dean Street were on a busy central London street. All the areas were clean and tidy.
- Most of the equipment used for examinations and procedures was single use. Reusable equipment, such as intrauterine device (IUD) kits and forceps, were sterilised by the trust's external contractor.
- Equipment, including resuscitation equipment and oxygen, was checked on the days the clinics were in operation and a record was kept of these checks and audits. We looked at a sample of the records and observed that, on most occasions, the checks had taken place. Any concerns were raised with staff on an individual basis or through staff meetings.
- John Hunter and Kobler clinics had standard hospital resuscitation trolleys. The resuscitation equipment at 56 Dean Street and WLCSH was on a 'dressing trolley' in unlocked rooms or in a corridor for ease of access in an emergency. The equipment and emergency medications were kept in sealed boxes. There was one set of equipment for each location.
- The clinics at each of the sites were located over two to three floors. Staff at the WLCSH had identified having emergency equipment on a dressing trolley was not appropriate for their needs as it was difficult to manoeuvre through doors and into the lift. We saw emails requesting a portable emergency bag which could be carried more easily between the floors but this had not been provided yet. Staff told us they were able to reach a patient requiring life support within two minutes of the emergency being raised. Staff told us it was very rare for a medical emergency to occur and could not recall a need for the equipment in the last year. All the equipment was easy to carry as individual items should staff be unable to use the lift to travel between floors.

- The samples of equipment we looked at had stickers to demonstrate they had been portable appliance tested and these tests were up to date.

Medicines

- There was a separate outpatients pharmacy for the HIV and sexual health clinics at each location.
- There were appropriate arrangements for the safe storage of medications in the pharmacy area and where medicines were stored in the outpatients department. These were stored in lockable rooms that could only be accessed by appropriate staff.
- Medication fridge temperatures were checked daily and controlled drug checks were completed appropriately.

Records

- Patient records were kept on a computerised system. Staff were able to explain the system they would use if a patient's computerised records were unavailable. Staff mandatory training included health record-keeping.
- The table below identifies the percentage of staff overall that have completed mandatory health record-keeping training. The figures in yellow identify the areas outside of an acceptable level as identified by the trust's targets of 86%–100% completion. Two areas did not have an acceptable number of staff attending this training.

56 Dean Street / Dean Street Express: 75%

WLCSH (Charing Cross Hospital): 93%

John Hunter Clinic: 93%

Kobler Clinic: 60%

St Stephen's Centre Management: 100%

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Patients told us they were asked for their consent prior to any tests or examinations. Staff told us patients' consent was recorded on their records.
- Staff used the Fraser guidelines to ascertain whether a patient under the age of 16 could be given contraceptive advice and treatment without the consent of their parents.
- The computer record system allowed staff to identify patients who were living in vulnerable circumstances. This meant staff could make any special arrangements or be more sensitive to a patient's personal circumstances prior to their appointment.
- Call centre staff asked for consent to send text message reminders and results to patients. Patients could indicate that they would prefer not to receive text messages from the clinic.
- Staff told us that, if they had any concerns that a patient using the service had mental health issues or learning difficulties, they would speak to their manager or a consultant.
- At Dean Street Express patients took their own swabs and, therefore, using the service was seen as an implied consent to have tests undertaken.

Safeguarding

- Staff told us they identified a large number of safeguarding concerns among children and young people. There was a lead consultant for safeguarding, and staff we spoke with were aware of the lead and who they could discuss any concerns with.
- Adolescent clinics were available at all three sexual health clinics. Due to an increase in seeing younger adolescents, the clinic had recently reviewed its policies and procedures to include 12-year-olds. This policy and procedure was new and going through an agreement process at the time of our inspection.
- The lead clinician for safeguarding was involved in a project to help staff screening young people identify child sex exploitation more easily through a proforma designed to identify concerns. The proforma was now mandatory within the trust. There was work with the paediatric team to strengthen the tool for use in paediatrics. The lead consultant told us the proforma had given staff confidence in identifying people in vulnerable circumstances.
- There were systems to identify and protect vulnerable in circumstances from abuse. These included how to recognise different signs of abuse and who to escalate any concerns to at the trust and local authority. One member of call centre staff had recognised a vulnerable person over the telephone and told us how they were able to access the right support from colleagues immediately.
- All staff were required to complete safeguarding children and adults training. Records showed that all staff had completed level 1 training 82% had completed levels 2 and but only 45% had completed level 3 training for specific staff roles.

HIV and sexual health services

Mandatory training

- All staff, including bank (overtime) and agency personnel, were required to complete a range of statutory and mandatory training according to their role. Staff told us they were regularly reminded through email of the importance of completing their mandatory training. Managers received reminders regarding staff who were breaching their training requirements. The trust policy for mandatory training imposed clear penalties for staff not attending statutory and mandatory training. This included fining the department, non-payment of annual increments and the possibility of disciplinary procedures.
- The table below identifies the percentage of staff overall who have completed all their statutory and mandatory training. The figures in yellow identify the areas outside of an acceptable level as identified by the trust's targets of 86%–100% completion. Only John Hunter Clinic had an acceptable level for staff mandatory training.

56 Dean Street / Dean Street Express: 70%

WLCSH (Charing Cross Hospital): 84%

John Hunter Clinic: 90%

Kobler Clinic: 58%

St Stephen's Centre Management /call centre: 77%

Assessing and responding to patient risk

- We heard administrative staff check patients' identity and contact details when they arrived for their appointment. The patients we spoke with told us the clinical staff were aware of their medical history and would check whether there had been any changes since their last visit if they were a regular visitor to the department.
- There was a procedure for patients whose condition might deteriorate during their visit to the HIV and sexual health outpatients departments. This included how to transfer stable and unstable patients to the main hospital for admission. Stable patients could be transferred with the aid of a porter and nursing staff, as opposed to unstable patients who would require an ambulance with a trained medical crew. Patients who were severely unwell were transferred to the nearest ED to the clinic they were attending.
- All staff were expected to attend mandatory training in basic life support in order to give emergency life support to a patient who may need it.

Nursing staffing

- The five HIV/sexual health clinics had six advanced nurse practitioners, 13 nurse practitioners and 66 nurses and health care assistants, one specialist HIV midwife and 10 nurse contraception trainers.
- Staff reported that they were very busy and often worked longer than their contracted hours. All the staff told us this was because the demand for services was more than the capacity of the clinics. This was identified on the trust's risk register on 30 August 2011. At the review on 2 May 2014 it was recommended that staff hours should be monitored to check the extent of working late and there should be a review every day at 5pm to assess clinical needs and contingency. The next review date was 2 November 2014. We were unable to identify from the risk register what action had taken place between 30 August 2011 and 2 May 2014.
- Clinics were run by specialist HIV and sexual health nursing staff with various amounts of experience and skills. Staffing levels varied on a daily basis according to the clinics running.
- There were advanced nurse and nurse practitioners who led clinics, such as clinics for men who have sex with men.
- Unexpected staff absence was covered by moving staff from another clinic or use of permanent bank staff to ensure that the clinic was covered by a member of nursing staff with the required skills.

Medical staffing

- There were nine consultants and 11 junior doctors working in the HIV and sexual health services.
- The medical staff over the division were made up of consultants who led in different specialities within HIV and sexual health, trainee doctors and associate specialists doctors. Members of medical staff were available at each clinic when the clinic was open.
- There was a 24-hour, seven-days-a-week, on-call consultant for HIV and sexual health for staff to access across the trust.
- Most consultants working in HIV and sexual health were trained in family planning. Many of the doctors were trained in procedures such as long-acting reversible contraception and IUDs.

HIV and sexual health services

Other staff

- Health advisers supported clinical staff on a day-to-day basis. Health advisers could support a patient after diagnosis in areas such as partner notification/tracing, sexual health promotion and counselling.
- Clerical staff supported the call/appointments centre, administration services and reception. They supported patients attending the clinics in completing paperwork prior to their appointment.
- The 56 Dean Street clinic had a substance use lead and a psychosexual counsellor to support staff in advising patients who may need help in understanding substance abuse or for patients living with difficulties of a psychological or sexual nature.
- Volunteer 'greeters' supported patients using the services at 56 Dean Street and Dean Street Express.
- Each location had its own pharmacy staff to support the pharmacy services.

Major incident awareness and training

- Staff we spoke with were aware of the evacuation procedure and their roles and responsibilities. However, there had been no evacuation drill in the clinics.
- Staff could explain the procedure they would follow in the event that the IT system should fail and they could not access a patient's electronic records or the appointment booking system.

Personal safety

- Staff could raise an alarm by pressing the emergency alarm fitted in all clinical rooms should they need help in a treatment room. Staff were able to describe the types of reasons the alarm may be pressed, such as a medical emergency or a violent patient. Some staff were able to explain what they would do if they responded to the alarm but drills using mock incidents had not taken place to practice different scenarios.

Are HIV and sexual health services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the outpatient departments.

Staff followed national guidelines where appropriate, along with the trust's policies and procedures, and guidelines relating to their profession. People received care from suitably qualified staff who were appropriately trained, regularly supervised and appraised. There were regular multidisciplinary team meetings. Staff took part in projects with other organisations specialising in sexual health and HIV.

People were able to take part in clinical research and drug trials, and could access help through one of the four clinics six days per week during working hours and some evenings.

Evidence-based care and treatment

- Patients' needs were assessed and care was delivered in line with best practice clinical guidelines to ensure that they received safe and effective care.
- Staff followed the British Society for Sexual Health and HIV (BASHH) and British HIV Association (BHIVA) guidelines.
- Specialist nursing staff were expected to follow the NICE guidance relating to speciality, such as the prevention of sexually transmitted infections and conceptions in young women aged under 18 years.
- Staff could access clinical guidelines, policies and procedures through the trust's intranet.
- There was a local audit programme; of 32 audits, 18 were currently in progress, although some of these were past their submission date, and five were completed. Nine were planned, as these were identified as trust 'must dos', but they had not yet been registered as started.

Patient outcomes

- The clinics held performance data against activity and outcomes.
- The service participated in suitable national audits and two were currently in progress: Clinical outcomes in young adults with perinatal-acquired HIV following transfer from the paediatric to young people's services, and the 2014 National BASHH Audit on the Management of Anogenital Herpes. These were currently in progress.

Competent staff

- Staff we spoke with had received an annual appraisal and told us it was a useful opportunity to discuss their achievements and future aspirations. Supervision

meetings took place regularly, either on a one-to-one basis or in a group. All the staff we spoke with felt confident that they could raise any difficulties, concerns or development needs with their managers.
- Each location arranged 'local' staff meetings. The whole HIV and sexual health team met once a month. Nursing staff met on a weekly basis at their respective clinic to share a patient story or experience. This gave staff emotional support and the opportunity to learn from each other.
- All staff had a trust-level and local induction. We spoke with one member of staff who was being shadowed by a mentor. They had recently joined the team and told us they were expected to reach a certain level of competency, as identified in their training handbook, before working independently of their mentor.
- All staff reported that they had good opportunities to further their development through attending courses and seminars appropriate to their role. The call centre staff gave us an example of having attended a course on sexually transmitted infections (STI) so that they could help patients access the correct service when they called for advice or to make an appointment.
- Each GUM consultant led in a specialism relating to HIV and sexual health. All sexual health consultants were all trained to be able to give advice on and prescribe contraception.
- Some staff had been trained in line with department's plans to offer a fully comprehensive contraception service across all the clinics as part of the sexual health improvement programme. However, staff told us they were unclear if the service would continue to be commissioned. The senior managers were aware that staff could lose the new skills if they were not using them. They perceived that this could cause some de-motivation for staff who wanted to provide improved sexual health services.
- A consultant at the WLCSH were completing a postgraduate course in training. The intention was to train internal and external staff in HIV and sexual health, creating a centre of excellence.
- Gaps in knowledge regarding any new guidance was explored in divisional governance meetings and was disseminated by the clinic leads at departmental meetings. Records showed that these meetings covered topics including training, policies and procedures and any staffing issues.
- Wednesday mornings were protected for staff to complete training and attend sessions or presentations.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within genitourinary medicine rated overall satisfaction with training as similar to other trusts. Local teaching was rated as better than other trusts.

Multidisciplinary working

- All staff we spoke with described a positive working environment where different staff groups worked as a team. There was a variety of multidisciplinary groups and forums that met on a regular basis to discuss incidents, individual cases and to share learning.
- Directorate multidisciplinary meetings took place every three months and involved all staff.
- The HIV and sexual health clinical governance board met every two months. Issues discussed between October and December 2013 included: pathology incidents, dermatology governance, the Lillie IT system implementation and the Keogh review into hospital mortality rates.
- The HIV and sexual health services discussed governance-related issues on a monthly basis.
- Staff led on projects with other agencies specialising in HIV and sexual health. For example, the lead for safeguarding took part in a joint project with the Department of Health, Brook (the sexual health charity for young people) and BASHH into screening young people who may be subject to child sexual exploitation.
- The Kobler Clinic established staff communication before each clinic by holding a multidisciplinary meeting led by a named consultant and involving a senior nurse, pharmacist and research nurse.
- The Dean Street clinics had received visits from other sexual health professionals in the country and from countries such as Australia and America.

Seven-day services

- Clinics times varied at each of the locations. Patients were able to access services at one of the locations from 8am to 7pm Monday to Friday and from 9am to 4pm on Saturdays.
- Services were not available to patients outside these times. There was clear information on the trust's website on options available in the case of an emergency. Patients were able to leave a voice message requesting a health adviser to call when the department was open.

Patients who had come into contact with HIV were advised to attend accident and emergency (A&E) where they had access to an on-call consultant. Patients who had an urgent HIV-related medical problem were advised to attend A&E or see their GP. Some clinicians contact details were available on the trust's website for people who were seeking specific consultants.

- Emergency appointments were available Monday to Saturday for patients who had HIV or STI symptoms.

Are HIV and sexual health services caring?

Outstanding ☆

Patients and their families were treated with compassion, dignity and respect. All the patients we spoke with talked highly of the care and attitude of the staff and said they never felt stigmatised. Staff put people at ease and "normalised" discussions about sex so that patients were able to talk freely about their sexual experiences.

Patients had time to discuss any concerns and to understand the treatment options available to them. There was good support for patients and their friends and family with long-term conditions.

Compassionate care

- Patients described staff positively and said, for example, that they were "warm" and "easy to talk to". They described the service offered at each of the clinics as "exceptional", "caring", "confidential" and "quick".
- Patients told us they never felt stigmatised by staff when attending the clinics. Some people told us they travelled to the clinics even though there were other options closer to their home because the staff were so good.
- All the patients we spoke with told us that the staff were respectful, caring and kind. We observed staff speaking with patients politely and quietly in the reception areas. Staff acknowledged people in a friendly way and stopped to chat with people who regularly visited.
- Staff told us how they "normalised" discussions about sex by being non-judgemental. They encouraged people to talk about their experience and identify the risks they may face by not participating in safer sex practices.
- Staff were very aware of patients in vulnerable circumstances, patients who may have been the victim of a sexual assault and patients who were from the transgender community.
- We observed receptionists talking discreetly with patients at the desk. We saw one receptionist speaking privately with a patient in another part of the waiting area so they could not be overheard while going through the patient history form.
- We heard the call centre staff speaking with patients in an efficient, reassuring and friendly manner.

Patient understanding and involvement

- Patients told us they understood how and when they would receive their test results and how to book their next appointment.
- Long-term patients told us they felt able to speak to a consultant about any concerns after leaving the clinic. Alternatively, they could contact the clinic or call centre where they would be put in touch with the appropriate clinician or support worker.
- Health advisers were available to discuss any queries patients had after their consultation, support them in talking with partners, dispel any myths associated with HIV and STIs, and advise on good sexual health.
- Patients received copies of letters to their GP in relation to their treatment and care if they were registered with a GP. All patients, particularly those who tested positively for HIV, were encouraged to engage with a GP if they did not have one.
- Pharmacy staff had a separate counselling service available, where each new patient had all their treatment explained to them prior to their therapy commencing. Patients reported that the clinical staff and pharmacy discussed any medication changes and treatment with them, and they understood any side effects they might experience. They knew who to contact if they had any concerns.

Emotional support

- Health advisers supported patients after a diagnosis. Staff were aware of the importance for patients testing positively for HIV or STIs to contact previous partners. They were conscious that this was not comfortable for some people to do. They supported patients by counselling them through it or making the calls. Health advisers could also support patients in coming to terms with their condition and the treatments available.

HIV and sexual health services

- There was a substance use adviser available to support patients using drugs and alcohol.
- There were a number of support groups available for patients such as: a Sober Sex Group, supporting men in understanding the relationship between sex and alcohol/drugs and helping them to make different choices; an HIV positive women only meeting for education and support was held four times a year for patients and their representatives to share experiences and concerns.

Are HIV sexual health services responsive?

Outstanding ☆

The service was designed to enable all people in the local community and from across London to have easy access. There were outreach programmes and service adaptations aimed at meeting the needs of people in vulnerable circumstances. The service took account of national guidelines recommending patient involvement and services were consistently planned, delivered and reviewed to respond to patient needs as well as to complaints and concerns. For example, premises were based in a busy central London street rather than a hospital environment and services were designed to so that they were modern rather than clinical. Most patients could have an appointment within 48 hours and there were walk-in facilities at Dean Street Express each day.

The service had responded to people in vulnerable circumstances and hard-to-reach groups and there were specialist clinics, effective community engagement, outreach and one-stop clinics to support patients. The service was effective in engaging with communities that would not normally seek HIV or sexual health services.

Service planning and delivery to meet the needs of people

- The Chelsea and Westminster clinics were accessible to anyone who wanted STIs (including HIV) tests, contraceptives including emergency contraception such as the morning-after pill. , condoms, pregnancy testing, hepatitis A and B vaccinations, safer sex education and support and counselling. Patients did not need their GP to refer them for care, nor did they need to live locally.
- There were approximately 450,000 people diagnosed with STIs in England in 2013*. In the period from April 2014 to June 2014 the four sexual health clinics had seen a total of 27,564 people for sexual health screening.
- At the end of 2012 an estimated 98,400 people in the UK were living with HIV, approximately 21,900 of those were infected but undiagnosed; there were 6,360 new HIV diagnoses; and 902,610 HIV tests performed in England.** The service diagnosed one in three HIV positive men in London and one in six over the whole country. They support more than 8,000 people who have been diagnosed positively for HIV, the largest HIV cohort in Europe. In the period from April 2014 to June 2014 the clinics across all five locations saw a total of 8,576 people for HIV.
- Staff demonstrated knowledge of the demographic of people using the service at each location and tailored their service to meet their needs. For example, WLCSH had a large female cohort using the services and changed the clinic dedicated to men who have sex with men, which had reduced demand, to a general clinic to provide more appointments for women. Men-only clinics were available at other locations.
- The team provided a service to people who were most at risk of coming into contact with HIV or STIs. 56 Dean Street, located in Soho, brought sexual health outpatient services to a busy street location in the heart of London. Patients were asked for their input on what type and feel of environment they would prefer to visit. As a result, the location is modern and trendy.
- 56 Dean Street proved immensely popular and became too busy to accommodate the walk-in clinic. As a result, Dean Street Express was planned and received board approval to go ahead within six weeks of submitting the proposal. Dean Street Express has also proved to be a hugely popular service and the number of patients using it has exceeded the expectations of the team. Therefore, at peak times, there can be waits of up to an hour to see a clinician for a blood test. However, patients were advised how long they may need to wait and quieter times identified if they preferred to revisit at another time.
- The service provided outreach clinics at G-A-Y Bar, Manbar and Sweatbox Gay Sauna and in hostels and community venues to engage with hard-to-reach groups

such as the Chinese and Muslim communities, young people and people socially excluded or those who use Supporting People programme services, such as the homeless.
- According to Public Health England's HIV-STIs: Sexually transmitted infections and chlamydia screening in England, 2013, Health Protection Report: Infection report, Volume 8 Number 24, Advanced Access report published on: 17 June 2014.

**According to Public Health England HIV in the United Kingdom: 2013 Report (Published November 2013: data to end December 2012).

Access and flow

- There used to be a national expectation that 100% of patients should receive an appointment within 48 hours of contact and that 98% of patients should be seen within 48 hours. However, the targets are now negotiated locally with the commissioners of the service. The Chelsea and Westminster Hospital still aimed to achieve the original national targets.
- Across the whole of the HIV and sexual health division there was a combination of walk-in clinics and appointments. People could travel to any of the clinics, depending on their needs. A walk-in clinic was available at Dean Street Express for people who were asymptomatic (showed no symptoms) and wanted sexual health and HIV tests. People who did not wish to attend 56 Dean Street or were symptomatic or needed treatment were usually offered an appointment within 48 hours. Each clinic had emergency appointments available for people who had symptoms.
- Dedicated walk-in only clinics at other locations had been withdrawn as the clinics were over capacity within 15 minutes of opening. Staff found that reducing the walk-in clinics meant they were able to see more patients as they could increase the number of booked appointment slots. They also introduced a slow release for emergency appointments to prevent the telephone lines being jammed first thing in the morning.
- Patients accessing the HIV and sexual health clinics generally received an appointment within 48 hours. In the period from April 2014 to June 2014 three people were unable to obtain an appointment within 48 hours. One was due to patient choice and two were due to lack of capacity. Approximately 100 patients were seen for appointments at each site each day, excluding Dean Street Express which is a walk-in clinic and sees over 250 patients a day
- Some call centre staff chose to have training in understanding and recognising STIs. This meant they were able to triage (assess and prioritise) patients more easily and book them into the right clinic first time.
- It was the department's aim to see patients within 15 minutes of their appointment. This had been identified as an acceptable benchmark by patients following an audit on wait times produced by the patient forum. If waiting time was longer than this, staff would let patients know how long the clinic was running behind when they booked in.
- Patients with new appointments had more time to talk and ask questions. This could delay clinic times as some people may have received bad news and needed more time to talk about their treatment and options. As a result, people who were attending appointments for the first time, for follow-up treatment or results were given a longer appointment than those who were attending for a routine check-up.
- On the day of our inspection we saw that the waiting area at Dean Street Express was full and some people were sitting on the floor while waiting for a blood test. Patients were informed of waiting times and advised when clinics were quieter, however, patients chose to wait even if it meant sitting on the floor. To give patients an alternative option, the service had just purchased a buzzer call system, similar to ones used in busy restaurants, where they could alert a patient when it was their turn to be seen. This meant that, during busy times, patients could sit in a local coffee shop while waiting for their turn. This system was due to be implemented imminently.
- At Dean Street Express there was very little waiting time for self-administered tests. However, waiting times to see a clinician for blood tests could be as long as one hour due to the demand for the service. Patients would be informed of how long they could expect to wait when they booked in.
- One-stop clinics were available for women's sexual health needs, for example, a woman could have a sexual health screening and family planning and contraception at one appointment. STI screening was available in HIV

clinics for patients with no symptoms. The department was planning to roll out screening for symptomatic patients, but there was no date for this to take effect at the time of our visit.
- Senior staff told us that around 11% of appointments were not attended by the patients. Patients were offered a choice of appointments and locations to attend. Some of the non-attendance rates are due to the erratic lives some patients have, as they may be homeless, or a substance user.

Clinic: 56 Dean Street; Booked appointments: 15,097; Non-attendance: 1,702 (11%)

Clinic: WLCSH (Charing Cross Hospital); Booked appointments: 8,440; Non-attendance: 1,185 (14%)

Clinic: John Hunter and Kobler clinics; Booked appointments: 8,118; Non-attendance: 1,014 (12%)

TOTAL: Booked appointments: 31,655; Non-attendance: 3,901 (12%)

Note: Dean Street Express is not included due to walk-in appointments only offered

- Text messages were sent to patients 48 hours and 24 hours in advance of their appointment to remind them or give them the opportunity to cancel or change it. Staff told us this helped to reduce the non-attendance rates.

Meeting people's individual needs

- The service took into account patients' individual needs. As well as general clinics for testing STIs, contraceptive clinics and vaccination clinics, the service offered many speciality clinics such as: SWISH for people employed in the sex industry; cliniQ and the Gold Service for the transsexual community; CODE clinic for men who were into harder sex or using drugs during sex; and the Pearl clinic for people with a learning or physical disability.
- Dean Street Express opened in February 2014, and was the first clinic in the world to have an on-site machine to use DNA gene technology. This allowed asymptomatic patients to receive STI screening results within six hours. Patients used a touchscreen check-in system which allowed them to include their recent sexual history. After checking in, patients were given the swabs they required to take their tests and a tube to put the test results in. Patients took their own swabs in one of four cubicles. Inside the cubicle was a mirror and a video playing on a loop explaining how to take your own intimate swabs. There was a toilet in each cubicle should a urine sample need to be taken. The samples were sent to the lab via a pressurised tube delivery system. Patients then went to the waiting area if they required a blood test for HIV where a clinician would perform the test. Sexual health tests were available within six hours and HIV tests were immediate. Patients were given a discreet swipe card with a barcode with all their information. They could swipe this if they visited the clinic in the future. Patients who were symptomatic or diagnosed with an infection were booked into 56 Dean Street for an emergency appointment for immediate treatment and support.
- Some clinics were available into the early evening and on Saturdays to allow for people who could only attend outside work hours. Outreach clinics were held for hard-to-reach groups such as the Asian and Muslim communities.
- The maternity and gynaecology and HIV/sexual health departments had worked in partnership to devise the West London African Women's Service to focus support on the needs of women affected by Female Genital Mutilation (FGM). The clinics had won awards because of their dedication to improving the care of women living with FGM
- All three clinics had walk-in appointments available at specific times for young people, aged 19 or under. It was found this age group were more likely to access the service if they could drop in.
- Each location had a different style of reception area to book in at arrival. Within a waiting area, people were asked to stand back until the person in front of them had finished speaking with the receptionist.
- Some staff spoke other languages and interpreting services were available for patients who did not use English as their first language. Staff had use of a telephone interpreting service or face-to-face interpreters could be arranged with prior notice.
- Patients were offered a chaperone if intimate examinations or treatment had to be given by a member of the opposite sex.
- Patient consultations and clinical examinations were held in private rooms and behind closed doors. We observed all staff knocking on treatment room doors before entering.

- Sign-posting to the WLCSH and Kobler and John Hunter clinics was easy to follow. 56 Dean Street and Dean Street Express were based on a busy street in the centre of London. The two clinics were easy to find and had a discreet 'shop front' to help safeguard people's privacy.
- Information leaflets about HIV, sexual health and other health-related concerns were available in all the clinics. Leaflets were not available in alternative languages, however, they could be translated if required.
- All the clinic details, specialities, locations, advice and videos about what to expect when attending clinics were available on the HIV and sexual health section of the Chelsea and Westminster Hospital website.

Learning from complaints and concerns

- The service learned from complaints and concerns from patients and staff. Most of the complaints the service received related to clinic waiting times, particularly at walk-in clinics, and getting an appointment within 48 hours. This was particularly prevalent at 56 Dean Street due to its popularity. As a result, the clinic was breaching the 48-hour contact to appointment targets and there were long waits at walk-in clinics. The demand for services at this location was outstripping capacity and complaints increased. In order to drive down breaches and complaints, a new location, within a two-minute walk of 56 Dean Street was found in 2013 and has been running since February 2014. This was Dean Street Express, a walk-in service for patients who were asymptomatic. 56 Dean Street's 48-hour breaches have reduced from 28 during the period October 2013 to March 2014, to two during April to June 2014.
- As a result of call centre staff raising a concern about a patient who failed to attend their follow-up appointments, the department was embarking on setting up a 'lost to follow-up service' to re-engage patients.
- Based on a patient feedback survey, a news sheet was provided to patients at the Kobler Clinic identifying patient concerns and what actions were being taken. For example, they were trialing a booked blood appointment service to try and reduce waiting times, while still providing an accessible service.
- The youth forum had identified a need to redesign the waiting area, increase service delivery, maintain the youth engagement officer to facilitate capture of ongoing feedback, use social media to enhance promotion and further develop partnership working with local community. The service now provided a waiting area for young people only, the youth engagement office continued to capture feedback, clinics were available at all locations over different times of the week, and outreach clinics were available at local colleges.

Are HIV and sexual health services well-led?

Outstanding ☆

The leadership at all levels and in all departments within the outpatient services for HIV and sexual health services was outstanding. The service had a strategy to deliver modern services and improve public sexual health. There was a consistently positive view from staff about the leadership of the service. All staff felt they could make a valuable contribution to running the service and impart ideas that could improve the patient journey. Governance arrangements were well-developed and risks were being managed at service level, although trust actions were not always identified.

Patients were regularly asked for their opinion of the service at each location to assess and improve the quality of the patients' experience. There was outstanding patient engagement that directly improved and developed the focus of services. All the staff had a genuine passion for ensuring that sexual health remained a priority on the trust's, patients' and public agendas. The service was innovative and was recognised locally and nationally.

Vision and strategy for this service

- All the HIV and sexual health staff at all levels showed a strong commitment to implementing the framework for sexual health improvement published by the Department of Health in March 2013. This report highlights areas for sexual health professionals to concentrate on. This included: reducing the number of unwanted pregnancies; increasing the number of people in high-risk groups being offered and accepting HIV tests; partner notification; helping people with HIV to access appropriate support and medication to live a long and active life; ensuring that people have access to free condoms and know how to prevent sexually

transmitted infections; protecting children from sexual abuse and exploitation; eradicating prejudice based on sexual orientation; and helping people to have the confidence and ability to say 'no' as well as 'yes'.

- The team had strategies to deliver on this guidance for there to be continued focus on excellent access to contraceptive advice, treatments and sexual health screening. Their future vision was to continue to build on the success of 56 Dean Street and Dean Street Express, which has brought a modern approach to sexual health services and strived to be a centre of excellence.
- All the staff we spoke with told us of ways they tackled the stigma, discrimination and prejudice often associated with sexual health. They aimed to bring sexual health into the 21st century and normalise conversations around healthy sex choices. All the staff spoke in passionate tones about the importance of keeping HIV and sexual health high on the agenda.

Governance, risk management and quality measurement

- HIV and sexual health services came under the directorate for women's health within the trust. This also included women, neonatal, children's and young people's services and dermatology.
- There was a system that facilitated reporting from the department to the board. Staff were aware of their responsibility to report any issues or concerns to their manager, who would then escalate this as appropriate.
- There were a number of risks on the trust's risk register that had been identified as long as go as 2011 and, although there were regular review dates, we were unable to ascertain what actions and resolutions had been identified in that period. For example, staff working longer than contracted hours (opened in August 2011), and the management of pathology results (opened in April 2010), and no review update since 10 April 2013.
- Senior staff were aware of any risks that may impact on the safety or effectiveness of the service. They had identified the biggest risk to the department was financial and the need to ensure appropriate commissioning and payment for services particularly from patients using the service that may come from outside of the Chelsea and Westminster catchment area. This had been escalated to the board and was rated as a moderate risk on the trust's risk register at the end of May 2013. However, there was nothing to identify what controls were in place, although the next review was on 2 August 2014.
- The department had identified other risks, such as staff working long hours, partial non-compliance of NICE guidance (raised in September 2012), management of pathology results (raised in April 2010), staff personal safety (raised in August 2011) and issues relating to the implementation of a new computer system (raised in November 2011). These risks had been appropriately reviewed, apart from the risk relating to pathology results, which was outstanding as it had been due for review in October 2013.
- The departmental meeting minutes showed that performance reports included complaints, incidents, environmental issues, such as design and lighting and anything related to staffing were discussed and actioned.
- The directorate's quarterly report covered patient safely, which included: serious incident; risk register; mortality and morbidity; infection control; patient safety news and training; learning and outcomes; clinical effectiveness, which included guidelines and those needing review, audits undertaken, and research; and patient experience. We noted that no information had been received for this area of the report for the last two quarters of the reporting period. No reason was given for this.

Leadership of service

- Staff spoke highly of the management team and their immediate managers. They told us they would feel comfortable speaking with them about any concerns or issues. Staff gave us examples of concerns they had raised with their manager and the support they were given.
- Staff spoke highly of the divisional director of operations. However, there was a mixed response from staff about how engaged they thought the board members were with the work of the HIV and sexual health team. Those members of staff who had met with the chief executive spoke positively of the experience. However, they said they would not be able to identify any other board members.

HIV and sexual health services

Culture within the service

- Staff said the culture was open and there was no blame attached to reporting incidents; there was cross-departmental learning, for example, work with paediatrics in recognising child exploitation.
- New members of staff told us that established staff were approachable, supportive and helpful.
- All the staff had a "let's try it and see how it works" attitude. They were open and flexible to change and new ideas. If they found something that didn't work, they would seek feedback and adapt the idea or process. All staff at all levels were encouraged to put forward their ideas. One member of staff told us they were a fairly new and junior member of staff but they had made a suggestion to make checking-in at the clinic easier and the process was now used in the whole of the clinic.

Public and staff engagement

- The Royal College of Obstetricians and Gynaecologists' Faculty of Sexual & Reproductive Healthcare guidance, Service Standards for Sexual and Reproductive Healthcare, published by the Clinical Standards Committee states: "Services should demonstrate that user and public involvement has been fundamental to service development, provision, monitoring and evaluation (Standard Statement 4). User engagement should be encouraged and evidence provided that it has been used in service planning." The patients and staff spoke positively of being engaged with the department.
- Two patient champions were funded by the division. They listened to patients' views by attending the clinics and through holding a patient forum every three months to discuss experiences and specific sexual health and HIV topics. There was an open email list available so that patients could provide feedback to the patient champions. The patient champions attended regional and national meetings to listen to patients' experiences of using HIV and sexual health services elsewhere. They shared this learning with the clinical leads for the service to drive improvement.
- The department invited people from different communities, such as the transgender community, to feed back on the services provided. As a result of these meetings, staff have been trained in appropriate terminology, and all toilets in the four sexual health and HIV services were genderless toilets
- The co-founder of the trans community cliniQ told us the Chelsea and Westminster HIV and sexual health team were always open to trying new ways of doing things and embraced change in an ever-evolving community.
- WLCSH ran a youth forum in 2013/14. They evaluated the service they were providing for young people. The team recognised that young people bear a significant burden of sexual ill health with high rates of STIs and unintended pregnancy, and they were a challenging group to engage. They decided on a more innovative evaluation strategy in partnership with Youth Projects International. The youth forum itself had been developed by the youth engagement officer through a series of discussions and debates (from September to December 2013) with young people who attended the service.
- Patients were regularly asked to give feedback about the services through surveys. There were patient feedback surveys for all the clinics, including specialist clinics such as female genital mutilation (FGM). The FGM survey was 100% positive with a 92% response rate and the service has continued to explore other methods of data capture.
- Dean Street Express completed a survey on 4 March 2014 to ascertain what patients thought of the service after the first months of opening. The results showed that, of the 343 responses, 98.3% of male patients and 94.8% of women thought the service was good to excellent.
- Staff of all levels gave us examples of how they had contributed to making changes within the service. For example, one receptionist had identified that it could be difficult for people to disclose, in a busy reception area, why they were visiting the clinic. They had developed a card that people could read and point to or say a number next to the problem they were attending for and symptoms they were experiencing. The call centre staff had also identified that they would be able to help patients reach the most appropriate clinic for their needs if they could identify the STI the patient was describing over the phone. A course in recognising STIs was available for call centre staff who wished to attend. Staff told us they were able to triage patients and direct them to the correct clinic first time and staff felt confident in supporting patients over the phone.
- Staff at WLCSH spoke of their concern about the future of their department. Chelsea and Westminster Hospital

leased space at another London hospital but, due to reorganisation at this trust, they were concerned that their department may close. However, staff were fully aware and supported through this time of uncertainty and were being informed of any future plans.

Innovation, improvement and sustainability

- The HIV and sexual health department constantly looked how they could improve services in innovative ways. However, as one manager told us, "sustaining the service with an increasing demand will be a challenge". Another manager told us the service was, "a victim of its own success. The demand for testing and support is far greater than we imagined". The demand was outgrowing the size of the buildings. For example, the success of Dean Street Express surpassed all expectations as the estimated number of people using the service was based on the number of people who had been using the walk-in centre at 56 Dean Street.
- Staff were always planning new and innovative ways of providing the service and, with sound business plans, were encouraged to put ideas forward. For example, Dean Street Express was approved within six weeks of the plan being presented to the board.
- 56 Dean Street runs cliniQ and the WLCSH runs the Gold service are the only specialist sexual health clinics in the country for the transsexual community. The model for this service was led by the transsexual community through public engagement.
- The trust's HIV and sexual health centres had an excellent national and international reputation. Their innovation started as far back as 2003, when they were the first NHS service to offer rapid, one-hour HIV point of care testing.
- In 2011, 56 Dean Street set the Guinness World Record for the most HIV tests performed in one location on World Aids Day at G-A-Y Bar in Soho, London. They tested 745 people in a period of eight hours. (The previous year's world record was 467.)
- On 8 July 2014, the House of Lords legislators took HIV tests in the House of Commons at a 'Halfway to World AIDS day' event. Twenty-two MPs, peers and councillors took a test administered by clinicians from the Chelsea and Westminster Hospital NHS Foundation Trust. This was in an act of solidarity with all those living with HIV and a demonstration of the UK's policy commitment to HIV testing.
- The department has consistently been shortlisted and won awards for a variety of projects every year since 2007. One of their most recent awards was for the work WLCSH produced with the West London African Women's Service for dedication to improving the care of women living with FGM. The trust had won the BMJ Group Award 2013 for transforming patient care using technology, and the adult sex project of the year at the Brook Sexual Health Awards 2013 for Dean Street at Home and cliniQ.

Outstanding practice and areas for improvement

Outstanding practice

- The A&E department staff had taken part in a research project to routinely test patients for HIV (with their consent). This had now been embedded practice for over a year and testing had resulted in a higher-than-normal proportion of patients being identified as HIV positive.
- The CSSD had introduced a metal detector which was used to identify surgical equipment that had been incorrectly discarded into rubbish bags. The aim of this initiative was to promote staff safety and reduce the cost of lost equipment.
- The burns unit had international recognition and published numerous research papers annually which identified best practice.
- The physiotherapy team in intensive care had an impressive research portfolio, for example, they had developed an innovative simulation-based physiotherapy course to improve quality and safety, and a standardised functional score assessment tool to improve compliance with NICE guidance. The tool is now used in more than 50% of intensive care units nationally.
- An NHS doula (a person who helps a mother through the birthing process) was available in the maternity service.
- The female genital mutilation (FGM) service in maternity had achieved a national award for innovation and care.
- The neonatal palliative care nurse had developed national standards for caring for very young babies with life-limiting conditions who needed palliative or end of life care on neonatal units. These standards had recently been shared with medical royal colleges and other hospitals for national use.
- The HIV and sexual health services provided outreach clinics at London's G-A-Y Bar, Manbar and Sweatbox Gay Sauna and in hostels, and community venues to engage with hard-to-reach groups such as the Chinese and Muslim communities, young people and people socially excluded or those who used Supporting People programme services, such as the homeless.
- The HIV and sexual health services gained community engagement through outreach work, taking part in London Pride, publicity stunts such as the Guinness World Record attempt for taking the most HIV tests at G-A-Y Bar on World Aids Day in 2011 and the House of Lords campaign to provide HIV tests for legislators.
- 56 Dean Street and Dean Street Express brought sexual health services to a high street location. Dean Street Express provided fast, self-testing modern facilities for asymptomatic patients.
- Public engagement in the HIV and sexual health services was an integral part of the service and had led to innovation and excellence across London. The service had two patient representatives on a part-time basis, funded by the trust to obtain the views of people using the service to help make positive changes.
- The HIV and sexual health services provided speciality clinics such as: SWISH for people employed in the sex industry; CODE clinic for men who were into harder sex or using drugs during sex; Pearl clinic for people with a learning or physical disability; and cliniQ and the Gold Service for the transsexual community. CliniQ and the Gold Service are the only specialist sexual health clinics in the country for the transsexual community. The model for this service was led by the transsexual community through public engagement.
- The HIV and sexual health services have consistently been shortlisted and won awards for a variety of projects every year since 2007. One of their most recent awards was for the work with the West London African Women's Service for dedication to improving the care of women living with FGM. The trust had won the BMJ Group Award 2013 for transforming patient care using technology, and the adult sex project of the year at the Brook Sexual Health Awards 2013 for Dean Street at Home and cliniQ.
- The leadership team had created an environment where all members of staff were part of quality project teams. These teams were then given time to undertake innovate projects and research to improve the quality of the service. As a result, a number of staff throughout the unit had been nominated for the trust's award for clinical excellence. Staff we spoke with told us how improvement to services had been undertaken through these projects.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

The hospital must ensure that:

- Patients are cared for in appropriate areas in the A&E department so that there is safe monitoring of their condition.
- All staff in A&E receive training in mental health awareness, and when and how to safely restrain patients.
- All staff receive training in the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards.
- Pain scores are recorded and reassessed for all patients in the A&E department.
- Consultants in A&E sign off and agree to the discharge of patients with complex needs in line with national guidance.
- There are suitable environments in outpatients areas to ensure accessibility for patients with a physical disability or poor mobility, to promote the privacy and dignity of patients, and protect patient confidentiality.
- Patient records and care plans are accessible to all staff, including agency staff.
- Regular checks of medicines are undertaken, that all medicines are stored safely, and are in date and fit for use.
- Nurse staffing levels are compliant with safer staffing levels guidance.
- A recognised acuity tool is used in all areas and staffing levels and skills mix reflects the findings of these as well as national guidance.
- Appropriate equipment is available and regularly checked and records maintained.
- Compliance with the 'five steps to safer surgery' checklist is improved and is embedded in surgical practice.
- The incidences of pressure ulcers in surgery and critical care are reduced.
- A record of the termination of pregnancy (TOP) forms (HSA4) sent to the Department of Health is kept by the trust.
- Compliance with statutory and mandatory training is improved.
- All staff use the incident reporting system, and that feedback is provided and learning from incidents is cascaded and shared. There should be evidence of appropriate action in response to any never event (serious harm that is largely preventable).
- Risks identified on the risk register have appropriate actions to mitigate them, with timely reviews and updates. Information on risks should be owned by the divisions.
- The safety thermometer is embedded across the trust and information on avoidable harms is available and displayed for the public to access.
- The time taken for the root cause analysis investigation of serious incidents improves so that issues are identified quickly to prevent recurrence.
- Clinical guidelines are up to date, in line with national guidance and action is taken as a result of audits.
- Governance and risk management procedures in children and young people's services improve.
- The trust continues to support staff and investigate and resolve culture of intimidation and bullying identified in the neonatal unit.
- Staff are aware of and use the trust's learning disability passport and operational standards for people with a learning disability are appropriately assessed and implemented.
- Do not attempt cardio-pulmonary resuscitation (DNACPR) forms are appropriately completed so that the decision and sign-off is clear and there is appropriate communication with patients, their relatives or carers.
- End of life care standards are appropriately monitored against national standards.
- Patients receiving end of life care are appropriately identified and referred to the specialist palliative care to receive timely support and treatment advice.
- There is an operational policy or guidance for the management of a deceased patient's belongings.
- Clinical governance arrangements are simplified so that there are effective processes to prioritise and escalate concerns.
- Discharge summaries are sent to GPs in a timely manner and include all relevant information in line with Department of Health guidelines

Outstanding practice and areas for improvement

- Support is given to frontline nursing staff to be involved in change and to ensure there is a just culture.
- Staff in lower pay bands feel they are treated similarly to all staff in the trust.
- Cost improvement programmes are developed and are also reviewed by the board.

In addition the trust should ensure that:

- Medical staffing levels meet national recommendations in A&E and palliative care medicine.
- Develop the nursing and midwifery profile so that their advanced skills can be used appropriately; this is particularly the case in A&E, maternity and for end of life care.
- Agency staff receive appropriate induction when working in the hospital.
- Patients living with dementia are appropriately screened and identified and that staff access the tools and advice available to ensure there is consistent care and support in all areas of the hospital.
- Information on staffing levels, safety and performance activity is displayed and accessible to patients and the public in wards and outpatient areas.
- Discharge is effectively planned and organised and patients are not waiting for long periods in the discharge lounge, or waiting after their outpatient appointment.
- Clinical supervision is developed for all staff.
- There is a 'just culture' for all staff when dealing with serious incidents.
- The critical care unit participates in the Intensive Care National Audit & Research Centre (ICNARC).
- There is better multidisciplinary working in maternity and children and young people's services.
- Governance arrangements in maternity continue to improve.
- All staff follow infection control practices, particularly the bare below elbow guidance in ward and outpatient areas.
- Waiting times meet the national referral time target of 18 weeks.
- Information leaflets and signs are available in other languages where relevant.
- Bereavement support is appropriately maintained when the officer is on leave.
- Outpatients clinics are not cancelled at short notice and patient waiting times are improved to within 15 minutes of clinic appointments.
- Staff engagement improves so that staff feel listened to and consulted about specific issues that affect service development, particularly in A&E and outpatients, and where job roles are affected for administrative, clerical and support staff.
- Patient and public engagement continues to develop to improve services, including formal approaches for patient feedback across all services.
- Human resources, IT and finance support improve for staff, in terms of payroll and consultation on job roles.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe.** • The assessments of the needs of service users were not always undertaken in a timely fashion either when arriving by ambulance or attending on foot in A&E. • Pain scores needed to be appropriately reassessed in A&E. • Patients receiving end of life care did not have appropriate DNACPR orders or mental capacity assessments • Compliance with the five steps to safer surgery checklist needed to improve to ensure safety in the planning and delivery of care. • The incidence of pressure sores was high in surgery and there was not a local action plan **Regulation 9- 1 (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing**

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider did not have effective systems to regularly assess and monitor the quality of services provided.** • Reporting and learning from incidents was not consistent and only 36% of serious untoward incidents were investigated within 45 days.

This section is primarily information for the provider

Compliance actions

- Quality information, including risk registers, were out of date and not embedded in practice.
- Changes to treatment provided following analysis of incidents and conclusions of local service reviews and clinical audits was not made consistently.
- Clinical guidelines were not consistently reviewed or updated in national guidance
- Clinical audit programmes were not being done according to identified plans
- There was no system for recording that the termination of pregnancy (TOP) forms (HSA4) were sent to the Department of Health. This was a statutory requirement.
- End of life care standards need to be appropriately monitored against national standards and the Tracey Court of Appeal in England Judgement (17 June 2014).
- Patients who need end of life care support were not always identified and referred to the specialist palliative care team
- Compliance with standards identified for the care of patients with a learning disability are appropriately assessed and action is taken to address areas for action.
- There was not an operational policy or guidance for the management of deceased patient's belongings.
- Staff were not always of aware of or used the trust's learning disability passport, and operational standards for people with a learning disability were not appropriately assessed and implemented.
- Discharge summaries are sent to GPs in a timely manner and include all relevant information in line with DH (2009) guidelines.
- There were only two resuscitation trolleys covering the outpatient area over two floors. There had not been a risk assessment to check if this was sufficient the of patients seen in clinics, the diverse amount of conditions patients had and the floor area that needed to be covered across two floors

Regulation 10 (a)(c)(i)(ii) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person had not ensured that service users using the premises were protected from the risks associated with unsuitable premises.** • The lack of space in the A&E department compared to the number of patients admitted meant that patients often received care and treatment in environments that were not suitable and where it was difficult to appropriately monitor their condition • Facilities in the outpatient department restricted access for patients with a physical disability (e.g. wide wheelchairs could not access the pre-operative assessment clinic rooms). • The height of the reception desk for pre-operative assessment was not accessible for people in wheelchairs (this was a recent refurbishment). • Many of the outpatient clinic areas were so small that patients had to wait standing up, and there was not enough space for wheelchairs to mobilise. **Regulation 15 (a)(c)(i)(ii) Health and Social Care Act 2008(Regulated Activities) Regulations 2010.**
Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment **The provider did not have suitable arrangements to protect patients against the risk of unsafe equipment** • The resuscitation trolley on Annie Zunz Ward had not been checked in two days. • The cardiac arrest call bell system in the AAU did not link to the nurses' station and the alarm was inaudible on the other side of the ward. • 5 out of 20 items of equipment in outpatients did not have appropriate PAT testing • 15 out of 20 items of equipment in outpatients were not appropriately recorded as cleaned.

This section is primarily information for the provider

Compliance actions

- The emergency equipment in the West London Clinic was not suitable for use in the environment and in particular could not be manoeuvred through doors and into the lift.

Regulation 16 (1) (a) Health and Social Care Act 2008(Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People who use services, did not, so far as practicably possible have suitable arrangements to ensure the privacy and dignity and independence of services users.** **The provider had not made suitable arrangements to ensure the dignity and privacy of patients as the** • Patients in A&E were, at times, being treated in the corridors of the A&E and their privacy and dignity was not maintained • In the paediatric area, parents with potentially infectious children were asked to sit outside the department in the corridor due to a lack of segregated space within the department. As a result, they were with adult patients using the corridor to access the x-ray department. • People using the toilet in the pre-operative assessment unit could be seen from the reception area • People could be overheard by patients waiting in the waiting area when talking about their condition to the receptionist in the pre-operative assessment area. **Regulation 17(1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records**

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

This section is primarily information for the provider

Compliance actions

People who use services were not protected against the risk of unsafe or inappropriate care or treatment because

- The electronic record did not support personalised care plans.
- Patient records were not accurately completed
- Two different pain scoring systems were used in surgery and the information did not correlate
- Advice from specialist teams was not always recorded in the notes
- accurate records were not kept in relation to the care service users received and
- records were not promptly accessible for agency staff.
- decision relating to resuscitation were not being accurately recorded and reviewed to ensure they were kept current.

Regulation 20(1)(a)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider did not have suitable arrangements to ensure that, at all times, sufficient numbers of suitably qualified, skilled and experienced nursing staff were employed.** • Nurse staffing levels in AAU level 1 did not meet guideline. There was concern about staffing on medical wards, including escalation ward. There had been up to 30% vacancy rates in some ward areas for over a year. • Paediatric nurse staffing levels was concern: One level 1 patient was being monitored by a healthcare assistant. Regulation 22 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010