

Imperial College Healthcare NHS Trust St Mary's Hospital

Quality Report

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

Ratings

Maternity (inpatient services)

Requires improvement



Medical care (including older people's care)

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Imperial College Healthcare NHS Trust provides acute and specialist healthcare for a population of around two million people in north west London and the surrounding areas. The trust has five hospitals Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye. Charing Cross Hospital is an acute general teaching hospital located in Hammersmith, London.

St Mary's Hospital is one of the two locations of Imperial College Healthcare NHS Trust which provides maternity and gynaecological services along with Queen Charlotte's & Chelsea Hospital. The maternity services comprised of the birthing centre. The postnatal and antenatal ward with 35 inpatients beds. The labour ward having eight delivery rooms, two theatres and two birthing pools. Maternity triage services are provided by way of three beds; this is a short stay area and is open 24 hours per day, seven days per week. A day assessment unit operating by an appointment system or low risk referrals from the emergency department. There is an antenatal outpatient service. The FMU services included fetal and perinatal scans and post termination of pregnancy and specialist pre-pregnancy fetal counselling. Two neonatal intensive care unit (NICU) with 22 cots including four intensive care beds, four high dependency beds and 14 special care cots. St Mary's Hospital also provides independently funded maternity healthcare service at the Lindo wing.

Medicine and specialist medicine at St Mary's Hospital sat under two directorates in the hospital. The majority of the medical wards were under the Medicine and Integrated Care Division while cardiac, haematology and oncology were under the Surgery, Cardiovascular and Cancer Division. Medical wards include acute assessment unit (AAU) and other assessment wards, a clinical decisions unit (CDU), care of the elderly wards, general medical wards and specialist wards such as respiratory medicine, gastroenterology and endocrinology. The hospital also hosts an endoscopy suite and discharge lounge.

We plan our inspections based on our assessment of the risk to patients from care that is or appears to be less than good. We inspected the maternity and medicine (including elderly care) services because we had information giving us concerns about the quality of this service.

We last inspected the maternity and medicine (including elderly care) in September 2014 as part of our comprehensive inspection program and rated the services as good and requires improvement respectively. For maternity during that inspection we found the risk of unsafe care had been mitigated by prioritising the needs of women in labour. However, the quality of care on postnatal wards was sometimes compromised. Evidenced-based care was promoted and there was an audit programme to assess compliance with best practice. There was an embedded multidisciplinary approach to learning from incidents and complaints. Specialist clinics assessed the needs of women with medical conditions. Specialist midwives and caseload midwives supported women who were at risk. There was training for midwifery staff and trainee doctors and opportunities for professional development. Staff were positive about their contribution to improving the quality of care and felt their contribution was recognised and valued. For medicine during that inspection we observed hospital discharges occurring after 10pm. We found that care plans for people living with dementia and diabetes were not used and we noted patients stayed in the hospital for longer than the national average. There were high vacancy rates among staff and it was not clear what the senior management was doing to address this.

During this inspection we found the overall quality of the maternity service had changed from good to requires improvement. We rated safe, responsive and well-led as requires improvement and rated effective and caring as good.

During this inspection we found the overall quality of the medicine and elderly care services had stayed the same as at the previous inspection; although there had been some positive changes, the service continued to be rated overall as requires improvement. We rated safe and responsive as requires improvement and rated effective, caring, and well-led as good.

Our key findings were as follows:

Summary of findings

In the **maternity** service:

- There was one Never Event reported between January 2016 and December 2016.
- Not all staff were able to give examples of learning from incidents or changes that had occurred as a result.
- The maternity services did not always follow the trust's medicine management policies so that medicines were safe for administration to patients. In particular, for date checking medicines and storing medicines in refrigerators.
- Staff compliance with trust mandatory training was low and below trust target of 95%. For example, midwifery staff compliance with mental health/mental capacity training was 58% and consultant compliance with consent training was at 40%.
- We found that 84% of relevant maternity staff had CTG training.
- An audit of Intrapartum CTG "Fresh Eyes Buddy System" demonstrated that 87.5% of the notes were not meeting the standard.
- The environment was challenging due to the nature of the building and in some need of repair.
- The service did not monitor infant fall rates quality and the service's safety dashboard information was not displayed for the public and patients. This meant that the public could not readily see information and statistics about the harms that had occurred in the maternity service.
- Midwives were required to scrub as scrub nurses for second and emergency theatre lists. However, the department was currently reviewing the competency framework for this.
- Between April 2016 and February 2017 90% of women had a named midwife, which was below target of 100% set by the clinical commissioning group as part of the clinical quality group acute quality metric.
- There was limited information available on the wards for women and their relative about how to make a complaint and how to access the Patient Advice and Liaison Service (PALS).
- We found two clinical guidelines that were out of date.
- Only 84% of midwifery staff had bereavement training.
- There was lack of visibility of executive team and senior leadership team on the floor.
- Not all staff were aware of the directorate vision and strategy.
- A recent serious incident identified weakness within the trust governance process and they had requested an external review of maternity clinical governance structure by Royal College of Obstetricians and Gynaecologists.
- Maternity wards were in a dated building, which did not provide an optimum environment for women.
- Throughout the maternity service, there was poor signage navigating to different parts of the maternity service.
- Not all risks identified by us during the inspection were on the maternity service's risk register and senior divisional leadership team did not have the oversight of all the problems at St. Mary's site.

In the **medicine** service:

- Staff on medical wards were not meeting the trust targets for almost all modules of mandatory training, including safeguarding, resuscitation, and infection prevention and control.
- Medical wards were not meeting targets for MRSA screening set by the trust.

Summary of findings

- The vacancy rate for nursing staff across medical wards at St Mary's Hospital was significantly higher than the England average.
- We noted that a number of medications checked on the medical wards had passed their expiry date, and some wards were not following the trust policy on refrigerator temperatures.
- Staff we spoke with stated that security could be slow to respond to incidents, and there were concerns this could result in staff being more exposed to aggressive or threatening patients.
- We found some inconsistency amongst nursing staff and junior medical staff in their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Medical services at St Mary's Hospital did not meet the NHS England national indicator for 18 weeks referral to treatment (RTT) times.
- Discharge forms from the wards were inconsistent or incomplete, and this could result in delays to patients' discharges from the discharge lounge.
- Data provided by the trust show patients being discharged out of hours between 22:00 and 07:00, suggesting patients being moved out of the hospital at unsociable hours.
- The hospital signage was not up to date and does not provide patients or visitors with information how to access the wards.

However,

In the **maternity** service:

- Safeguarding vulnerable adults, children and young people was given sufficient priority and staff take proactive approach to safeguard and focus on early identification.
- Staff had good understanding of the major incident and fire safety plans.
- Information about people's care and treatment and their outcomes was routinely collected and monitored. This information was used to improve care.
- There was participation in relevant local and national audits and there were detailed follow up action plans to ensure improvement in patient care.
- Consent to care and treatment was obtained in line with legislation and guidance.
- All women we spoke with on antenatal, postnatal and labour ward were positive of their experiences, and the kindness, skill and supportiveness of staff.
- Between April 2016 to February 2017, 0.7% of all births at St Mary's Hospital (SMH) were home births and in January there were no home births, which was below the trust maximum target of 1%.
- Staff were conscious of the need to protect the dignity and privacy of women in all areas of the service. Curtains were drawn around beds during examination all time and during ward round to ensure privacy.
- Specialist staff offered sensitive bereavement support for women suffering miscarriages or stillbirth.
- Services were planned and delivered in a way that met the needs of the local population.
- Women were given a choice of times and dates for antenatal clinic appointments.

In the **medicine** service:

Summary of findings

- There were systems in place for staff to report incidents, and for incidents to be discussed in clinical governance meetings.
- Staff we spoke with stated the electronic records system was accessible, and that they had received training in use of the system as part of their induction.
- We reviewed trust policies on delivering clinical care throughout medical wards and found them to be in date and in line with best practice guidelines.
- Local and national audits were used to benchmark care, treatment and practice against guidance established by a range of organisations that represented best practice.
- Patients we spoke with were very positive about their experiences on the medical wards, particularly regarding their interactions with staff. We observed positive interactions between staff and patients throughout the medical wards we visited.
- There were measures in place to manage patients being cared for on wards outside of the specialty for which they were admitted. The hospital also had systems in place to increase capacity to meet the needs of the local population during winter pressures.
- The introduction of complaints investigators had much improved response times and the quality of investigations for complaints.

We saw several areas of outstanding practice including:

- The trust had introduced Side by Side for Alzheimer's patients, an initiative by the Alzheimer's Society service which helps people with dementia to access recreational activities. This included arts and crafts, harmony singing and Friday afternoon tea parties.
- The trust developed a nutrition pathway called the Nutrition Support in Hospital (NoSH) which was designed to ensure patients particularly people with dementia, received the food and drink they need while in hospital without losing the independence they had before admitted to the hospital.
- The Medicine and Integrated Care Division introduced a nurse-led cirrhosis clinic offering improved screening to patients at high risk of developing of severe complications from substance misuse, such as liver cancer. The clinic recently won the "Innovative Project of the Year" award from St Mungo's homelessness charity.

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

Importantly, the trust must:

- The maternity and medical service must ensure that they always follow the trust's medicine management policies so that medicines are safe for administration to patients. In particular for date checking medicines and storing medicines in refrigerators.
- The service must improve compliance with its mandatory training for all staff groups.
- The maternity service must ensure to ensure there is comprehensive oversight of problems and that the risk register is reflective of all risks within the directorate.
- The service must improve the management of CTG monitoring. This should include improving CTG training rates for relevant maternity staff and improvements in the "Fresh Eyes Buddy System" to ensure standards are met
- The trust must take action to ensure medical wards are meeting resuscitation training requirements for their staff.

Summary of findings

- The trust must ensure they implement the recommendations made in the Royal College of Obstetricians and Gynaecologists (RCOG) report from April 2017, 'Review of Maternity Services at Imperial College Healthcare NHS Trust, St Mary's Hospital site'.

In addition the trust should:

In the **maternity** service:

- Ensure that up to date safety thermometer and key relevant information are displayed on the quality improvement boards.
- The service should ensure that second theatre and emergency theatre lists are appropriately staffed.
- The service should ensure that all clinical guidelines are up-to-date.
- The trust should ensure that there is more visibility of executive and senior leadership team.
- The service should ensure a consistent approach and more user friendly patient information available and displayed in wards including information about PALS.
- The service should urgently review and improve the signage for the various maternity wards and department, particularly for fetal medicine unit.
- The service should address the estates issues related to kitchen and patient shower areas.

In the **medicine** service:

- The trust should improve performance of the number of staff on medical wards completing mandatory training in relation to trust targets.
- The trust should ensure medical wards are meeting targets for MRSA screening set by the trust.
- The trust should ensure that medications are not retained past their expiry date, and medication refrigerators are within the temperature range identified in the associated trust policy.
- The trust should ensure there is a clear process for a timely response from hospital security to incidents or staff being expose to violence and aggression.
- The trust should ensure staff have a clear understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The trust should improve the consistency and completeness of discharge information for patients transferred to the discharge lounge.
- The trust should improve hospital signage, ensure it is up to date and provides clear information for visitors on how to access the wards.
- The trust should ensure that patients are not discharged out of hours (between 10pm and 7am), without a clear reason for doing so, a robust discharge plan in place, and a safe place to discharge patients.

Professor Edward Baker
Chief Inspector of Hospitals

St Mary's Hospital

Detailed findings

Services we looked at

Maternity (inpatient services); Medical care (including older people's care)

Detailed findings

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Background to St Mary's Hospital

Imperial College Healthcare NHS Trust is based in north west London, United Kingdom. The trust was formed in October 2007. It is a large trust registered with the CQC for 12 location, five of which are hospitals. The trust together with Imperial College London forms an academic health science centre. For the period of November 2015 to October 2016 there were 95,538 admissions trust wide for the medical core service, with the majority of admissions being day cases. Trust wide the top three specialities in the medical core service by activity were; medical oncology, gastroenterology and clinical haematology. The average length of stay in the mentioned period was 6.7 days.

St Mary's Hospital is an acute general teaching hospital located in Paddington, London. The present hospital was founded in 1845 and is part of Imperial College Healthcare NHS Trust. The hospital has 154 inpatient beds providing a range of acute medical care services.

The hospital has five birthing rooms, 35 bedded post and antenatal ward, labour ward with eight delivery rooms, two theatres, two birthing pools, three recovery and one high dependency bed. An antenatal outpatient service, foetal medicine unit, level two neonatal intensive care unit with four high dependency beds and 14 special care cots.

The trust had 95,538 medical admissions between November 2015 and October 2016. Emergency admissions accounted for 24,836 (26.0 %), 6,565 (6.9 %)

were elective, and the remaining 64,137 (67.1 %) were day case. Admissions for the top three medical specialties were; Medical Oncology (18,794 admissions), Gastroenterology (14,722 admissions) and Clinical Haematology (14,427 admissions). From October 2015 to September 2016, 10,270 women delivered their babies at the trust and from April 2016 to February 2017 a total of 3136 women delivered their babies at the hospital. A profile of all the deliveries is not available for this inspection.

During our inspection, we visited all the medical wards under The Medicine and Integrated Care Division at St Mary's Hospital (excluding wards covered under different core services such as surgery, cancer, and cardiovascular). This included the medical assessment or short stay units (Acute Assessment Unit, Clinical Decisions Unit, and Joseph Toynbee) older person's wards (Lewis Lloyd and Witherow), respiratory wards (Manvers and Rodney Porter), endocrinology ward (Thistlewayte), Hepatology ward (Samuel Lane), general medical ward (Almoth wright), the endoscopy suite, and the discharge lounge.

We inspected only the maternity services due to a serious incident that raised concerns around their risk management and clinical governance structure. We did not inspect gynaecology and termination of pregnancy services at this location this time.

Detailed findings

Our inspection team

Our inspection team was led by:

Inspection Manager: Michelle Gibney, Care Quality Commission

The team included CQC inspectors and a variety of specialists including consultants of varying medical professions, senior and junior medical nurses, nurse matron, pharmacist, governance lead and an Expert 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?







We carried out this inspection as an unannounced focused inspection. We carried out the unannounced inspection on 7, 8 and 9 March 2017. Before visiting, we reviewed a range of information we held about the hospital. During the inspection we talked with a range of staff throughout the maternity and medical core service, including senior managers, clinicians, nurses, healthcare assistants, administrative staff and volunteers. We also spoke with patients and relatives of those who used the maternity and medical core services.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity (inpatient services)	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Overall	N/A	N/A	Requires improvement	N/A	N/A	N/A

Maternity (inpatient services)

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

Information about the service

St Mary's Hospital is one of the two locations of Imperial College Healthcare NHS Trust (ICHT), which provides maternity and gynaecological services along with Queen Charlotte's and Chelsea Hospital.

The maternity services comprised of the birthing centre, a midwife-led service located on first floor Cambridge wing, manages deliveries for those women who have been risk assessed as being low-risk pregnancies. It has five birthing rooms within the Birth Centre.

The postnatal and antenatal ward (Aleck Bourne 2) is located on the second floor in Clarence wing with 35 inpatients beds. The 25 bedded postnatal ward is on the west side and on the east side there is a 10 bedded antenatal ward.

The labour ward (Aleck Bourne 1) is located on first floor in Clarence wing and has eight delivery rooms, two theatres and two birthing pools; the ward also hosts a dedicated bereavement room. Women who undergo elective or emergency caesarean sections, or who developed complications before, during or after birth are supported by a team of high dependency midwives and included three recovery and one high dependency beds on the labour ward.

Maternity triage services are provided by way of three beds; this is a short stay area and is open 24 hours per day, seven days per week. There is also a maternity day assessment

unit, which allows for the monitoring of pregnant women five days per week; this unit operates by way of an appointment system or low risk referrals from the emergency department.

There is an antenatal outpatient service within the main outpatient department, which provided ultrasound and blood tests.

There is a fetal medicine unit (FMU) on first floor of Cambridge wing, which had ultrasound services as well. The FMU services included fetal and perinatal scans and post termination of pregnancy and specialist pre-pregnancy fetal counselling.

There is a level two neonatal intensive care unit (NICU) with 22 cots including four intensive care beds, four high dependency beds and 14 special care cots.

St Mary's Hospital also provides independently funded maternity healthcare service at the Lindo wing.

From April 2016 to February 2017, 3136 women delivered their babies at the hospital.

We inspected only the maternity services due to a serious incident that raised concerns around their risk management and clinical governance structure. We did not inspect gynaecology and termination of pregnancy services at this location this time.

We spoke with seven women who were accessing either antenatal care or had recently delivered their baby and two relatives. We spoke with 38 members of staff including doctors, nurses, midwives, ward managers, ward co-ordinators, administration staff, as well as clinical, nursing and midwifery risk leads and managers. We visited

Maternity (inpatient services)

each of the clinical areas including the antenatal clinic, sonography unit, antenatal and postnatal ward, maternity triage, maternity day assessment unit, labour ward, theatre, fetal medicine unit, neonatal intensive care unit, private wing and the Birth Centre. We reviewed 15 sets of patient records and a range of equipment including resuscitation equipment, birthing pools, beds, mattresses, resuscitaires and cardiotocography (CTG) devices.

Summary of findings

We rated this service as requires improvement because:

- There was one Never Event reported between January 2016 and December 2016.
- Not all staff were able to give examples of learning from incidents or changes that had occurred as a result.
- The maternity services did not always follow the trust's medicine management policies so that medicines were safe for administration to patients. In particular, for date checking medicines and storing medicines in refrigerators.
- Staff compliance with trust mandatory training was low and below trust target of 95%. For example, midwifery staff compliance with mental health/mental capacity training was 58% and consultant compliance with consent training was at 40%.
- We found that 84% of relevant maternity staff had CTG training.
- An audit of Intrapartum CTG "Fresh Eyes Buddy System" demonstrated that 87.5% of the notes were not meeting the standard.
- The environment was challenging due to the nature of the building and in some need of repair.
- The service did not monitor infant fall rates quality and the service's safety dashboard information was not displayed for the public and patients. This meant that the public could not readily see information and statistics about the harms that had occurred in the maternity service.
- Midwives were required to scrub as scrub nurses for second and emergency theatre lists. However, the department was currently reviewing the competency framework for this.
- Between April 2016 and February 2017 90% of women had a named midwife, which was below target of 100% set by the clinical commissioning group as part of the clinical quality group acute quality metric.

Maternity (inpatient services)

- There was limited information available on the wards for women and their relative about how to make a complaint and how to access the Patient Advice and Liaison Service (PALS).
- We found two clinical guidelines that were out of date.
- Only 84% of midwifery staff had bereavement training.
- There was lack of visibility of executive team and senior leadership team on the floor.
- Not all staff were aware of the directorate vision and strategy.
- A recent serious incident identified weakness within the trust governance process and they had requested an external review of maternity clinical governance structure by Royal College of Obstetricians and Gynaecologists.
- Maternity wards were in a dated building, which did not provide an optimum environment for women.
- Throughout the maternity service, there was poor signage navigating to different parts of the maternity service.
- Not all risks identified by us during the inspection were on the maternity service's risk register and divisional leadership team did not have the oversight of all the problems at St. Mary's site.

However,

- Safeguarding vulnerable adults, children and young people was given sufficient priority and staff take proactive approach to safeguard and focus on early identification.
- Staff had good understanding of the major incident and fire safety plans.
- Information about people's care and treatment and their outcomes was routinely collected and monitored. This information was used to improve care.
- There was participation in relevant local and national audits and there were detailed follow up action plans to ensure improvement in patient care.

- Consent to care and treatment was obtained in line with legislation and guidance.
- All women we spoke with on antenatal, postnatal and labour ward were positive of their experiences, and the kindness, skill and supportiveness of staff.
- Between April 2016 to February 2017, 0.7% of all births at St Mary's Hospital (SMH) were home births and in January there were no home births, which was below the maximum target of 1% set by the clinical commissioning group as part of the clinical quality group acute quality metric.
- Staff were conscious of the need to protect the dignity and privacy of women in all areas of the service. Curtains were drawn around beds during examination all time and during ward round to ensure privacy.
- Specialist staff offered sensitive bereavement support for women suffering miscarriages or stillbirth.
- Services were planned and delivered in a way that met the needs of the local population.
- Women were given a choice of times and dates for antenatal clinic appointments.

Maternity (inpatient services)

Are Maternity (inpatient services) safe?

Requires improvement



We rated safe as requires improvement because:

- There was one Never Event reported between January 2016 and December 2016.
- Not all staff were able to give examples of learning from incidents or changes that had occurred as a result.
- The maternity services did not always follow the trust's medicine management policies so that medicines were safe for administration to patients. In particular, for date checking medicines and storing medicines in refrigerators.
- Staff compliance with trust mandatory training was low and below trust target of 95%. For example, midwifery staff compliance with mental health/mental capacity training was 58% and consultant compliance with consent training was at 40%.
- We found that 84% of relevant maternity staff had CTG training.
- An audit of Intrapartum CTG "Fresh Eyes Buddy System" demonstrated that 87.5% of the notes were not meeting the standard.
- The environment was challenging due to the nature of the building and in some need of repair.
- The service did not monitor falls involving babies and the service's safety dashboard information was not displayed for the public and patients. This meant that the public could not readily see information and statistics about the harms that had occurred in the maternity service.
- Midwives were required to scrub as scrub nurses for second and emergency theatre lists. However, the department was currently reviewing the competency framework for this.

However:

- Staff had a good understanding of the major incident and fire safety plans.

- Staff were aware of the incident reporting system and there was a good incident reporting culture.
- Safeguarding vulnerable adults, children and young people was given sufficient priority and staff took a proactive approach to safeguard and focus on early identification.

Incidents

- There were 1005 reported incidents in the maternity service between January 2016 - March 2017. Out of these, 865 of these were related to patients, 74 affected staff, 65 affected the organisation and one involved a visitor. 66% of these incidents resulted in no harm and 7.9% were classed as 'near miss'. The top category of incidents reported were related to labour and delivery, which included 80 cases of post-partum haemorrhage, 86 unexpected fetal admission to the neonatal unit and 58 third or fourth degree tears. The second highest category related to admissions and about unexpected re-admission. The third most common type of incident reported related to medication and included incidents like omitted medication or delayed medication.
- Between January 2016 and December 2016, there was one 'never event' reported within maternity services at St Mary's Hospital. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. The never event was where a 'swab/ vaginal pack' was left in a patient for two days following labour and discharge. An action plan was being developed at the time of our inspection and was submitted to us afterwards. We saw evidence of lessons learnt shared with staff via the trust's 'risky business' newsletter. For example, reminding staff not to use vaginal packs to absorb blood whilst suturing and any swabs while in use to be clipped to the drapes.
- Between March 2016 and February 2017, the trust reported 19 serious incidents (SIs) in maternity and gynaecology, which met the reporting criteria set by NHS England. Out of these, eight incidents were related to St Mary's Hospital. We looked at three SI investigation reports, which included chronology of events and root cause analysis. There were recommendations for immediate and future action and arrangements for

Maternity (inpatient services)

sharing these recommendations across the hospital. However, it was unclear in one SI report into neonatal death if neonatal staff input was sought into the investigation, there was no neonatologist on the investigation panel, there was no input from bereavement midwife and scope of investigation was limited to only maternity care.

- All staff we spoke with were aware of the incident reporting procedures and knew how to raise concerns. Junior doctors and nursing staff showed us how they reported incidents on an electronic incident reporting system.
- Senior staff informed us that the current process of incident was that when an incident occurred, it was graded according to the trust risk management policy. Incidents graded moderate harm and above were reviewed at a weekly meeting chaired by the trust's medical director with the divisional management team and staff from the local clinical commissioning group (CCG) in attendance. At this meeting, the decision was made as to whether the incident should be investigated as a serious incident based on national guidance and available evidence. Once this decision was made, the incident was declared as a Serious Incident (SI), reported to the Strategic Executive Information System (STEIS) and the investigation commenced. The investigation was conducted in the service in which it occurred by the identified investigation team, with oversight by the divisional management and governance teams. On completion of the investigation, the report was approved by the divisional director and their senior management team (including the divisional director of governance). The report was then heard at a panel by the deputy medical director (DMD) for safety and effectiveness on behalf of the medical director, with the divisional senior management team and members of the investigation team in attendance to present the investigation report. The report was approved as complete by the DMD and submitted to the CCG. The CCG reviewed the report and had the opportunity to submit any comments or questions they may have to the Trust before confirming closure at which point the report was finalised.
- Divisional leadership team informed us that all staff involved in root cause analysis have had training in January 2016. Medical director told us that they were in the process of gathering information and looking at staff competency in dealing with SI investigations, and has identified this as an area of improvement.
- To ensure any learning was embedded and actions were completed at local level, SIs and other incidents were reviewed locally at risk meetings during and after the investigation process. All staff we spoke with were aware and told us that serious incidents were discussed at the weekly critical risk review meeting, risk management meeting and monthly directorate and divisional quality and safety meetings. We saw evidence of minutes of these critical review meetings of April 2016 to March 2017 and risk management meetings of December 2016 to February 2017. However, not all junior staff were able to give any example of lessons learned from a specific serious incident. We asked staff if there had been any early learning from the recent SI and one staff said, "I do not think there was any learning and if there would be then it would be shared via risky business newsletter". However, this was not reflected in the feedback from senior leadership team.
- We asked the divisional management team, medical director, risk management team and senior clinicians regarding changes implemented in response to a serious incident that triggered this CQC inspection. They informed us that a number of actions had been taken to improve the trust's processes around SIs and governance and included a full review of the trust policies and processes against national policy and legislation. We were informed that to support stronger communication across the clinical divisions and ensure a consistent approach to governance, the divisional governance teams were restructured in autumn 2016. The divisional governance leads and their teams now reported to the medical director's office through the head of safety and effectiveness. A weekly operational meeting was implemented, which provided oversight and tracking of all SIs across all divisions. Progress with each investigation was tracked at this meeting with a revised investigation tracker spread sheet was used for this. A full review of the governance team structure was also commenced with the new structure expected to be fully in place by September 2017. In addition to this, the SI panel process was strengthened in January 2017 to ensure reports were received five days before the panel and the report is quality assured.

Maternity (inpatient services)

- The divisional team also informed us that an SI monitoring report was presented monthly to the trust's executive quality committee and clinical quality group. As a result of this SI, since February 2017, this report was also presented to the bi-monthly quality committee, which is a sub-committee of the trust Board.
- Senior staff we spoke with told us that an internal investigation was currently taking place to review the internal SI investigation process. Post-inspection we were informed that further actions had been taken by the trust to improve the SI process, which included an addition to their SI policy to clarify how and when to involve and support patients/relevant persons in the investigation process and bring the policy in line with the national framework. An additional SI notification letter was now sent to the patient or relevant person giving key information about the investigation process, timeline and a single point of contact.
- Lessons learned from incidents were shared across teams via newsletters and during handover. There was a cross site bi-monthly newsletter called 'Risky Business' on the trust's intranet and circulated to all staff about learning from incidents. All staff we spoke with referenced this newsletter when we asked them about learning from incidents. However, not all junior staff were able to give us a specific example where an incident had actually resulted in change of practice.
- The trust used an electronic system to record all data related to maternal mortality cases. All reviews of death were overseen by the trust's quarterly mortality review group which was chaired by the deputy medical director and attended by senior clinicians from each division. The learning was reviewed and disseminated within the responsible division via their Quality and Safety Committee. There were no direct maternal deaths at SMH between April 2016 to February 2017. There was one indirect maternal death (psychiatric) in the community for which an investigation was undertaken. Matrons and consultants told us there were monthly cross-site perinatal mortality and morbidity meetings. We saw evidence of cases that were presented at these meetings, which included in depth discussions. However, one midwife told us that at times it was difficult to attend due to work pressure.
- Most staff were able to explain the meaning of duty of candour and were able to give examples of how they

applied this requirement in practice. Duty of candour sets out some specific requirements that NHS providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Some junior staff did not always understand the terminology. However, the process they described in communicating with patients and their relatives reflected openness and transparency.

- Senior staff told us that because of a serious incident in 2016 the directorate re-launched their duty of candour policy and since January 2017, duty of candour letters were reviewed at the weekly Medical Director's incident review panel to check the content was appropriate and sent by the correct member of staff.

Safety thermometer

- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enables measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, urinary tract infections (in patients with a catheter) and venous thromboembolism (VTE). There had been no pressure ulcers, falls, urinary tract infections or VTE in the previous 12 months before our inspection. However, the service did not record falls involving babies and only recorded patient's falls.
- We saw quality and safety information boards were visible on the wards; however, the information on those boards was out of date. For example on postnatal ward, there was information from August 2016 that was not updated.
- The Maternity Safety Thermometer allowed maternity teams to take a 'temperature check' on harm and recorded the proportion of mothers who had experienced harm free care. It also recorded the number of harms associated with maternity care. It was intended for public display so that the public were informed about the level of harm free care within the service. Senior staff informed us that they did not adopt the Maternity Safety Thermometer, as information regarding safety and quality metrics within the directorate was collected via maternity scorecards, the Northwest London maternity dashboard and harm free

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care monthly audits. Between April 2016 and February 2017 the maternity wards showed 100% harm free care was provided to patient in all the months it was recorded. We saw that the metrics were displayed in the staff rooms and information was shared via the directorate monthly newsletter, but not on the quality and safety boards in the ward. This meant that the public could not readily see the harm specific to maternity care.

Cleanliness, infection control and hygiene

- The maternity wards were in an old building and there were limitations to the layout of the service. However, the areas we visited were visibly clean.
- The areas had cleaning schedules and infection prevention measures in place, such as infection prevention and control guidance and wall mounted hand gels. We saw that these schedules were completed.
- There were dispensers with hand sanitising gel situated in appropriate places around the unit, including the main entrance to the unit and inside rooms. The seven-step guidance for effective hand washing was displayed above hand washbasins. Hand washbasins were equipped with liquid soap and disposable towels.
- The maternity service audited the hand hygiene practice on a monthly basis. Between April 2016 and February 2017, compliance was consistently 100% except for labour ward where compliance was in the range of 97.5% and 100%. We observed staff using hand gels appropriately.
- We noted good use of hand hygiene on neonatal unit and good barrier infection control procedures being observed.
- Personal protective equipment (PPE) including gloves and aprons were available and we saw staff using these appropriately. However, we found that PPE and glove dispensers were not available in some of the side rooms on labour ward. We noted that staff adhered to the 'bare below the elbows' policy in the clinical areas. However, we noticed that one clinical staff member was wearing open toe shoes and not protective footwear and a few other clinical staff were wearing excessive jewellery.
- The maternity service audited the bare below the elbow practice on monthly basis. Between April 2016 and February 2017, the compliance was 100% consistently except for labour ward where compliance was in the range of 96% and 100%.
- There were sufficient sharps bins throughout the maternity services and the ones we checked were not overflowing. We also inspected the linen storage areas and noted that there was sufficient clean linen available.
- Disposable curtains around the cubicles were clean and stain free with a clear date of first use indicated on them.
- Midwifery staff were aware of cleaning and infection control procedures for birthing pools. We saw cleaning records completed for those.
- We observed domestic staff cleaning the department throughout the day in a methodical and unobtrusive way. We spoke with cleaning staff, who showed good understanding of separating different types of waste and the use of color-coding to dispose of waste. However, on the first day of inspection the room on labour ward to store the waste bag was not locked, even though there was a sign on the door to say the door should be kept locked at all times. The door was locked on subsequent days of our inspection. Domestic staff informed us that porters came three to four times a day to remove waste bags.
- Staff received infection prevention and control training as part of their annual mandatory training programme. Trust training statistics confirmed that 82.7% nursing and midwifery staff, 58.5% doctors in training and 70% of doctors had completed infection control training as of 14 March 2017 against a trust target of 90%.
- There was no reported case of MRSA and Clostridium Difficile infection between April 2016 and February 2017 within maternity services.
- In maternity services, 12 cases of surgical site infection were reported between April 2016 and February 2017. Staff informed us that they investigated all readmissions for surgical site infections.

Environment and equipment

- The ward's main entrance and corridors were clean. The birthing unit and maternity day assessment unit (MDAU)

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was visibly clean and free of clutter. However, there were six steep steps to access MDAU, senior staff told us that the original plan was to have a wheelchair lift as well as steps into the MDAU. However, building issues prevented this from happening. This was at that time logged in the risk register and a risk screening was built into the clinical guideline for the area. We saw evidence that there were clear exclusion criteria for MDAU, for example women in labour were to be seen in triage on labour ward and not in MDAU and an information leaflet was given to women to explain that. We were informed that to date there had been no clinical incidents or risk issues identified due to the steps to the MDAU at SMH.

- The environment on postnatal ward was cramped with equipment and trolleys in corridors due to lack of storage. We also found that some shower rooms and kitchen on Aleck Bourne two were in a poor state of repair.
- Senior staff informed us that in response to feedback from the staff survey and patient feedback they had refurbished the triage room and repainted the staff room on labour ward.
- The environment in the antenatal outpatient department was suitable for patients. Furniture was clean and water dispensers were available. However, the temperature within the antenatal outpatient and the entrance corridors leading to the maternity wards was exceptionally warm during our inspection due to limited ventilation. The senior staff were aware of this and we saw table fans were available in the antenatal clinic but there was no consideration given to resolve this for the corridors to the wards.
- The midwife-led birth centre provided a calm and quiet environment, with artwork on the walls. The physical appearance of the environment was recognised as important to encourage women to choose to use the birth centre. The matron told us that they made the conscious decision not to have any notice boards on the walls to make the space feel less clinical. Instead, a folder with all relevant information was available in the waiting area. There were two birthing pools and beds and couches to support active labour and provide relief from pain. There were other birthing aids such as a birthing support 'rope' and birthing balls to promote the comfort of women in labour.
- There were two lifts for maternity services; one with a priority key access for emergency transport of patients; however none of those lifts could accommodate a bed or trolley. Both lifts were at some distance from the birthing unit. During January 2016 – March 2017, there were two incidents and one near miss reported when both lifts were out of order. Senior staff informed us that they were aware of this and they were limited by the layout of the building. This was risk assessed and was on the estates department's risk register and part of the overall trust plan to improve all the lifts across the hospital. However, both of these lifts were not identified as the highest priority requiring upgrade or replacement; but significant work was carried out to replace defective parts and upgrade of the doors.
- The environment of two out of four ultrasound rooms at St Mary's Hospital was on the department risk register as it did not conform with recommended national standards, and could potentially result in poor patient experience.
- There was a large room on the postnatal ward which staff told us was used for different purposes. Some said it was used for breastfeeding, some as a discharge lounge, some as a waiting area for family members. The room had worn out sofas and there were several baby cots and other equipment stored in there. The room also had a large pile of several cardboard boxes, which we were told contained 'baby red books' that the hospital had ordered in bulk as these would not be available for free in near future, however they now had no other place to store them.
- The discharge room also had the fridge to store baby milk. The fridge should only be used to store baby milk; however, we found two frozen saline and cooling packs in there, which a midwife told us should not be there and they were removed.
- Document submitted by the trust indicated the majority of equipment were in service, and the rest had a job reference number assigned with a service date. We randomly checked equipment in the MDAU, antenatal and postnatal ward and all equipment were in working order, with clinical engineering checks done and within the service date.
- Resuscitation trolleys were available in all areas, except in the maternity day assessment unit. There was also no

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resuscitation trolley within the antenatal clinic, however there was access to a resuscitation trolley in a different clinic on the same floor. We inspected the resuscitation trolleys throughout the department and these were clean, secure and fully stocked. Staff we spoke with were informed about the location of the trolleys at their induction; however, there was no signage within the antenatal clinic regarding the location of this trolley.

- One patient we spoke with told us that she was concerned about lack of equipment. Staff needed to get the cardiotocography (CTG) monitor from antenatal ward as the CTG machine on labour ward was not working. There was one risk related to insufficient functioning CTG equipment on divisional risk register but this was not related to St. Mary's site. Post inspection we were informed that there were 12 CTG machines and seven computerised CTG machines at the hospital and all were in working order.
- The safe ward environment included CCTV cameras and secure entry through swipe card access only. Entry and exit from the wards was also by swipe card and created extra security and was monitored by reception staff during daytime. However, there was no intercom at the entrance of postnatal ward and this created some challenges for reception staff, as they would have to lean over the counter to indicate to visitors that the door was open.
- The Birth centre unit had scored 95% in 2016 Patient Led Assessments of the Care environment (PLACE) scores for cleanliness 87.7% for condition 83% for privacy and 50% for disability access.
- The decor in antenatal, postnatal ward and labour ward was worn but visibly clean. However, no Patient Led Assessments of the Care environment were done in 2016 for these wards.

Medicines

- Medicines were stored in secure rooms, doors were locked and access was limited to clinical staff. Records showed that medicines were checked daily on all maternity wards. However, in the storage room on labour ward we found one fluid bag of Glucose, which had expired in December 2016. The IV fluid shelf was disorganised; one box contained four different IV fluid bags, which increased the chance of error. In the clinical room for medicines, we found out of date medicines on

shelves: including eurotrol control solution (expired February 2017), pH indicator strips (expired December 2016), furosemide ampoules (expired February 2017), phytomenadione ampoules (expired November 2016), saline 0.9% eye drops (expired December 2016), insulin (expired May 2016) and insulin pen (expired September 2016). We highlighted these to the midwife in charge and chief pharmacist. In the clinic room on the postnatal ward, we found three syringes with drawn up antibiotics in a plastic tray on top of the fridge without patient identification. We highlighted this to the staff present who discarded it immediately. The next day we asked staff if the incident was reported via the trust electronic incident reporting system and we were informed that staff had been very busy and it had not been reported.

- Controlled drugs (CDs) were stored in a separate locked cupboard and a registered midwife held the keys at all times. Two midwives were involved in checking CDs for administration and two signatures were seen in the CD record book. However, clinic room six also stored CDs and was not in use at the time of inspection. We found the key hanging in the lock of the cupboard which contained 10 syringes of Fentanyl and Levobupivacaine. We highlighted this to the ward manager who immediately signed the controlled drugs back into the controlled drug cupboard. No controlled drugs were stocked in the birth centre. Women were transferred to labour ward if controlled drugs were required.
- A CD audit in September 2016 showed that midwives were adhering to trust policy with regards to administration of controlled drugs, balance and requisition books checked were all correct, incorrect recording of written in error drugs were being crossed through several times instead of one single line and most of the noncompliance stock checks at shift change. Staff informed us that six monthly CD audits were done and we saw the action points from the audit on the notice board.
- Medicines were stored in a secure, temperature-controlled room, which staff checked and documented for safe temperature twice daily. However, the thermometer in the clinic room in birth centre read a

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temperature of 27°C. Temperatures were not recorded for this room. The chief pharmacist was aware that there was an issue with warm clinic rooms; however, the risk was not on the pharmacy risk register.

- A temperature checking system was in place for refrigerated medicines that complied with the Royal Pharmaceutical Society of Great Britain (2005) guidance. However, on the labour ward, some maximum readings were above 8°C and there was no record of actions taken (the refrigerator contained vaccines). The freezer temperature was recorded daily, but the maximum was recorded as 4 and 5°C in March 2017 and there was no record of action taken. The recommended temperature was less than 2°C. The chief pharmacist told us the trust fridge policy changed in 2016 and that all fridges should be maintained between 2 and 8°C. There were fridge audits every six months, but based on the evidence we found, the policy was not always being adhered to and that either the audits were not identifying the issues or action plans were not implemented.
- The trust's chief pharmacists informed us that the trust had written a policy on the use of unlicensed BCG (Bacillus Calmette-Guérin is a vaccine used against tuberculosis), which showed that the unlicensed product was suitable for multiple uses and must be discarded 6 hours after reconstitution. We saw an open ampoule of BCG vaccine stored in the medicine fridge. However, the BCG ampoule was opened a day before at 10:55 am and was outside the time frame, we informed the midwife who then discarded it in the cytotoxic waste bin. There was no safety notice on the fridge for staff to inform that live vaccine was stored in the fridge and to avoid injury from sharp edges of the ampoule. After our inspection, data submitted to us by the trust showed that every midwife who performs vaccinations was required to undertake training as part of their competency assessment and sign a declaration form.
- We reviewed two prescription records in the Birth Centre. Both prescriptions were written clearly and administrations were signed for.
- Staff were aware of how to report medication incidents and how duty of candour might apply. Learning from medication incidents was shared via monthly newsletter. The ward manager gave an example of

several incident reports about prescribing and delayed administration of antibiotics. The prescribing paperwork was reviewed and revised, which resulted in improved safety and there had not been an incident report since.

- The midwives worked to patient group directives (PGDs). Training and competence was assessed at induction or during preceptorship. PGDs seen on the trust intranet were in date, written in line with legislation. However, the labour ward did not use the correct paperwork to authorise staff. Therefore, they were not following trust policy and PGD legislation.
- Resuscitation trolleys were checked and logged on a weekly basis. Staff informed us that the policy had recently changed to checking the trolley weekly and applying a tamper evident seal. However, we found that labour ward resuscitation trolley had two adrenaline injection expired in February 2017. The trolley had been checked on the day of our inspection (7 March 2017) and this had not been identified. We brought this to the attention of the ward co-ordinator and the adrenaline was replaced immediately. In addition, the oxygen cylinder was full but the regulator said it needed reconditioning in February 2014.

Records

- All pregnant women carried their own hand-held notes, mainly handwritten. The service also kept a set of hospital notes. The service used mixed paper and electronic records, except in postnatal ward where an electronic record system was used. The directorate was working towards full implementation of electronic record system by June 2017.
- We reviewed 15 sets of maternity records and two prescription charts. We saw that initial risk assessments were made, operations notes including anaesthetic notes were completed, patient observations recorded and completed at correct intervals, maternal obstetric early warning scores (MEOWS) calculated correctly and escalated where appropriate. The medical team recorded multi-disciplinary care planning and appropriate documentation when they had reviewed women. Notes were legible, signed and dated. However, in three sets of records entries did not always have the name and grade of doctor or midwife clearly documented. The two electronic prescription charts we reviewed had allergies documented.

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- The maternity service participated in the ward accreditation programme which was a peer review led by trust's senior nurse or midwifery team. The 2016 audit found that majority of the notes met the trust documentation standards. Core assessments were completed, appropriate care plans were in place and appropriate observations and fluid balance charts were completed.
- The local clinical commissioning groups (CCGs) provided red books, 'My Child's Health Record' which staff gave to local mothers. Red books are used nationally to track a baby's growth, vaccinations and development.
- Information governance formed part of the staff induction and mandatory training was updated annually. 56% of doctors in training, 80% of consultants and 82% of midwifery and nursing staff in maternity directorate had completed information governance training, against a trust target of 90%.
- Hard copies of discharge letters were sent to GPs on the same day of discharge. Discharge letter was sent to community midwives via email. If the patient was from outside the catchment area, relevant hospital was contacted to confirm patient was in their catchment area before discharge. Supporting information was included in the letter and any specific follow-up arrangement that may be required for example glucose test required for women with gestation diabetes. We saw evidence of the administrative standard operating procedure for postnatal discharge and a copy of the electronic discharge summary.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2015). Senior staff told us that this was provided for all staff working in maternity services.
- The trust had a named safeguarding lead midwife and two safeguarding midwives, who worked cross-site at both hospitals.
- Safeguarding was part of mandatory training. Data showed that 75% of nursing and midwifery staff within the department had completed level three safeguarding of vulnerable children and 79.9% had completed training in safeguarding vulnerable adults to level two. This was below the 90% trust-wide standard.
- Data showed that 90% of medical staff within the department had completed level three safeguarding of vulnerable children training and 80% had completed training in safeguarding vulnerable adults to level two. The latter was below the 90% trust-wide standard.
- An action plan was submitted to us post inspection detailing steps to be taken by the directorate to improve compliance with safeguarding level three training and included setting up additional training days and monitoring of staff allocation to training at directorate maternity quality and safety meeting.

Mandatory training

- The trust mandatory training programme included equality and diversity, moving and handling, medicine management, and blood transfusion training amongst others. The trust target for compliance with mandatory training was 90%.
 - At the time of our inspection, doctors in training' compliance was 65.8% with conflict resolution, 70.7% with equality and diversity, 58.5% with IPC level two, 65.85% resuscitation level two, 68.2% with mental health/mental capacity and 65.8% with blood transfusion. However, some areas fell below the trust minimum target. For example, compliance with medicine management and safe use of insulin was 4.8%.
 - At the time of our inspection, consultant compliance was 76% with conflict resolution, 86% with equality and diversity, 70% with IPC level two, 73.3% resuscitation
- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect. These arrangements reflected up-to-date safeguarding legislation, including national and local policy. Staff we spoke with demonstrated an understanding of the hospital's safeguarding procedures and reporting process for any concerns.
 - To ensure the safety of babies whilst on hospital premises, there was a child and baby abduction policy in place. However, the policy was out of date (November 2016). Senior staff told us that only high risk babies had an electronic tagged bracelet applied at birth, which was removed immediately prior to discharge home.

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level two, 86.6% with mental health/mental capacity and 76.6% with blood transfusion. However, some areas fell below the trust minimum target of 50%. For example, compliance with consent training was at 40%.

- At the time of our inspection, midwifery and nursing staff compliance was 86% with conflict resolution, 94% with equality and diversity, 86% with IPC level two, 96% with resuscitation level two and 58% mental health/mental capacity. However, some areas fell below the trust minimum target. For example, compliance with nutrition, preventing pressure ulcers level one training, mental capacity and VTE training were below the minimum target.
- Senior clinicians told us the trust was very committed to training and provided training on cardiotocography (CTG) interpretation. There were frequent CTG refreshers and case discussions to keep skills current. 84.2% of maternity staff had CTG training. There was an annual workshop followed by an assessment for all midwives and there were remedial plans for those who did not pass the assessment. There was annual two day CTG master class training arranged in July 2017 and a refresher training for consultant was planned in May 2017.
- Post inspection we were informed that in addition to low compliance by staff, deficiencies had been identified within the recording systems and the two separate used by the directorate to record the mandatory training data. We were informed that clinical director had allocated head of specialty for obstetrics at St Mary's hospital to improve the mandatory training compliance by all obstetric medical staff. Actions taken included, staff been reminded to complete their training, additional training sessions been organised for all staff to complete safeguarding level three training, medicines management and insulin management training.
- There was a practice development team, who would lead on all aspects related to midwifery education and preceptorship, which included; preregistration students, annual mandatory training, preceptorship programme, clinical skills, resuscitation and return to practice.

Assessing and responding to patient risk

- All patients, on admission, received an assessment for VTE and bleeding risk using the clinical risk assessment criteria described in the national tool. Performance was monitored monthly.
- Women were offered vaccinations against influenza and whooping cough. There were dedicated trained midwives who ran the vaccination clinics during the week. We saw notices on the maternity day assessment unit and midwives told us that the uptake was good.
- For women using maternity services the booking visit took place before 12 weeks and six days of pregnancy and included a detailed risk assessment. An initial maternity booking and referral form was completed by midwives at the booking visit. Between April 2016 and February 2017 95 % of women were seen by a midwife by 12 weeks and six days gestation of pregnancy.
- Women who developed problems in pregnancy were reviewed on the maternity day assessment unit. From there, they could be admitted to the antenatal ward for short periods of time to be reviewed regularly by the obstetric staff.
- We observed one transfer of a woman in active labour from birthing centre to labour ward via wheelchair. The process was efficient and communication between the two departments was appropriate and there was effective handover. The whole transfer took approximately eight minutes.
- Midwifery staff used an early warning assessment tool known as the modified early obstetric warning score (MEOWS) system to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond to additional medical support if required. The records we reviewed contained completed MEOWS observations and appropriate escalation took place, where required. The head of midwifery told us that since the start of recording MEOWS on the electronic patient record system in 2015, compliance had improved. A MEOWS audit in March 2017 of 30 sets of notes showed that no observations were missed and any triggers were escalated and acted on appropriately.
- There were arrangements in place to ensure clinical checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health

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Organisation's (WHO) five steps to safer surgery guidelines. We saw documentary evidence that all the stages were completed correctly and that checklists showed that this was usual practice. We observed one emergency operation where all five steps of safer surgery were completed. The WHO checklist audit between April 2016 and March 2017, showed 100% each month except in October (95%), January 2017 (83%) and in March (65%) where in one case the WHO checklist was not completed. In all cases of non-compliance, relevant staff were contacted.

- Intrapartum CTG "Fresh Eyes Buddy System" was introduced to St Mary's Hospital in September 2015 to comply with the Imperial maternity guideline "Electronic Fetal Monitoring and Fetal Blood Sampling" 2016. This was in accordance with NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that it was within normal parameters. Between December 2016 and January 2017 an audit of Fresh Eyes was completed. The standard was set at 100%, which meant it was expected that midwives would have the CTG reviewed every hour by another trained member of staff and that the CTG would be categorised and agreed together and that this would happen 100% of the time. The audit demonstrated that 87.5% of the notes were not meeting the standard. However, it showed that Fresh Eyes hourly review was more likely to take place hourly when the midwives had been reminded to do so and also been assigned a designated "Fresh Eyes buddy" at the start of the shift. Evidence of action plan submitted showed specific roles assigned to labour ward coordinator to ensure midwives to complete fresh eye sticker every hour and the obstetrician in attendance to complete fresh eye sticker with the midwife at each ward round.
- The maternity service conducted an audit on puerperal sepsis between August 2016 and March 2017, which showed that investigations were ordered appropriately in the majority of cases, there was an improvement seen in the six hours review and there were no admissions to the Intensive Care Unit (ICU). We saw evidence of a detailed action plan to inform all obstetric staff to consider stopping all antibiotics if all observations were normal at six hours after delivery. Another action was to increase awareness of sepsis and posters have been developed summarising guidelines on labour ward and postnatal ward and to continue with mandatory training in sepsis at staff induction and mandatory midwifery study day.
- There was one dedicated high dependency unit (HDU) bed for women needing additional postnatal care. Staff used modified chart for monitoring women in HDU bed.
- Staff told us that they feel well supported by the neonatology and paediatric team and having an on-site level two NICU. There was 24 hours onsite availability of senior registrar neonatal doctor (level 4-8) to attend within 10 minutes and a consultant neonatologist within 30 minutes.
- We saw evidence that the maternity services were compliant with Safer Child Birth Standards (standard seven: emergencies and transfers). For example, there were local agreements with London ambulance services on attendance at emergencies or when transfer were required, a consultant obstetrician was available within 30 minutes outside the hours of consultant presence and complicated births in the obstetric units were attended by consultant obstetrician.
- 84% of the maternity staff had completed the yearly basic life support training. Advance life support and intermediate life support was provided by the trust cardiac arrest team. Senior staff post inspection informed us that there was a focus on newborn life support (NLS), advanced life support in obstetrics (ALSO) and management of obstetric emergencies and trauma (MOET) as this was most relevant in a maternity setting. The majority of consultant staff were teaching skills and drills and ALS on a regular basis and trained and taught on MOET.
- There were separate handovers for medical and midwifery staff twice per day. We observed the 7.30am midwifery handover which was structured and included discussion on all maternity inpatients and overnight deliveries. Care was assessed and planned at this handover and work allocated to the appropriate member of staff, consideration was given for continuity of care, choice and preferences and skill mix, buddy system and additional midwife allocated for fresh eyes

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and medication checks. After the handover, a hot topic of the day was discussed. We also observed the 8 am medical handover, which was structured, but there were frequent interruptions during the handover.

- There was a 'care in the presentation of concealed pregnancy or unbooked for maternity care policy' in place. Women who arrived in labour without having booked were treated as high risk cases and were allocated to the on call consultant.
- There was a Did Not Attend (DNA) policy that the trust adhered to. This meant that staff were aware of women who had missed appointments and could arrange follow up to ensure that women attended for care and safeguarding concerns were raised when they did not do so. The maternity directorate monitored the DNA rate as one of the data quality indicators. An audit in November 2016 showed that the directorate was within the trust target of 11% except in December 2016 when DNA rate was 11.3% for follow up appointment. We saw a detailed action plan to make further improvements.
- Venous thromboembolism (VTE) risk assessment and thrombo-prophylaxis compliance was monitored monthly by the maternity service. Between April 2016 and January 2017, the compliance rate was 87.5% to 94.8% and was consistently below trust target of 95%. VTE risk assessment training was part of the mandatory training and was well below the trust target of 95% at 21.95% for doctors in training, 36% for doctors and for midwifery staff group was 41.5%.

Midwifery staffing

- For the financial year 2016/2017, the midwife-to-birth ratio was funded to be 1:30. This was improved from last inspection in 2015 when it was 1:33 and worse than national average of 1:29.
- The trust employed 126.14 whole time equivalent (WTE) qualified and 40.95 (WTE) unqualified maternity staff, which included lead midwives, matrons, band 7 and 6 level midwives, maternity care assistants and support workers.
- Between March 2016 and August 2016, the vacancy rate for all nursing and midwifery ranged between 3.2% and 13.8% and was 4.9% in February 2017. We saw evidence

that midwifery vacancy rate was regularly monitored via the maternity directorate's risk register. In November 2016, 19 new midwives were recruited and the vacancy rate was reduced.

- Between April 2016 and November 2016, the sickness rate amongst midwifery staff ranged between 7% and 2.4% and at 6% in February 2017. This was above the trust target of 3.1%.
- Between April 2016 and January 2017, the rate of women reported as receiving one-to-one care during labour ranged between 96% and 98%, this was above the trust target of 95%.
- The maternity unit used agency staff and had its own bank of temporary staff, which was made up of permanent staff who undertook extra work to cover shortfalls. Between February 2016 and February 2017, 6.6% agency and 93.4% bank staff filled the shifts.
- The maternity service implemented the Birthrate Plus Acuity Tool at the end of January 2017. Birthrate Plus is a midwifery workforce planning tool which demonstrates required versus actual staffing needed to provide services. This is recommended by the Department of Health and endorsed by the Royal College of Midwives. It enables the workforce impact of planned change(s) to be clearly mapped, in order to support service improvement and planning for personalised maternity services. Data submitted showed that directorate trialled the inputting of data in February 2017 with full data collection from 6 March 2017. We were informed that the data would be reviewed through maternity quality and safety meetings with upward escalation to the divisional groups on a quarterly basis.
- There were two elective theatre lists two days per week. We were informed that only one theatre had the scrub nurse, for second theatre and for out of hours emergency cases, a midwife would go into theatre to 'scrub' for operations. The local supervising authority annual audit report (October 2016) also concluded to review the appropriateness of using midwives to scrub in theatre. Senior staff told us that they were currently working on establishing a competency framework for midwives that scrub in theatre.
- The recent never event of retained vaginal swab within maternity services identified three recommendations

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around scrub nurse availability within maternity theatre. These were; 'review requirement of scrub nurse in theatre routinely for all procedures in maternity theatres against compliance with NatSSIPs (National safety standards for invasive procedures). Lack of designated scrub nurse for Maternity out of hours to be added to the risk register as non-compliance with NatSSIPs. In the short term, confirmation of the members of staff who were able to adopt a 'scrub nurse' role in an emergency'.

- Some staff that we spoke with raised concerns about the frequency with which they were redeployed from postnatal ward to labour ward either at the beginning or during the middle of their shift. We ascertained that the midwifery staff were accepting of the reasons for the redeployment in that they were required to work where women required care and support. However, some staff felt that labour ward would not accept staff without theatre experience and this was affecting the morale within the department. We discussed this concern with the head of midwifery, who was aware of the concerns amongst staff and was currently working on establishing a competency framework for midwives that scrub in theatre.
- We observed the morning handover between shift changes for midwives, which was followed by a ward round. All staff had a list of patients on the ward. Although midwives did not use any formal handover tool, such as Situation, Background, Assessment and Recommendation (SBAR) the handover process was detailed and structured.

Medical staffing

- As of October 2016, the service employed 103.2 whole time equivalent (WTE) doctors. The demographic of medical staffing within obstetrics and gynaecology demonstrated that the trust employed same number of consultants (39%) when compared to the national average. The service had more specialist trainee registrar (55%) when compared to the national average (47%). The number of foundation year (FY) doctors (year 1 and 2) was lower than the national average, with 3% locally, versus 6% nationally
- There was 98 hours per week consultant presence on the labour ward. This was in line with recommended practice by the Royal College of Obstetricians and

Gynaecologists (RCOG) when considering the number of deliveries that occurred at St Mary's Hospital. At inspection, consultants, doctors and midwifery staff confirmed a 98 hours consultant presence on delivery suite each week.

- Consultant presence was from Monday to Friday 8am to 5.30pm. A consultant was present on labour ward Monday to Friday 8am to 10.40pm. On call non-resident consultant cover was provided after 10.40pm.
- Weekend consultant presence was from 8am until 8:30pm. Outside of these hours, the consultants were non-resident on-call. However, the consultants told us that when on-call, several of them chose to provide onsite cover.
- Midwifery and junior medical staff reported they had no issues speaking with a consultant when needed and they were always contactable.
- Between March 2016 and August 2016, the vacancy rate for consultants ranged between 5.8% and 8.6% and was 6.17% in February 2017.
- Between April 2016 and November 2016 the sickness rate amongst consultant was 0%.
- Between March 2016 and August 2016, the vacancy rate for doctors in training ranged between 0.33% and 16.4% and was 8.18% in February 2017.
- We observed an 8am handover between medical staff. This was found to be effective but there were various disruptions. For example, staff interrupted with telephone calls or staff left to get something.
- The General Medical Council (GMC) national training survey 2016 identified one red flag related to handover, the issue surrounded labour ward handover, some consultants were late for the 8am handover and there was not always a consultant present for handovers at 5pm and 8pm. However, we saw evidence of an action plan and minutes of obstetrics and gynaecology local faculty group (LFG) meetings where these issues were discussed and in January 2017 meeting, the minutes reported that trainee feedback was positive.
- A resident consultant anaesthetist was based on the labour ward, Monday to Friday 8am to 6pm.
- In addition to the consultant anaesthetist, a middle grade trainee anaesthetist was assigned to labour ward

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8am to 5:30pm and was supervised directly by the consultant for the day. One additional junior level trainee was assigned to elective caesarean section list, but attendance varied from week to week depending on trainee numbers and was not guaranteed.

- Out of hours, there were three consultants on call for covering multiple sites including general theatres, trauma/A+E and labour ward. In addition to this, there was a trainee anaesthetist on-site and dedicated to labour ward.

Major incident awareness and training

- The hospital had major incident and business continuity plans in place. Staff we spoke with were familiar with how to access the guidance and instruction cards for their respective areas.
- All staff we spoke with were able to describe the process to follow in case of a major incident and plans were in place for wide range of uses. For example, staff showed the fire exits and pathway to move patients out of the unit in case of an emergency.
- Staff had received fire safety awareness and fire safety clinical and high risk areas training as part of their annual mandatory training programme. Department training compliance with fire safety awareness training was 100% for nursing and midwifery staff and 90% for doctors and compliance with fire safety clinical and high risk areas training was 81% for nursing and midwifery staff and 63% for doctors as of 14 March 2017.

Are Maternity (inpatient services) effective?

(for example, treatment is effective)

Good



We rated effective as good because:

- Women's care and treatment was planned and delivered in line with current evidence-based guidance and this was monitored to ensure consistency of practice.
- Information about women's care and treatment and their outcomes was routinely collected and monitored. This information was used to improve care.

- There was participation in relevant local and national audits.
- Staff can access the information they need to assess, plan and deliver care to people in a timely way.
- Consent to care and treatment was obtained in line with legislation and guidance.

However,

- We found two clinical guidelines that were out of date.
- Only 84% of midwifery staff had bereavement training.

Evidence-based care and treatment

- Trust policies and procedures were available on the trust intranet. Clinical policies and procedures we reviewed all referenced relevant National Institute for Health and Care Excellence (NICE) and Royal College of Obstetrician and Gynaecologists (RCOG) guidelines.
- Staff demonstrated how they accessed guidance, policies and procedures on the hospital intranet. Staff told us the guidelines were clear, comprehensive and updated frequently. There was a trust wide multidisciplinary guideline group that reviewed and approved clinical guidelines. Staff told us that they would keep track of guidelines that would be due for review and inform the department. We sampled six guidelines, four of these were in date and two guidelines - postnatal care guidelines (August 2016) and child and baby abduction policy (November 2016) were out of date.
- Appropriate care pathways and protocols were available for the management of intrapartum care, induction of labour, major obstetric haemorrhage (MOH) and sepsis.
- The trust contributed data to the national neonatal intensive and special care programme (NNAP), National Screening Committee Antenatal and New-born Screening audit and to the Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK).
- We saw that the care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out

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guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service.

- We saw evidence that the inability to achieve one to one care in labour was a midwifery 'red flag' event and in such instances, the maternity escalation plan was instigated. NICE state that trusts should 'provide a woman in established labour with supportive one-to-one care, that is care provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same midwife for the whole of labour)'. This was one of the quality standards on the directorate dashboard; however, the trust target was set at 95% and though the maternity service at St Mary's hospital was consistently above the trust target (96% to 97%), it meant that up to 4% of women did not receive one to one care. However, this was similar to other trust within the NWL network.
- We found from our discussions and from observations that care was being provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy. For example, pregnant women to have their smoking status recorded at the booking appointment, this was one of the quality indicators and showed between April 2016 and February 2017, 3% of women were known to be smokers at the time of delivery.
- We found evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, and care of the new-born baby.
- The latent phase of labour is the early stage of labour before contractions become regular, longer and stronger. Best practice (NICE, 2014) is that women who are not in established labour have better outcomes if they stay at home. We saw that their maternity led guideline for intrapartum care pathway was that low risk women would have care provided in line with this best practice.
- Caesarean section rate was one of the quality standards on the directorate dashboard. The caesarean section rate for April 2016 to February 2017 was 31%, which was higher than the trust target of less than 29%.
- We saw evidence of a local strategic plan, which showed that identification of high emergency caesarean section (EmCS) rates at St Mary's led to an emergency caesarean section action plan which had helped to reduce EmCS rates to target levels of less than 13%.
- Senior staff told us, and we saw evidence, that care was being provided in line with the NICE Clinical Guideline (CG110) pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.
- Senior staff informed that the directorate of maternity across both Queen Charlotte's and Chelsea Hospital (QCCH) and St Mary's Hospital (SMH) had an agreed annual clinical audit and service evaluation plan. This plan was agreed by the maternity directorate to reflect the key local areas of concern across the trust. We were informed that following the change in trust divisional structure in 2016, their future audit strategy would include the production of a clear annual audit plan identifying and prioritisation of the divisional and local priority audits with Identified leads, sponsors and key dates with improved training and support for clinical staff participating in audits. A list of audits undertaken by the directorate in 2016 – 2017 was submitted to us post inspection.
- The vaginal birth after caesarean section (VBAC) audit March 2017 showed how the department managed these cases and as a result, the number of successful VBAC had increased in the last two years (68% from 40%).
- An audit of induction of labour (IOL) showed that the overall success rate for IOL had improved and the emergency caesarean rate for women undergoing IOL had fallen due to the interventions used (32% in 2017 from 44% in 2016). The directorate felt that they can still improve on this and had initiated an IOL quality improvement programme which was currently on-going.
- An audit of rate of instrumental deliveries and rate of failed instrumentals was conducted in April 2014 – August 2016, which showed that the rate of operative vaginal delivery was 11.6% and the rate of failed

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instrumental delivery was 3.2%. All cases were carried out with appropriate supervision. Maternal and neonatal outcomes were good (there was no 3rd/4th degree perineal tears and no Apgar scores less than 8 at 5 minutes - Apgar is a quick test performed on a baby at one and five minutes after birth to determine how well the baby is doing after birth). We were informed that a consultant obstetrician as part of the emergency caesarean section action plan was reviewing all cases of failed instrumentals and if there were any themes and trends identified, the individual operators received feedback immediately. There were also instrumental workshops on Tuesday afternoon to improve training in the use of suction cups used for ventouse (vacuum assisted vaginal) delivery.

Pain relief

- Women giving birth had a choice of pain relief, including epidural anaesthesia. Midwives provided support to women who did not want to use pain relief. Women who had undergone caesarean section said they had been offered pain killers regularly and had received it promptly.
- Birthing pools were available in both the birth centre and consultant led labour ward, so women could use water immersion for pain relief in labour.
- We reviewed five patient records, which showed that staff used a standardised scoring tool, to assess patients' pain and recorded pain assessments in women notes.
- One woman we spoke with told us that she felt her pain was managed well.
- There was an epidural analgesia in labour policy in place. The policy stated that an anaesthetist to attend within 30mins of a request when possible and if it was anticipated the wait would be more than 60mins then a second anaesthetist should be called to assist. However, information submitted to us by consultant anaesthetist post inspection stated that they have not audited the time from women requesting an epidural to when they received one.

Nutrition and hydration

- The infant feeding midwife led on all aspects of infant feeding both clinical care and teaching.

- The trust's maternity and neonatal unit were jointly awarded UNICEF Baby Friendly Initiative stage one in July 2016, which meant the trust had a policy in place and a plan for staff training. Senior staff informed that they were now ready to submit evidence for stage two accreditation this year.
- Women told us they received support to feed their babies and had been supported to feed their babies in their preferred method, be it through breastfeeding or bottle feeding. Verbal information was supplemented by written leaflets and there were infant feeding support classes available on Tuesday and Friday. There was an infant feeding policy and formula milk was provided for mothers who chose not to breast feed and where supplementation for babies was recommended by neonatologist.
- Between April 2016 and December 2016, the initiation of breast feeding rate for the trust was in the range of 93% to 94% and constantly above trust target of 90%.
- Babies with tongue-tie (a condition where the string of tissue between the baby's tongue and floor of the mouth is too short and affects the baby's ability to latch onto the breast causing feeding problems) were referred to a complex breastfeeding and tongue-tie assessment clinic where the doctor could divide the tongue-tie if required. This meant that women and babies received timely intervention when feeding was complicated by tongue-tie.

Patient outcomes

- The RCOG Good Practice No. 7 (maternity dashboard: clinical performance and governance score card) recommends the use of a maternity dashboard. The maternity dashboard serves as a clinical performance and governance scorecard to monitor the implementation of the principles of clinical governance in a maternity service.
- The trust was using the North West London Maternity dashboard. This enabled comparative data to be used across the trust and across the maternity units in North West London.
- Information on the maternity directorate dashboard from April 2016 to February 2017 showed that: the overall caesarean section rate was 31%, which was higher than the trust target of less than 29%. The

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elective caesarean section rate was 11.7%, which was lower than the trust target of less than 13%. The emergency caesarean section rate was 19.2 %, which was higher than the trust target of less than 16%.

- The instrumental delivery rate was 13%. The differentiation between vacuum assisted and forceps delivery was not recorded. This was consistently lower than trust red flag target of 20% each month.
- The third or fourth degree tear rate was 1.8% (% of all maternities) and 2.7% (% of all vaginal births). This was consistently below the trust red flag rate of 12 per month. This was lower than other trust reported on the NWL dashboard.
- The trust recorded postpartum haemorrhage above 1.5 litres on the dashboard and there were 74 such haemorrhages between April 2016 and February 2017 which equated to 2.3% of patients and there were no red flag breaches (more than 12 cases) in any month.
- The trust recorded 14 stillbirths between April 2016 to February 2017. The North West London Network dashboard 2016 -2017 showed that crude still birth cases per 1000 total births was at 4.7, which was lower than compare to its sister hospital and one other hospital within the network, but it was one of the red flags for this unit.
- The trust reviewed the MBRRACE Perinatal Surveillance Report 2014 published in May 2016, which showed that Imperial College Healthcare NHS Trust (ICHNT) was an outlier of up to 10% higher than the average for neonatal and stillbirth rates in 2014 compared to comparable trusts within UK. This was an improvement from the MBRRACE 2013 report, which showed ICHNT to be more than 10% higher than average for the group. As a recommendation from this, the trust reviewed all stillbirths and neonatal deaths and none of the 2014 neonatal deaths felt to be avoidable on detailed review by neonatal consultant body. However, they also identified issues that not all deliveries were reported on their electronic system and this was to be rectified. Post inspection trust submitted the MBRRACE 2015 report, which showed ICHNT results moved in positive direction, to up to 10% lower than similar trust for still births and more than 10 % lower for neonatal mortality.
- Between April 2016 to February 2017, 0.7% of all births at St Mary's Hospital (SMH) were home births and in

January there were no home births, which was below the maximum target of 1% set by the clinical commissioning group as part of the clinical quality group acute quality metric. We noted that there were 0% home births in January 2017.

- Between April 2016 and February 2017, there were 12 cases of puerperal sepsis. This was constantly lower than the trust red flag of eight cases per month. The Northwest London maternity dashboard for 2016-2017 showed that there were 0.4% puerperal sepsis cases, which was lower than some of the other hospitals within the network.
- Between April 2016 and February 2017, there were 13 cases of shoulder dystocia, which is an obstructed labour where the shoulders fail to deliver shortly after fetal head and requires significant manipulation.
- Between April 2016 and February 2017, 27 term babies with a gestational age of over 37 weeks were admitted to the neonatal unit.
- The 2015 National Neonatal Audit showed that St Mary's Hospital's performance was above the national average for three out of five applicable questions and below the national average for two. For example, There were 65 babies born at less than 32 weeks included in this audit measure for this unit. 82% of these babies had their temperature measured within an hour of birth; this was below the national average, where 93% of eligible babies had their temperature measured within an hour of birth.
- We saw documented evidence that in 2015, the trust benchmarked its compliance against the Morecambe Bay investigation report and Dr. Kirkup recommendations, and had completed all actions except one. The was one action which stated 'in progress' was to be completed in March 2016. The recommendation was that 'the trust should set out how they ensure incidents are reported and investigated in an open and honest way including requirements, benefits and processes. This should include a review of the structure, training, reporting and support for staff involved in SIs'.

Competent staff

- We saw evidence that the maternity services were complaint with Safer Child Birth Standards (standard

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five: leadership and standard four: staffing levels). For example, there was a labour ward lead consultant obstetrician, a lead obstetric anaesthetic, a labour ward manager and a supernumerary shift coordinator midwife.

- Supervisors of midwives (SoMs) were available to help midwives provide safe care of the mother, baby and her family. SoMs were experienced midwives with additional training and education, which enabled them to help midwives provide the best quality midwifery care. They made sure that the care received met women's needs. The average number of supervisors to midwives ratio was 1:13 and they had completed 96% of the required annual reviews.
- Local supervising authority annual audit report of monitoring the standards of supervision and midwifery practice October 2016 stated that all the midwives present had their annual reviews. The midwives described their experience of supervision at the trust as being one that was visible, approachable, supportive, helpful and compassionate.
- In the maternity service 92.4% of nursing and midwifery, 80% of doctors and 88.8% of consultants have had their appraisals. Post inspection evidence submitted to us stated that 100% of junior doctors in run through training programme have had their appraisal. However, several actions had been taken to improve appraisal rate of consultants and doctors who were in clinical or research post. For example, all non-compliant staff had been identified and reminders had been sent from the clinical director, meeting arranged with clinical director if remain non-compliant and further escalated divisional director and medical director.
- All newly qualified midwives followed a 12 months preceptorship programme. This enabled new midwives to become competent in cannulation and perineal suturing and gain experience in all areas of the maternity service.
- Bereavement training took place as part of the midwifery yearly mandatory training programme. The current midwifery training compliance figures was 84%.
- There was a fetal monitoring meeting held on alternate Mondays and Fridays with presentations from doctors and midwives of real cases to discuss and share learning.

Multidisciplinary working

- There were joint meetings and cross-site working with maternity staff at Queen Charlotte's and Chelsea Hospital.
- A handover took place twice a day on the wards. The medical handover used an SBAR (Situation-Background-Assessment-Recommendation) handover sheet and included an overview of all maternity patients.
- There were clear guidelines and pathways for transitional care for term babies who required additional levels of support. The aim of the transitional care was to keep those babies who would otherwise need to be admitted to neonatal unit with their mothers. There were clear admission criteria for admission to transitional care and included the administration on intravenous antibiotics, phototherapy and birth weight under 2000 grams.
- There was onsite multidisciplinary support provided by the paediatric services that included haematology, infectious disease, radiology, nephrology, ophthalmology, genetics and comprehensive long term neonatal follow up.
- Neonatal sister in charge visited labour ward daily to discuss any cases.
- The maternal medicine team offered a multidisciplinary approach. Midwives ensured that women with pre-existing conditions such as epilepsy or diabetes had their medical care integrated with their maternity care.
- There were weekly multidisciplinary meeting attended by obstetrician, specialist midwife, endocrinologist, diabetic nurses and dietician to discuss endocrine cases jointly on Wednesday mornings at 8am.

Seven-day services

- Consultants worked seven days a week and a consultant was on site for 12 hours a day at weekends on the labour ward.
- There was access to scanners and the outreach services seven days a week.

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- The two dedicated obstetric theatres were fully staffed, Monday to Friday. Out of hours, theatre staff were on call. However, the second theatre did not have a dedicated scrub nurse.
- Pharmacy service was available 9am to 7pm Monday to Friday and five hours on Saturdays and Sundays. A pharmacist was on call outside of pharmacy opening times. Pharmacy was open 365 days a year.

Access to information

- Trust intranet and e-mail systems were available to staff, which enabled them to keep pace with changes and developments elsewhere in the trust, and access guidelines, policies and procedures to assist in their specific roles. One doctor told us that the trust was “one of the best trusts for easily accessible guidelines online”.
- There were posters located throughout the maternity service containing guidance for staff such as how to contact the critical care outreach team, identification of sepsis, protocols for escalation of deteriorating patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that consent to treatment for women was obtained following the correct guidelines and procedures. Staff on the wards were familiar with the trust policy relating to the application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Women told us that procedures were explained to them; explanations included the risks, benefits and any potential alternative treatments available. Women said that receiving this information and being able to ask the clinical team any questions allowed them to make informed decisions prior to consenting to treatment.
- All staff we spoke with were aware of the trust’s consent procedure and could describe the legislative requirements regarding consent in young people who were deemed as being underage. Staff were able to describe Gillick competencies and the requirements for seeking consent from young people when they had been assessed as competent to make decisions about their care and treatment. The Gillick competence is a test in medical law to decide whether a child of 16 or younger was competent to consent to medical examination or treatment without the need for parental permission and knowledge.

- We reviewed eight records where consent was applicable and in all cases consent forms were signed and documented.
- A trust consent audit in 2017 showed that some risks including infection (100%), haemorrhage (100%), thromboembolism (99%), fetal laceration (90%) and injury to bowel, bladder and ureters were well documented. However there was low compliance with documentation of risks about ITU admission (5%), uterine rupture (23%), repeat caesarean section (7%) and death (1%). None of the patients were counselled regarding the increased future risk of readmission to hospital, further surgery or antepartum stillbirth. Only 66% of patients were told of a possible emergency hysterectomy. As a result of this the trust was implementing formal training and introducing pre-printed stickers to be used on consent forms.

Are Maternity (inpatient services) caring?

Good



We rated caring as good because,

- All women we spoke with on antenatal, postnatal and labour ward were positive about their experiences, and the kindness, skill and supportiveness of staff.
- Friends and Family Test results showed women and their families had a good experience in the maternity services and women and their partners told us they would recommend the service.
- We observed staff behaving compassionately and with patience towards women. We observed positive patient interactions from all levels of staff, from ward domestic staff to consultants. Staff were seen to be calm and compassionate, altering their communication style depending on the situation. We heard staff providing advice and encouragement, as well as dealing with urgent situations with calmness and efficiency.
- Staff were conscious of the need to protect the dignity and privacy of women in all areas of the service. Curtains were drawn around beds all time to ensure privacy.
- Specialist staff offered sensitive bereavement support for women suffering miscarriages or stillbirth.

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- Women told us they understood their care and treatment and were able to ask staff if they were not sure about something.

Compassionate care

- Women told us that they felt well informed and able to ask staff if they were not sure about something. One woman on labour ward said “all the doctors, midwives and support staff are very helpful and always explain everything”.
- Discussions with women and families were evident in all of the notes that we examined, including care plan and obtaining consent.
- We observed staff responding promptly and respectfully to requests for help, even when they were busy.
- We observed staff respected women’s privacy and dignity and curtains were pulled around bays during examination and ward rounds.
- Overall the trust’s Friends and Family test (FFT) for maternity services in December 2016 showed 28.4% response rate which was above the trust target of 15%. 95.7% service users recommended the service which was above trust target of 95%. Between December 2015 and December 2016 the trust’s Maternity Friends and Family Test for antenatal, birth and postnatal community performance (% recommended) was generally similar to the England average. In December 2016 the trust’s performance for antenatal and birth was the same as the national average with 96%. Postnatal ward performance (% recommended) was generally worse than the England average. In December 2016 the trust’s performance for postnatal ward was 96%.
- The CQC survey of women’s experiences of maternity services 2015 showed that the trust performed about the same as other trusts for all of the 16 questions in the CQC Maternity survey 2015.
- Women discharged home were provided with detailed information on the signs and symptoms that they should look for in case of any complications and how to seek advice.

Understanding and involvement of patients and those close to them

- Women told us that they felt well informed and able to ask staff if they were not sure about something. One woman told us that she felt the staff took her pregnancy complications professionally and seriously and involved her in all reviews of her care.
- A woman we spoke with on the postnatal ward who had her fourth baby told us, “staff have been supportive and very kind and call bells were answered straight away”. Another woman said “nothing outstanding but a good hospital and very happy with care”.
- One woman’s mother told us she had also been treated well and welcomed on the ward. Another woman said she was involved in decisions about her care and the woman’s partner said that he was kept informed and involved in the care and felt supported.
- Partners were made to feel welcome and involved in their partner’s pregnancy, labour and birth, and able to stay with their partner and baby on the birthing unit and post-natal ward. We observed that partners were allowed to accompany in theatres for the duration of whole procedure.
- We observed positive interactions from all staff from ward domestic to consultant level with women and their partners. Staff were seen to be calm and compassionate. We heard staff providing advice and encouragement, as well as dealing with urgent situations with calmness and efficiency.
- We spoke with two women waiting for their antenatal appointments. One woman was aware of the named midwife while the other said that she was not aware who her named midwife was and saw a different midwife or doctor at each visit. Both women said that they had not had any discussion regarding birth plans, one woman was in her third trimester.

Emotional support

- Women we spoke with and their partners commented on the supportiveness of the midwives before, during and after birth. All the patients and relatives we spoke with told us they felt supported throughout their journey. Patients said the support provided by staff from consultation, pre-assessment, treatment and therapies was all satisfactory.
- One woman said to us that she had received “very good emotional support and reassurance in labour”.

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- We were informed that parents of deceased infants were able to spend as much time as they wished with their baby in the dedicated bereavement room. A designated room was provided for the care and support of women and their respective partners to be cared for during and after the loss of their baby. This was located toward the end of the main corridor on labour ward so bereaved women and their partners could not hear labouring women and crying babies from the main ward area to reduce distress. Staff told us that there were plans to refurbish the room to make it less clinical.
- There were two specialist bereavement midwives cross-site that helped couples with emotional and practical support, and also provided support to midwives involved in bereavement. There was a bereavement clinic, which was designed to see women and couples that have had stillbirth, late miscarriage or pregnancy loss at 20-24 weeks of gestation, termination of pregnancy for fetal abnormality and early neonatal death. Midwifery staff told us they valued the support of the bereavement midwife.
- There was a 'counselling after trauma and loss' service established at the Trust. This was offered to all bereaved couples over 20 week's gestation. It consisted of six hours long counselling sessions by a charity originating from another hospital.
- The hospital had a multi-faith chaplaincy service that provided services to patients across the hospital.
- Support was offered to parents to make funeral arrangements from the patient affairs officers and the trust chaplaincy service. Funerals organised by the trust were funded by the trust. The trust charity had a hardship fund to which parents could apply for financial support for a funeral if required.
- There was a National Bereavement Midwife Forum at St. Mary's Hospital. The forum comprised of 30 bereavement midwives from across the UK who joined to discuss concerns, exchange best practice tips and standardise maternity bereavement care. Representatives from NHSE, Department of Health, Royal College of Midwives and the Ministry of Justice attended this forum.

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

Requires improvement



We rated responsive as requires improvement because:

- Throughout the maternity service, there was poor signage and navigating to different part of the maternity service.
- Between April 2016 and February 2017 90% of women had a named midwife, which was below target of 100% set by the clinical commissioning group as part of the clinical quality group acute quality metric.
- There was limited information available on the wards for women and their relative about how to make a complaint and how to access the Patient Advice and Liaison Service (PALS).
- Maternity wards were in a dated building, which did not provide an optimum environment for women.

However,

- Women were given a choice of times and dates for antenatal clinic appointments.
- Outpatient appointments made within five working days of receipt was an average 97.7%.
- 91% of pregnant women accessing antenatal care were seen before 10 weeks plus six days excluding later referrals.
- There were specialist services and teams were available to meet the needs of individual patients.

Service planning and delivery to meet the needs of local people

- There was reorganisation of the divisional structure in 2016 and maternity services were within the division of women's, children's and clinical support.
- Maternity wards were in an dated building, which did not provide an optimum environment for women. The facilities in antenatal and postnatal wards were poor, such as ensuite facilities and the nearest toilets and separate showers were across the corridor within the

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wards. The management was aware of these issues and it was on their risk register. The Head of midwifery informed us that there were limitations due to the structure of the building. The triage area was recently refurbished to modern standards.

- The maternity day assessment unit was opened in 2016 to improve access and flow.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The red book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the child until five years of age.
- Women were given a choice of times and dates for antenatal clinic appointments.
- Between April 2016 and February 2017 93% of women had a named midwife which was below the trust target of 100%. Mandate 13 in the NHS England Mandate 2014/15–2016/17 specifically states, “every woman has a named midwife who is responsible for ensuring she has personalised, one-to-one care throughout pregnancy, childbirth and during the postnatal period, including additional support for those who have a maternal health concern”. The London Maternity Strategic Clinical Network (SCN) published a Continuity of Care toolkit for increasing the number of women accessing continuity of midwifery care in London. The trust participated in the SCN programme of auditing however, April 2016 audit showed low compliance with questions related to continuity of care. For example, 47% women did not see the same midwife every time for their antenatal check-up and 86% of women said that they had not met any of the midwives who cared for them during labour and birth before they went into labour. Senior staff informed us that they were an early adopter of the Better Births Programme and their focus was on improvement of continuity of carer.

Access and flow

- Senior staff informed us that access and flow was not an issue and they had not closed the maternity unit in the previous four years due to lack of capacity.

- Between Q1 2015/16 and Q2 2016/17, the maternity bed occupancy levels for the trust were generally lower than the England average, with the trust having 60% occupancy in Q2 2016/ 2017 compared to the England average of 63%.
- The average length of stay for combined episode of care in maternity was 2.5 days.
- Most women who gave birth on the midwifery-led birth unit were discharged from there. All babies born in the birth centre had a newborn infant physical examination prior to transfer home. There was a separate nursery on the postnatal ward to carry out the examinations for babies on the postnatal ward.
- Patient flow was observed to be smooth across the post-natal ward during the inspection. The triage within labour ward was reopened after refurbishment on the day of our inspection. Staff told us that there had been some cancellations of elective operations and delays due to lack of scrub nurses for the second theatre. Data showed there were 56 non-clinical cancellations during April 2016 to January 2017 and highest in January 2017 with 12 cancellations. Post inspection senior staff informed us that all these 12 operations were in fact gynaecology procedures and not maternity. They had identified the error, which was due to incorrectly recorded treatment function code. The non-clinical cancellation reasons for these cases included ward bed unavailable, patient request, surgery was not required any more, lift to day surgery unit was not working, theatre environment was too cold and in one case surgeon was unable to scrub as no hot water was available.
- The maternity services implemented a quality improvement project on ‘Enhanced Recovery for Caesarean section’ in 2016, which demonstrated that there was no negative consequence in women being discharged less than 48 hours. There was a working party for the enhanced recovery for caesarean section (C-section) and we saw evidence of those meetings. There was a dedicated midwife on the maternity day assessment unit (MDAU) to facilitate pre-operative blood tests and to obtain consent from the obstetrician and anaesthetist one day in advance of the scheduled operation to allow smooth running and preparation for these women. From April 2017, a dedicated physiotherapy team would be running two sessions a

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week on MDAU. Enhanced recovery for C-section information was available on the trust intranet and all doctors were asked to provide the patient with information on enhanced recovery for C-section.

- There was a maternity day assessment unit (MDAU) open from 8am to 4pm Monday to Friday. This allowed women for elective caesarean and inductions to have a place to arrive as well as the other scheduled MDAU activity. Staff told us that there was normally an influx of patient around 3 pm from the emergency department, which would result in an influx of patients just before the closure of the department and there were talks about extending the opening hours. We corroborated this with senior staff who informed us that the maternity directorate was currently looking into extending the working hours within MDAU to see if this would improve patient flow on the labour ward and triage. They were in the process of collecting data related to patients' admissions after 4pm to determine the level of activity that could potentially move to MDAU.
- Maternity outpatient 'Did Not Attend' (DNA) rate was 11% from April 2016 to August 2016, which was higher than the trust standard. There was a decline from September 2016 onwards with 10.3% DNA in January 2017, which was within trust target.
- Hospital initiated outpatient cancellation rate with less than six weeks' notice was an average 4.3% during the same time period. The trust target was less than 8.5%.
- Outpatient appointments made within five working days of receipt was an average 97.7%.
- 91% of pregnant women accessing antenatal care were seen before 10 weeks plus six days excluding later referrals.
- Between June 2016 and March 2017 16% of women that were late referrals were seen after 12 weeks plus six days but before 20 weeks.
- 0.7% of all births at SMH were home births and below the maximum target of 1% set by the clinical commissioning groups. We noted that there were 0% home births in January 2017. We were informed that maternal choice was the main factor driving the number of home births. Imperial College Healthcare NHS Trust (ICHT) offered women choice of place of birth and 17% of women were opting to birth in the trust's home from

home midwifery led unit (MLU) birth centres.

Additionally 40% of women who give birth with ICHT lived outside the community catchment area; therefore, they would book homebirth with their local provider. However, the trust was planning to introduce the 'Birth Place App' later this year to provide evidence based information on place of birth for women and placed a bid to the hospital charity for a new App, which assists women in making a choice of place of birth. The directorate was also updating the online literature on the trust website and commenced rotation of their community midwives into birth centres, with the aim to further increase midwife's confidence in offering home birth. All community midwives were given a day's training in 2015 - 2016 on Home Birth, which included decision making for place of birth and emergencies which may occur in the home setting.

- Half of the fetal medicine unit's work at SMH was perinatal. Additionally, 1660 complex scans had been carried out in 2015.
- The daily escalation meeting at 9:15am was an effective and efficient means of ensuring that all operational managers were aware of the overall position for the next 24 hours including staffing, bed and cot availability, inductions and caesarean sections planned, transitional care and discharges. This was a cross-site meeting and any staffing issues on both sites were highlighted and considered including cross cover of midwives or any potential transfers from Queen Charlotte's and Chelsea Hospital.

Meeting people's individual needs

- We saw that there were effective processes for screening for fetal abnormality in the fetal medicine unit (FMU). We observed a team of fetal medicine doctors and midwives who were supported by administrative staff. The service performed fetal medicine and perinatal medicine scans and post termination pregnancy and specialist pre-pregnancy fetal medicine counselling.
- Specialist midwives supported women with infections such as HIV and hepatitis, women with multiple pregnancies, women with mental health conditions and those who had perinatal loss. Community midwives could refer women to these services. The service also

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had specialist community midwives to support vulnerable women including a specialist midwife for mental health, substance misuse and domestic violence.

- The women we spoke with were generally happy with the standard of the food provided to them. However, one woman commented on the small portion size.
- The perinatal psychiatry service at St Mary's Hospital was a consultant-led service and was part of the psychological medicine (formerly known as liaison psychiatry) team and provided initial assessment, screening and joint management with local community mental health services for women with mental health condition. The team also provided training and supervision to midwives, particularly those managing highly vulnerable women on a one to one basis.
- The maternity services at SMH had a model of care where vulnerable women were looked after by a caseload midwifery team. There were five band 7 midwives in the team and a band 6 rotational midwife. Each midwife would case load 28 women per year including on calls for homebirth. Referral criteria included safeguarding concerns, physical or learning disability, substance or alcohol misuse, sexual abuse, under 16 years old at time of booking and domestic abuse. Vulnerable women were booked by the team who provided all antenatal, labour and postnatal care up to 28 days.
- Visiting times on the antenatal and postnatal ward were 9am to 3pm for one person at the patient bedside and 3pm until 8pm it was open visiting. Partners could visit at any time and this enabled new parents to spend private time with their babies. In general, there were limited facilities for birth partners.
- We spoke with two women who were waiting for an antenatal appointment. They both reported that they were frustrated with the long wait in clinic. The maternity services at St Mary's hospital, rolled out a system where patient were notified to go to a clinic room via an audible and visual message on the TV and this monitors the patient waiting time within the outpatient clinic. During February 2016 – December 2016, waiting time of 2678 patient across antenatal clinic was monitored through this system. Out of these 35% were seen on time, 51% were seen within 20 minutes and 1% were seen over 60 minutes.
- Translation services were provided via telephone interpreter services and from face-to-face interpreters. Midwifery staff reported that translation services were easily available. However, this was not as readily used in the antenatal outpatient clinic and in particular, if women were attending for blood tests. The phlebotomist we spoke with was not aware of how to access the interpreter service.
- We saw various information leaflets were available. However, there was no consistency of the layout or format for those. For example, there was no trust logo on many leaflets, there was no version control, some information leaflet were not in user-friendly format. There was no provision of literature in other languages.
- There was various information displayed on the notice boards within the clinic and wards. However, most of the information was very wordy and dense, imagery was not reflective of workforce or demographics and did not meet the accessible information standards.
- Throughout the maternity service, there was poor signage and navigating to different part of the maternity service. This could potentially be confusing for patients who could not read English. For example, the antenatal clinic was in a separate building with all other outpatient clinics but there was no signage for antenatal clinics, there was no signage to indicate that Aleck Bourne was a maternity ward. There were two separate locations for ultrasounds, one was in antenatal clinic and another was in fetal medicine, staff told us that they get many women who turn up at the incorrect areas for their ultrasound. We spoke to a woman who was looking for the ultrasound department for a 'baby scan'. The appointment letter indicated 'fetal medicine unit' and this was not explained to her.
- The trust had a learning disabilities and autism policy and procedure in place. A 'purple pathway' was developed as a structured approach to support staff in caring for patients with a learning disability/autism in the maternity department. People with a learning disability / autism who choose to have their babies at the trust would be assessed to see what reasonable

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adjustments were necessary. For example, allow more time – double consultation periods, avoid noisy, busy period and offer first or last appointment, work in partnership with the carer and expectant mothers with learning disabilities to be allocated to case load midwives to provide continuity of care throughout the pregnancy and delivery.

Learning from complaints and concerns

- There were 61 formal complaints for the maternity services between April 2016 and January 2016.
- There was a trust complaint's policy and complaints were graded (high, medium or low grades) and dealt within in line with the seriousness of the grading. There was a central complaints and service improvement team responsible for dealing with all complaints responses in line with trust policy. If a woman or relative wanted to make informal complaints, they were directed to the midwife or nurse in charge. Staff told us that mostly complaints were dealt with "in house". Data submitted to us showed that 100% of complaints were responded within the timeframe with the exception in August 2016 when this was 87.5% and below trust standard of responding to 95% of complaints within timeframe.
- Senior staff told us that a weekly complaint's tracker was sent to all directorates from the central team and this helped in timely completion of formal complaints responses and the process was managed tightly. We saw the complaint tracker for the week and there were only two complaints for maternity that were due next week and both were within trust timescale. We saw evidence of four complaints response letters that were detailed and offered apologies to the complainant.
- There was limited information available on the wards for women and their relatives about how to make a complaint and how to access the Patient Advice and Liaison Service (PALS). Reception staff told us that PALS leaflets were usually given out at the booking. There were no PALS leaflets and posters available in most wards, we saw a quality and safety board on postnatal ward stating 'to talk to a member of staff or manager if patients had any concerns about their care' but there was no information about PALS. Most women and

relatives we spoke with were not aware of how to raise concerns or make a complaint; but they all said that they would be comfortable to speak with their midwife or matron if they had any concerns.

- Staff at all levels were able to give examples of recent informal and formal complaints. Staff told us that findings from complaints were shared via email and in handovers or meetings. We saw evidence of the quarterly complaints report which highlighted "you said we did" where complaints had resulted in change but when we asked staff, junior clinical staff were less familiar with any learning or changes due to a complaint.

Are Maternity (inpatient services) well-led?

Requires improvement 

We rated well-led as requires improvement because:

- There was a perceived lack of visibility of the executive team and senior management team in clinical areas such as wards.
- Not all staff were aware of the directorate vision and strategy.
- Though there was positive working culture not all staff felt supported by their senior management staff.
- A recent serious incident identified weakness within the directorate governance structure and they had requested an external review of their clinical governance structure.
- Not all risks identified by us were on the maternity service's risk register.
- Divisional leadership team did not had the oversight of all the problems within the maternity services at St. Mary's site.

However:

- Junior clinical staff were clear of their line of supervision.
- There were systems and processes in place to manage current and future performance.

Maternity (inpatient services)

- Information and analysis were used to identify opportunities to drive improvements in care.
- There was focus on continuous learning and improvement at all levels.

Leadership of service

- Oversight of the maternity service was in the form of a triumvirate; general manager, clinical director and head of midwifery. The general manager and clinical director reported to the divisional director and head of midwifery reported to divisional director of nursing.
- A named consultant and a matron managed each of the clinical areas, including: antenatal ward, labour ward, MDAU, birth centre and postnatal ward.
- During interviews with the divisional leadership team we found that they did not have the oversight of all problems within the maternity services. For example, they were not aware of all maternity risks for St Mary's site on the divisional risk register, the divisional director was not aware of when the first external midwifery review into a serious incident was authorised and it was not escalated to divisional level at initial stage.
- We were told 'Back to the floor Fridays' were introduced a few years ago, where clinical staff in management roles would go back to the clinical environment to support clinical staff. However, one senior staff member told us that although they were in their clinical uniform on Fridays, at times they might not get the opportunity to go into clinical areas and remain in the office all day to carry out managerial duties.
- The junior doctors we spoke with were clear about their lines of supervision. They told us consultants were supportive.
- We observed good leadership skills during handovers. There was clear communication with junior staff and midwives regarding their roles and responsibilities for the shift. Staff felt matrons and consultants were approachable and they could discuss any issues with them.
- Many of the clinical staff we spoke with, including midwives, midwifery assistants and doctors told us that the senior leadership team and in particular the hospital executive team were not visible 'on the floor'. Some reported they had never seen the medical director or

chief executive officer (CEO) on the ward. One staff member told us they had seen the executive team only on television. One junior staff member was not aware who the head of midwifery was.

Vision and strategy for this service

- There was a trust clinical strategy 2014-2020 and all senior leadership staff we spoke with were aware of this and how it linked with departmental strategies, associated challenges and plans.
- The divisional director informed us that the long term strategy was to create a tertiary maternity centre at St Mary's and to consolidate some of the services from their sister hospital and development of a paediatric surgical service, which was currently provided by a neighbouring NHS trust. However, not all staff we spoke with were aware of this long-term plan and vision.
- Evidence of the local strategy plan submitted to us showed key work streams linked to the trust clinical strategy. This included an outpatient redesign project, processes developed to increase cross-site transfer of patients to manage capacity at QCCCH, and an action plan to reduce emergency C-section rates. As part of the North West London maternity network the hospital was an early adopter of continuity of carer following the publication of national maternity review 'Better Births – improving outcomes of maternity services in England' and was actively involved in this two year project which commenced in January 2017.

Governance, risk management and quality measurement

- As a result of a serious incident (SI), which identified weaknesses within the directorate governance structure, the directorate commissioned an external midwifery-led review. However, the review was withdrawn before publication of the final report.
- Senior leadership told us that they were conducting an internal review of its SI process and had also requested an external review by the Royal College of Obstetrician and Gynaecology to review their clinical governance arrangements. At the time of inspection the terms of reference for this external review were being agreed. However, the senior leadership team informed us that there were systematic errors in communication with the family involved in the SI and since the incident they had

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changed their SI reporting structure. The initial letter to inform the family about the initiation of the investigation and the final investigation report were now signed off by the Medical Director (MD).

- The directorate also identified that previously there was no formal system to request an external review, the request was not escalated to the most senior level, the scope was limited to maternity care only and maternity service did not engage with parents in agreeing the term of reference. The divisional director told us they have learned from this SI and implemented a formal process for requesting an external review.
- Staff were able to tell us about the department governance arrangements and which individuals had key lead roles and responsibilities within the department. They were clear of their own individual roles and responsibilities and where to access information from when needed.
- There were monthly divisional quality and safety meetings, monthly risk management meetings and weekly cross-site critical review meeting with staff based at QCCH. We noted from the minutes of these meetings that complaints, incidents and emerging risk were discussed, evaluated, and monitored.
- A number of clinical audits were undertaken regularly in the maternity service, which provided assurance that delivery of services were in line with local and national guidelines. The department undertook monthly audits of its compliance with quality indicators; however current assurance results were not displayed on quality and safety boards, including no feedback results from patients and visitors were displayed.
- We looked at the divisional and directorate risk register for the maternity directorate. The risk register was a joint register with Queen Charlotte's and Chelsea Hospital and there were nine risks recorded on the directorate register. Each risk had a grading depending on the severity of the risk. There were details of the lead person responsible, actions taken to mitigate the risks and progress was recorded, demonstrating active management of identified risks. All risks graded above 12 (high risk and high impact/likelihood) would feed into the divisional risk register to be escalated to senior staff in the division. We saw evidence that there were five maternity risks on the divisional risk register and

these included risks related to full establishment of the sonography staff within the maternity ultrasound department and insufficient functioning CTG monitoring equipment. The directorate level leadership team was able to tell us key risks on their risk register and how those risks been mitigated. However, not all risk identified by us were on their risk register. For example, low compliance with mandatory training, lack of dedicated scrub nurse for second theatre list and lack of signage for the department was not on their risk register.

Culture within the service

- We found there was a good team spirit within the maternity service and staff felt their contribution was valued, which meant morale in the department was high.
- We noted a positive team spirit in the birthing centre. However, some midwives felt that there was a division between labour ward and postnatal ward and there was "cliquey" behaviour on the labour ward. We asked the divisional team about this and they were not aware of details, but knew that similar concerns were raised in the past and those were handled and resolved by the directorate leadership team. We were told these concerns would be investigated.
- Junior doctors felt well supported in their training and supervision. We saw that the medical team worked well together, with consultants being available for junior doctors to discuss patients and give advice. However, one midwife said "senior staff on labour ward are not very helpful". Another member of staff told us "they don't feel supported by their senior staff". One junior doctor told us, "consultants body a difficult bunch to manage and there was not always cohesion over what should be done clinically". However, these comments were not reflective of most of the feedback we received.
- Consultants and junior doctors we spoke with enjoyed working at the trust.
- St. Mary's Hospital (SMH) merged with Queen Charlotte's and Chelsea Hospital (QCCH) in 2008. Consultants told us that there were still remnants of an "us and them" culture. They tried to develop more collaborative working across sites but there was some anxiety from QCCH consultants about the long term strategy to make SMH the tertiary site as this would transfer more activity at SMH.

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- We noted, staff within the neonatal unit were proud of the team dynamics and the willingness to change and develop their service, to meet changing demands.
- All staff we spoke with were passionate about providing empathetic care. Staff told us they enjoyed working in the department.

Staff and public engagement

- The local Maternity Service Liaison Committee (MSLC) focus groups were organised with involvement of the management and team of supervisors of midwives.
- The trust had a patient and public involvement (PPI) strategy for 2016-2017. The trust board ratified this strategy to enable more effective patient and public involvement. The PPI strategy included the development of a strategic lay forum with twelve lay representatives from various backgrounds and experience, to support staff to deliver quality improvement projects with support from public stakeholders.
- There were monthly staff newsletters from the directorate leadership team that explained the corporate and directorate happenings of the hospital and the budget.
- There was a bi-monthly newsletter called 'Risky Business' available on the intranet and circulated to all staff about learning from incidents. All staff we spoke with referenced this newsletter when we asked them about learning from incidents.
- There was an award initiative for staff called 'make a difference award', where nominations were made by




staff, patients and relatives. Staff received a certificate during the 'make a difference award' ceremony. We saw staff nomination forms on postnatal wards for patient and visitors to complete.

- Staff took part in the annual NHS staff survey 2016. 44% of staff agreed and 18% strongly agreed they would recommend their organisation as a place to work.

Innovation, improvement and sustainability

- Staff were proud to inform that a colleague specialist mental health midwife was awarded 'Rising Star' at the Nursing Times Awards 2016 for her commitment to improving the care of pregnant women and new mums with mental health problems.
- The trust had introduced cervical ripening balloons for induction in women aiming for a vaginal birth after caesarean section to unify practice across whole trust (ICHT).
- The service used pre-printed stickers to obtain informed consent for caesarean sections, which was aimed at improving informed consent and decreasing patient complaints.
- The service had developed risk scores used to predict the preterm delivery of twins.
- The directorate was also working on three quality improvement projects; to improve maternity service for women living in Ealing, improving patient experience of the induction of labour pathway and improving the caesarean section pathway.

Medical care (including older people's care)

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

Information about the service

St Mary's Hospital is an acute general hospital with 154 inpatient beds providing a range of acute medical care services. Medical wards include acute assessment unit (AAU) and other assessment wards, a clinical decisions unit (CDU), care of the elderly wards, general medical wards and specialist wards such as respiratory medicine, gastroenterology and endocrinology. The hospital also hosts an endoscopy suite and discharge lounge. This service was last inspected in September 2014, and was rated as requires improvement.

We inspected medical care at St Mary's Hospital for two and a half days and the inspection was unannounced. During our inspection, we visited all the medical wards under The Medicine and Integrated Care Division at St Mary's Hospital (excluding wards covered under different core services such as surgery, cancer, and cardiovascular). This included the medical assessment or short stay units (Acute Assessment Unit, Clinical Decisions Unit, and Joseph Toynbee) older person's wards (Lewis Lloyd and Witherow), respiratory wards (Manvers and Rodney Porter), endocrinology ward (Thistlewayte), Hepatology ward (Samuel Lane), general medical ward (Almoth wright), the endoscopy suite, and the discharge lounge.

We spoke with 17 patients including their family members and carers. We spoke with 56 staff members including consultants, middle grade and junior doctors, nurses and healthcare assistants, specialist nurses, student nurses, clinical practice educators, directorate leads, senior managers, pharmacists, discharge team,

learning disabilities team, psychiatric liaison service, dementia team, therapists and other support staff, such as domestics and catering staff. We reviewed patient and medication records and observed care being delivered on the wards. We observed interactions between patients and staff, considered the environments and looked at 25 care records. We also observed staff handovers, board rounds and other multidisciplinary meetings on the wards. To support the information provided by staff during the inspection, we reviewed documentation and computer based information on the wards including policies, risk assessments and the trust intranet.

Medical care (including older people's care)

Summary of findings

We rated this service as requires improvement because:

- Staff on medical wards were not meeting the trust targets for almost all modules of mandatory training, including safeguarding, resuscitation, and infection prevention and control.
- Medical wards were not meeting targets for MRSA screening set by the trust.
- There was significant nursing vacancies within medical wards at St. Mary's Hospital, which were consistently covered with bank and agency staff.
- We noted that a number of medications checked on the medical wards had passed their expiry date, and some wards were not following the trust policy on refrigerator temperatures.
- Staff we spoke with stated that security could be slow to respond to incidents, and there were concerns this could result in staff being more exposed to aggressive or threatening patients.
- We found some inconsistency amongst nursing staff and junior medical staff in their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Medical services at St Mary's Hospital did not meet the NHS England national indicator for 18 weeks referral to treatment (RTT) times.
- Staff we spoke with stated that discharge forms from the wards could at times be inconsistent or incomplete, and this could delay patients discharge from the discharge lounge.
- Data provided by the trust show patients being discharged out of hours between 22:00 and 07:00, suggesting patients being moved out of the hospital at unsociable hours.
- The hospital signage was not up to date and does not provide patients or visitors with information how to access the wards.

However:

- There were systems in place for staff to report incidents, and for incidents to be discussed in clinical governance meetings.
- Staff we spoke with stated the electronic records system was accessible, and that they had received training in use of the system as part of their induction.
- We reviewed trust policies on delivering clinical care throughout medical wards and found them to be in date and in line with best practice guidelines.
- Local and national audits were used to benchmark care, treatment and practice against guidance established by a range of organisations that represented best practice.
- Patients we spoke with were very positive about their experiences on the medical wards, particularly regarding their interactions with staff. We observed positive interactions between staff and patients throughout the medical wards we visited.
- There were measures in place to manage patients being cared for on wards outside of the specialty for which they were admitted. The hospital also had systems in place to increase capacity to meet the needs of the local population during winter pressures.
- The introduction of complaints investigators had much improved response times and the quality of investigations for complaints.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement 

We rated safe as requires improvement because:

- We noted that a number of medications checked on the medical wards had passed their expiry date, and some wards were not following the trust policy on refrigerator temperatures.
- Staff we spoke with stated that security could be slow to respond to incidents, and there were concerns this could result in staff being more exposed to aggressive or threatening patients.
- In three of the medicines rooms on-site we noted that either the door to the medicines room was either unlocked or currently broken and awaiting repair, or had refrigerators unlocked. This presented a risk of unauthorised access to medications.
- Staff on medical wards were not meeting the trust targets for almost all modules of mandatory training, including resuscitation, fire safety, and infection prevention and control.
- Medical wards across St Mary's Hospital did not meet the trust targets for staff training in safeguarding adults.
- Not all staff we spoke with were able to demonstrate an understanding of the principles of duty of candour.
- There was significant nursing vacancies within medical wards at St. Mary's Hospital, which were consistently covered with bank and agency staff.
- Medical wards were not meeting targets for MRSA screening set by the trust.

However:

- There were systems in place for staff to report incidents, and for incidents to be discussed in clinical governance meetings.
- We observed positive attitudes from all staff towards hand hygiene and compliance with the trust policies on infection control.

- Staff we spoke with stated the electronic records system was accessible, and that they had received training in use of the system as part of their induction.
- The trust had a major incident plan in the event of a major event or catastrophe, as well as a business continuity policy in the event of services being temporarily closed.

Incidents

- Between March 2016 and February 2017 there were no never events in medical care services. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- During this same period, the trust reported 46 serious incidents across medical services. The serious incidents included pressure ulcers (13), hospital acquired infections (8), slips, trips and falls (13) and hospital acquired infection or infection control incidents (8).
- The trust provided data on all incidents at St Mary's Hospital in medical services during the same reporting period. From the 1,314 incidents reported, 16 resulted in moderate harm to the patient. These incidents related to pressure ulcers (4), slips, trips and falls (5), sub-optimal care of deteriorating patient (2), manual handling injuries (2), delayed resuscitation (1), delayed diagnosis (1), and wrong patient (1). The number of incidents at St Mary's Hospital was significantly higher than at other trust hospital sites.
- Incidents were reported through an electronic reporting system and staff we spoke with stated they received training in how to correctly identify and report incidents as part of their induction. Staff were also able to give examples of incidents they had reported and demonstrated an understanding of when incidents needed to be escalated.
- A senior manager or lead investigated the circumstances of each incident and developed actions plans to address risks or concerns where necessary. The lead investigator for the incident would interview

Medical care (including older people's care)

- staff and review any available evidence before reaching a decision on any actions. We reviewed a number of investigations and root cause analysis following incidents and found them to be robust
- Staff informed us they would be informed about outcomes from incidents either in supervision with their managers, in team meetings, or via email. However some staff stated that they did not always hear back about incidents that they had reported, and did not know if there had been any outcomes. Senior leaders for the division we spoke with recognised that informing staff of outcomes from incidents they reported was an area the directorate would like to improve their performance.
 - We saw that incidents were discussed at monthly divisional clinical governance meetings, in daily multidisciplinary team (MDT) meetings, and in the trust Medicine and Integrated Care Division 'messages of the week' sent to all staff. Managers attended divisional clinical governance meetings and disseminated learning or outcomes from incidents to their teams; however as the frequency of team meetings varied across wards, this meant some staff received more regular feedback than others.
 - Medical staff held monthly mortality and morbidity meetings, led by the medical director, to discuss any patient deaths occurring on-site within the directorate. Medical services had a mortality lead who reviewed any patient death and monitored monthly compliance of reporting mortalities. We reviewed minutes of mortality and morbidity meetings from the last six months and found patient deaths were routinely discussed, and any action points or outcomes were identified.
 - Not all staff we spoke with were able to demonstrate an understanding of the principles of duty of candour. The duty of candour is a regulatory duty that rates openness and transparency and requires providers of health and social services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Some staff were not sure of the principles of duty of candour, however did say that they had received training on duty of candour as part of their mandatory training.
 - The division had measures in place to ensure duty of candour principles were followed when an incident occurred. We observed investigations of incidents and found the duty of candour to patients or their families had been addressed, and the trust had a policy on duty of candour to ensure the process was consistently followed.
- ## Safety thermometer
- The NHS Safety Thermometer is an improvement tool to measure patient harm and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheters and associated urinary tract infections (UTIs). Medical services collected and audited Safety Thermometer data on a monthly basis and the results were made available to ward managers. We saw evidence in patient records that VTE was assessed in line with NICE guidance.
 - Between February 2016 and February 2017 medical wards at St Mary's Hospital reported to the Patient Safety Thermometer: 25 pressure ulcers (grades 2, 3 and 4), 9 falls with harm and 21 catheter acquired urinary tract infections.
 - We saw that quality metrics pressure ulcers, falls, VTE and UTIs was displayed on the safety noticeboards on the wards visited. This meant patient, relatives and visitors could identify how well the ward was performing in relation to significant patient safety indicators. However it was not consistently up to date across all medical wards.
- ## Cleanliness, infection control and hygiene
- Hand sanitising gel dispensers were visible at the entrance to all wards and clinical areas. We noted that three alcohol dispensers were empty during our inspection at the entrance to wards. We informed staff about this at the time, however noted that one of the dispensers at the acute medical unit had not been replaced when we checked the next day.
 - Staff in the Medicine and Integrated Care Division at St Mary's Hospital were not meeting the trust targets for

Medical care (including older people's care)

- training in Infection Prevention and Control. Clinical staff had an overall compliance rate of 75%, with 44% of administrative staff compliant, against a trust target of 90%.
- We observed positive attitudes from all staff towards hand hygiene and compliance with the trust policy on “bare below the elbows” in clinical areas. Monthly hand hygiene and ‘bare below the elbow’ audits conducted by the infection control team show most medical wards with 100% compliance between April 2016 and February 2017. The lowest performing medical ward was the acute medical unit, which varied between 91% and 100% in the last twelve months.
 - From April 2016 to March 2017 the trust medical and integrated division reported 10 cases of *Clostridium Difficile* (C.diff) incidents which was higher than the England average, with no incidents of methicillin-resistant staphylococcus aureus (MRSA). Medical wards also had consistently poor performance in MRSA screening compared to the overall hospital average (90-95%) between September 2016 and February 2017 (between 71-85%). We saw evidence C.diff and MRSA screening were discussed at the clinical governance meetings.
 - We observed that personal protective equipment (PPE) such as aprons and gloves was available in clinical areas and that staff used this appropriately. Staff also took necessary measures to correctly dispose of waste in the correct bins and use sharps containers to dispose of needles.
 - The trust had a number of policies relating to the infection prevention and control which followed current best practice guidelines. Staff informed us that Infection Prevention and Control (IPC) nurses also visited the medical wards regularly and were available to provide advice if needed.
 - The trust displayed information on cleaning and hand hygiene audits, last incidents of MRSA, and information on hand hygiene practices on patient information boards on all wards.
 - The Endoscopy suite followed national guidance on the management and decontamination of flexible endoscopes, and was meeting JAG accreditation standards relating to equipment decontamination.
 - Staff identified equipment which had been recently cleaned with green ‘I am clean’ stickers. We checked the dates on cleaned equipment throughout medical wards and found them to be in date.
 - Each medical ward and the endoscopy unit had side rooms available, which could be used to care for patients with an infectious condition. Patients with suspected or confirmed tuberculosis were cared for in negative pressure rooms. This prevented the condition spreading to other patients.
 - The trust contracted an external organisation to provide housekeeping services on medical wards. Staff we spoke with stated they were satisfied with the quality of the cleaning, but said that it can be difficult to get the wards cleaned in a timely way, as the external organisation seems understaffed. Staff stated that a manager for the external organisation visited wards weekly to make sure standards were being maintained, and staff conducted monthly cleaning audits to monitor performance.
 - Patient Led Assessments of Clinical Environments (PLACE) in 2016 rated cleanliness on four medical wards at St Mary's Hospital between 97% and 100%.
 - All of the clinical areas we visited were visibly clean and tidy, and sluice rooms were well-maintained. However some of the cleaning cupboards and bathrooms, particularly on Thistlewayte ward which was partially under refurbishment, were untidy and cluttered. A number of macerators, equipment which is used to deep clean commodes, were also out of order and this made it more difficult for staff to effectively clean commodes which was more of an infection control risk.

Environment and equipment

- Maintenance support was available from an on-site hospital team in the event of equipment breaking down on the wards or repairs needed to the ward environment. Staff we spoke with stated it was quick and efficient to organise repairs when needed. Although staff noted that the macerators had been out of order for some time, staff stated this was due to repairs for this equipment being subcontracted to the manufacturer.

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- Electrical equipment was regularly checked by the maintenance team, and staff stated equipment could be checked quickly if electrical safety testing was found to have expired. We checked electrical safety testing on equipment throughout medical wards and found testing to be in date.
- Each ward manager was responsible for the ordering and monitoring of stock. Managers we spoke with stated the system for ordering new equipment and disposables was efficient and responsive if something was needed urgently.
- Each medical ward had access to resuscitation equipment with emergency drugs, oxygen and an echocardiogram machine. We observed evidence on crash trolleys that daily checks were completed to ensure all equipment was accounted for and ready for use.
- Some of the medical wards had a lack of storage for available equipment, and this could frequently be seen to clutter up space in corridors. Staff we spoke with were aware of the lack of additional space for equipment, but as they were constrained by the building environment there was limited capacity for storage. This was particularly noticeable on Thistlewayte Ward, which was under refurbishment and had lost some storage space. This clutter in corridors could prevent problems with safe evacuation from the wards in event of fire or major incidents on the ward
- Staff we spoke with stated that the computer on wheels trolleys were useful to remotely write up notes while also seeing patients. Staff also stated that the IT facility from the trust was rapid in responding when computers stopped working or needed repairs.
- Fire awareness, health and safety training formed part of the staff mandatory training programme and was normally completed on induction. Staff also received information fire safety procedures when they started employment with the trust. Fire alarms were checked weekly on the medical wards and we noted that fire extinguishers had been checked and were in date.
- The trust had environmental security procedures in place to protect patients and staff. For example, entry

to medical wards was limited by swipe cards and key codes at the entrances. We observed staff requesting inspectors to identify themselves prior to gaining access to the wards.

- The hospital had an infection control policy, which included safe disposal of waste and cleaning and control of the environment. This policy was available to staff on the intranet.

Medicines

- We visited the treatment rooms, storage rooms and medicine preparation areas in all medical care services. Some of the treatment rooms were cluttered and did not have organised storage of medicines. In three of the medicines rooms on-site we noted that either the door to the medicines room was either unlocked or currently broken and awaiting repair, or had refrigerators unlocked. This presented a risk of unauthorised access to medications.
- We noted that a number of medications checked on the medical wards had passed their expiry date by between 6-18 months on Manvers Ward, Thistlewaite Ward, and Grafton Ward. Medications past their expiry date may not work as intended and present a risk to patient safety. Pharmacy staff stated that it was the responsibility of the lead on each ward for topping up medicines stocks to check for expired medication, as some medications were delivered directly to the wards.
- The trust policy on refrigerated medicines stated that temperatures should be between two and eight degrees. We checked a number of fridges on medical wards and found some on occasion to be as high as 12 degrees, with no action taken to address this. Pharmacy staff we spoke with stated that the policy had been changed in 2016 to include a temperature range of two to eight degrees, and this was evidence that the policy were not being adequately adhered to. Although the pharmacy team completed refrigerator audits every 6 months, this suggests audits were not identifying the issues.
- A registered nurse was responsible for the keys to the drug cupboards and lockers and the doors to the room housing medicines were locked. Drug trolleys were secured or immobilised when not in use.

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- Wards had access to direct pharmacy support Monday to Friday between 9am and 7pm, and for five hours on Saturday and Sunday. Pharmacists were responsible for screening drug charts, medicines reconciliation (ensuring the medicines a patient is taking are correct and appropriate), ordering of drugs and ordering discharge medicines for patients. Pharmacy support was also available between 9am and 1pm on Saturday and Sunday, with the on-call pharmacy available for support out of these hours.
- The trust completed an audit of medicines reconciliation in December 2016. This showed that 50% of patients had their medicines reconciliation completed within the required time frame. A further 29% of patients had had their medicines reconciliation started but not fully completed at the time of audit. The trust had not stated what would have been an acceptable compliance rate, however stated that they are currently reviewing the audit process and how to improve the e-prescribing functionality to improve medicines reconciliation.
- Pharmacists clinically screened discharge prescriptions. For patients who required compliance aids the pharmacy team assessed patients could use these aids. On-site pharmacy also liaised with the community pharmacy to ensure timely supply of further compliance aids (e.g. medication boxes) or prescriptions. The pharmacy team intervened in 60% of discharge prescriptions, which provided monitoring to the quality of medication available to patients on discharge.
- Medical wards had good procedures in place for monitoring controlled drugs (CDs) on the ward. Ward staff conducted random stock checks to ensure CD balances were correct, and two nurses were required to sign out any CDs for administration. We checked recording of CD administration and found staff had consistently signed out CDs for patient use. However, the documentation did not allow clear recording of stock checks or administration from patient own CDs, and managers were unable to account for the storage of patients own CDs effectively.
- The trust had a good structure of medicine governance and safety meetings. Incidents relating to medicines were regularly reviewed in the monthly medicines safety group and quality of performance addressed in a number of other regular committees. We saw minutes from these meetings in the last six months and saw incidents being addressed and action plans to address concerns being discussed.
- There were local microbiology protocols for the administration of antibiotics and prescribers using them. We observed a trust policy for the administration of antibiotics and there was an antimicrobial review group which met monthly.
- The hospital reported 160 medicine incidents for the period of January 2016 to March 2017 across the medical wards. We saw that the incidents were mostly on the acute medical unit, clinical decisions unit (Joseph Toynbee) and the respiratory ward (Manvers). The reason for the medical incidents included but were not limited to delayed medication (26), omitted medicine (20), wrong dose (9), wrong drug (14) and wrong patient (5).

Records

- The trust used an electronic records system to record patients' information, supplemented by paper records for some risk assessments. Staff we spoke with felt the system was accessible, and said they had received training in use of the system as part of their induction. Medical wards had also introduced Care Compass the week of our inspection, a program for flagging and responding to patient risks. Staff stated that this new system would help to identify at risk patients more quickly and support quicker action on risk.
- Staff accessed the electronic system using a smart card access and individual nurses completed their patient record which was trackable. We saw that staff stored records securely when electronic records were not in use or staff logged off their computer. Senior staff provided training and supervision for agency until they were confident using the system independently and then given their own password.

Safeguarding

- Staff we spoke with stated they knew how to access the safeguarding team and social workers, and were able to demonstrate the procedure for accessing support. Staff could access the safeguarding policy through the trust intranet and felt the safeguarding

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process in place met the needs of the trust. Staff also demonstrated a good understanding of when they would need to make a safeguarding referral to protect patients.

- The trust had a policy in place to regarding the safety and welfare of women or children who have suffered or may be at risk of suffering Female Genital Mutilation (FGM).
- Medical wards across St Mary's Hospital did not meet the trust targets for staff training in safeguarding adults. Overall, 80% of clinical staff had received safeguarding level two training, against a trust target of 90%. 44% of administration and clerical staff had completed safeguarding level one, against the same trust target. Staff on medical wards did not meet targets for safeguarding children training. Similarly, 78% of clinical staff had completed safeguarding level two training, while 44% of administration staff completed safeguarding children level one. Senior managers for the trust stated that there had been turnover in the safeguarding team, and this had impacted on being able to run courses. The trust did not have an action plan in place for improving training rates
- Senior staff at the trust recognised that the adult safeguarding team was stretched in terms of vacancies. To address this the trust planned to pull both the adult safeguarding team and children's safeguarding team into one, and the trust had also appointed a safeguarding nurse consultant to provide additional expertise and support to the new team. Staff we spoke with were able to identify signs and symptoms of abuse when asked.
- The hospital had an alerting system which helped staff to identify vulnerable adults in the hospital and access support from the safeguarding team if needed. Staff told us that the accident and emergency department identified most of the safeguarding concerns, which were later updated on the wards. Staff stated that social workers provided any necessary support in linking to the social services and contact details for the safeguarding team and social service was available on the electronic system when needed.
- Referrals pathways from the medical wards to clinical nurse specialists was embedded in the electronic

system, which streamlined access and reduced waiting times. Staff stated if they wished to contact a clinical nurse specialist, such as a tissues viability nurse, this could be done through the electronic records system. Clinical staff were also able to order and access tests and results through the Electronic Patient Record (EPR).

- Information Governance formed part of the staff induction and mandatory training updated annually. 65% of staff on medical wards at St Mary's Hospital had completed Information Governance training, against a trust target of 90%. Information Governance for doctors and for nurses was at 48% 69% respectively against a target of 90%. The trust did not have an action plan in place to address this.
- We reviewed 25 sets of patient records on medical wards at St Mary's Hospital. Case notes for patients were well recorded, with general completion of risk assessments and care plan including tissue viability, nutrition, early warning scores, body maps, VTE assessments, and allergies. Staff documentation on patients' records were legible and written in accordance with the NMC record keeping guidance. Records also included notes of conversation with patients and family members.

Mandatory training

- Mandatory training topics were established by the trust and each clinical area managed this in line with staffing levels. The trust had a 90% target for up to date training and included modules such as infection control, equality and diversity, fire safety and moving and handling.
- Medical wards were not meeting compliance for safeguarding, information governance, conflict resolution (81%), equality and diversity (87%), fire safety in clinical and high risk areas (64%), health and safety (80%), Infection Prevention and Control Level 2 (75%), moving and handling (87%) and required areas of resuscitation. Staff on medical wards at St Mary's Hospital only achieved the trust target in Fire Safety Awareness (94%). This suggests significant gaps in learning of staff across a number of areas which could impact on patient safety. The trust did not have an action plan in place for improving training rates

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- The trust used a mix of classroom based and online training modules to provide mandatory training. Staff could access the mandatory training software through the trust intranet and would be able to identify which training was due for completion. Managers received notifications when a staff member's training had not been completed by the system, and could then discuss this with staff. A deputy director of nursing also monitored performance. Staff demonstrated to us how to use the mandatory training system and stated it was accessible and easy to use.
- Locum and bank or agency staff were required to complete a competency checklist of their mandatory training compliance before being cleared to work on the medical wards.

Assessing and responding to patient risk

- Resuscitation and basic life support training formed part of the trust's mandatory training provision and had a 90% minimum completion rate for each team. However, staff on medical wards at St Mary's Hospital were not meeting these trust targets. Of qualified nursing staff requiring resuscitation level three, 71% of staff had completed the training. For staff requiring resuscitation level two, 78% of staff had completed the training, including 58% of doctors in training. Lack of resuscitation training could present risks for deteriorating patients. The trust did not have an action plan in place to address this.
- Staff used the national early warning scores (NEWS) systems to identify patients who were at risk of deteriorating. Where patients were identified to be a significant risk following assessment (a NEWS score of seven or more), the critical care outreach team was contacted and a bed would be arranged with support from the site nurse practitioner. The introduction of the Care Compass also provided staff with a guide on what steps they need to take to best manage the needs of a deteriorating patient. Monitoring of NEWS scores also allowed staff to identify patients with sepsis, who then used the sepsis pathway to address patient needs. We saw effective monitoring, calculating, and recording of NEWS scorings in patient records.
- Staff told us they used the Situation-Background-Assessment-Recommendation

(SBAR) framework to support their conversation when escalating concerns about a patient clinical condition or deterioration, and this was supported by evidence in patient records. Staff said they found this framework useful in identifying the kind of information they discuss with the critical care outreach team.

- Staff completed a number of risk assessments in key safety areas using national validated tools for all patients shortly after their admission on the ward. Staff told us patients received skin and pressure areas assessments immediately when admitted on the wards. The risk assessments included falls, manual handling, nutrition risk assessments, infections, allergies, cannula and tissue viability. We observed in patient records that risks assessments were updated regularly with appropriate risk management actions.
- Staff responsible for the process of admitting patients to wards prioritised patients based on clinical risk, and modified their working patterns to ensure patients were seen appropriately and prioritised for beds when needed. Multidisciplinary bed meetings were held several times a day to discuss the needs of patients and how best to effectively manage the risk on the wards. Staff we spoke with stated that patients transferred onto medical wards were generally transferred with risks assessments completed.
- The trust had a number of procedural policies in place to support the effective monitoring of patients on the ward, and transfer of patients to other areas of acute care when needed. This included best practice guidelines on observations, transfer policies, and management of deteriorating patients.
- Staff we spoke with stated that security could be slow to respond to incidents, and there were concerns this could result in staff being more exposed to aggressive or threatening patients. Staff told us of an incident where a patient on the acute assessment unit had recently been verbally aggressive towards staff and destroyed some equipment while disorientated. Staff had pressed the alarm for security but felt they did not receive a prompt response and felt they would be at risk in similar situations in the future.

Nursing staffing

- The hospital used the Shelford Group Safer Nursing Care tool to establish the minimum staffing

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requirements in inpatient areas based on patient acuity. Senior nursing staff monitored nurse to patient ratios against established criteria on a monthly basis. The nurse in charge decides acuity and dependency of patients on the ward at the end of each shift using this tool. Any additional patient needs are identified and additional nursing staff may be required to meet specialist needs, for example mental health nurses for mental health patient. Daily staffing coverage was displayed on whiteboards of each ward.

- The vacancy rate across medical wards at St Mary's Hospital as of February 2017 for staff was 16% which is similar to the London average of 17%, however compared favourably to other medical sites in the trust. The voluntary turnover rate for December 2016 was 14% which was worse compared to the England average of 10%. Senior staff we spoke with stated the service had a robust rolling recruitment program to address gaps in nursing staff on wards, however there was still consistent use of bank and agency staff in some areas. The trust submitted data for the December 2016 for the Medicine and Integrated Care Division, which showed 12.8% use of bank and agency staff.
- As of January 2017, the hospital's medical divisions reported a 5% staff sickness absence which was worse than the England average (3.1%). Overall staff sickness rate (4%) was also worse than the England average for November 2015 to October 2016, however the Medicine and Integrated Care Divisions at other trust hospital sites compared favourably to medical wards at St Mary's Hospital.
- Frontline staff and senior nurses we spoke with stated they mostly used regular staff when bank or agency nurses were needed to cover shifts. We saw that bank and agency staff had local inductions and orientation sheets so that they could familiarise themselves with the ward quickly. Staff were able to source regular bank staff if needed to fill shifts, however if agency staff were required this had to be signed off by the Divisional Director of Nursing.
- We saw that for the period of January 2017 across the medical wards, the day shifts were covered with 95% of HCAs and 95% of registered nurses, while the night shifts for the same period were covered by 97% of registered nurses and 96% of HCAs. Staff we spoke

with stated that it can feel stretched on the ward at times to meet the needs of the patients. For example, the acute medical unit had a nurse to patient ratio of 1:4 during the day shift and 1:6 at night, but also delivered care for some complex patients, some requiring 1:1 nursing care. The trust informed us that 1:1 care was provided by an additional nurse or healthcare assistant. Senior leaders we spoke with stated they were in the process of reviewing their nursing establishment.

- Wards were generally staffed with 70% registered nurses and 30% Healthcare Assistants (30%)
- Mentors supported student nurses in their roles and student nurses received a full induction by the trust. Student nurses we spoke with stated that although the role was busy, they felt they could get time with mentors if needed, and did not feel pressured into taking on work they were not qualified to deliver.
- We observed handovers on the ward both in the morning and in the evening. The nurse in charge led the handovers and communication was facilitated with print-outs from the electronic records systems to discuss patients. The handover included discussion of preparing patients for discharge and any needs they may have in relation to medication, social worker, or transport. The nurse in charge also reviewed the staffing mix on the ward in relation to the bed management meetings.
- A team of practice development nurses were available on-site between 9am and 5pm, Monday to Friday and provided on-demand support for staff as well as scheduled drop-in training sessions.
- We observed on all the medical wards visited that the numbers of staff planned and actually on duty were displayed at ward entrance in line with guidance contained in the Department of Health Document 'Hard Choices'.

Medical staffing

- The medical staff on medical wards included consultants, specialist registrars, and foundation level doctors.
- Medical wards at St Mary's Hospital employed 164 Whole Time Equivalent (WTE) doctors in medical care services. The trust submitted their medical staffing

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data for October 2016 for the medical and integrated team. The trust registrar group (50%) was better than the England average (42%). The consultant staffing (33%) was similar to the England average (32%). The junior doctors (10%) was lower than the England average (20%) while the middle grade doctors was 1% which was lower than the England average (6%). This suggested that the trust had more senior doctors than the England average. Junior doctors stated they were supported and patients had access to adequate senior doctors input.

- As of February 2017, medical wards at St Mary's hospital had a vacancy rate of 10%, with a staff turnover rate of 2%. Use of locum medical staff accounted for less than 1% of total hours of whole time equivalent (WTE) work on medical wards. Medical staff we spoke with at the hospital, who stated there was not much use of locum doctors and that medical grades were generally filled, supported this.
- The medical sickness rate for February 2017 was less than 1%, which was better than national average for hospitals (3%).
- Trainee medical staff we spoke with stated they felt clinically supported and well supervised. Junior doctors stated there was two hours of dedicated teaching time each week, as well as involvement in ward rounds and review of discharge summaries, which they felt supported their learning well. Staff we spoke with stated that although the medical wards varied in how busy they were, they would recommend working at the hospital.
- There was consultant cover seven days a week on all medical wards between 8am and 8pm. Consultants provided an on call service out of hours and at night after 8pm covering all the medical wards, and reviewed any evening patients the following morning. At night a specialty registrar and four junior doctors covered the medical wards. At weekends two consultants, a specialty registrar and junior doctors were on site to see new admissions and seriously ill patients. Junior doctors and registrars supported the consultants and covered seven days through a rota system. Staff we spoke with stated that support from on-call consultants or other medical support was accessible and responsive when needed.

- We observed handovers on medical wards between consultants and other medical staff, as well as ward rounds led by the consultant with junior doctors. Patient needs and arrangements were discussed in detail and information was communicated well. All medical wards had a daily consultant ward rounds Monday to Friday with junior doctor ward teams working alongside the specialist teams.

Major incident awareness and training

- The trust had a major incident plan in the event of a major event or catastrophe, as well as a business continuity policy in the event of services being temporarily closed. The continuity plans had actions in place for staff to refer to in the event of any impact on the delivery of services. Frontline staff demonstrated a good understanding to inspectors of how services would continue to run in the event of an incident impacting the delivery of care. For example, staff on Samuel Lane Ward discussed an incident with us where a water pipe had burst recently, requiring the service to be moved to another ward.
- We saw that staff were compliant with their major incident and business continuity training; staff were all trained between June 2016 and February 2017. All directors and general managers across the trust received training in Emergency Preparedness, Resilience and Response (EPRR). All site nurse practitioners also received EPPR as they work across hospitals. Staff who completed the EPPR course received training to support the service continuity during an incident or event at whichever hospital site.
- Staff took part in a large-scale casualty scenario as part of their training to prepare them on how to manage major incidents. Major incidents plan training were given to security staff and nursing and medical staff as a standard training. There was a non-obligatory drop in session for staff to attend to refresh their skills. Senior leaders also called local borough partners every six months to address potential major incident scenarios.

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Are medical care services effective?

Good



We rated effective as good because:

- We reviewed trust policies on delivering clinical care throughout medical wards and found them to be in date and in line with best practice guidelines.
- Local and national audits were used to benchmark care, treatment and practice against guidance established by a range of organisations that represented best practice.
- The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015) and there was consistent evidence staff followed this in practice.
- Medical wards had good processes in place to monitor and support the nutritional needs of patients.
- Clinical practice educators (CPEs) were available to provide support and advice for staff regarding training opportunities and personal development.

However:

- We found some inconsistency amongst nursing staff and junior medical staff in their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The trust did not complete ward level or trust level audits of pain score assessments, so they could not be assured that pain score assessments were being completed effectively.

Evidence-based care and treatment

- The trust used local and national audits to benchmark care, treatment and practice against guidance established by a range of organisations that represented best practice. This included organisations directly involved in health and social care, such as the National Institute for Health and Care Excellence (NICE), the World Health Organisation and the Health and Care Professions Council.
- We reviewed trust policies on delivering clinical care throughout medical wards and found them to be in

date and in line with best practice guidelines. Policies were reviewed to incorporate up-to-date guidance, and sources for best practice were referenced throughout. Staff we spoke with stated they received notification of any new best practice guidance through the staff intranet and by email. Staff we spoke with provided examples of policies that had been updated recently.

- Medical wards undertook a number of audits to measure quality of performance on the ward. Audits included ward infection prevention and control, patient records and documentation, medication and patient satisfaction amongst others. We observed the outcome of audits were regularly reported in the monthly directorate quality and safety committees.
- The hospital had a process for reviewing clinical guidelines which ensured their current practice reflected relevant national guidelines, policies or research. A policy and guidelines committee reviewed any policies approaching expiry or which needed updating, and involved clinical expertise when required.
- Endoscopy staff used the World Health Organisation (WHO) surgical safety checklist for each procedure, and this was audited monthly with overall compliance at 100% between April 2016 and March 2017. This meant patients received consistent care and treatment to established standards. We looked at five sets of patient records and found staff had fully completed the WHO checklist in each case.
- Staff also provided care in line with some clinical pathways; however, some staff were unsure if there were specific pathways of specialised care for patients. Staff we spoke with were aware of a sepsis pathway which helped staff to recognise deteriorating patient through the NEWS score.
- However some staff on specialist medicine wards we spoke with were unaware of a specific pathway for patients admitted to their wards. This suggested staff were unaware if patients being admitted or discharged to their wards were consistently receiving the same quality of input or assessment as others.

Pain relief

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- The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015) and there was consistent evidence staff followed this in practice.
- Staff we spoke with stated they used a pain assessment tool which rate pain on a scale of one to ten, or a smiley face score for patients with diminished capacity. Staff also stated they would monitor patients with existing-chronic pain and patients who were unable to express their pain level for signs of discomfort or agitation. We saw examples of the pain assessment tool in use in patient records.
- Patients we spoke with stated they felt their pain levels were managed well and staff asked them regularly if they were comfortable. Patients also stated they were given pain medication when needed.
- The trust did not complete ward level or trust level audits of pain score assessments. This meant it was difficult to be assured that pain score assessments were being completed effectively
- An acute and chronic pain relief team was available 24-hours, seven days a week. Staff stated they referred through the electronic records system to this team for support with patient needs, or contacted the team for advice on pain management.

Nutrition and hydration

- Staff we spoke with stated they could access advice and support on patient diets through nutritional specialist care workers. Patients were also referred to dieticians or speech and language therapists (SALT) if they needed assistance with eating and drinking or had swallowing difficulty. If there were concerns about a patient's ability to swallow prior to SALT assessment, staff identified the patient was Nil By Mouth (NBM) until they could be have a swallowing assessment. We saw evidence of this in patient records.
 - We observed staff assisting patients with reduced mobility or dementia assisting in the eating. The trust had developed the Nutritional Support in Hospital (NoSH) Project, aimed to improve nutrition and hydration in patients with dementia whilst in hospital through enhanced nutrition pathways. The NoSH project delivered tiered pathways depending on the patient need including offering pictures of food, assisted eating, monitoring of nutritional assessments, and dementia friendly equipment such as red lunch trays. Staff we spoke with stated the NoSH project provided additional support to patients vulnerable to not getting their nutritional needs met.
- A Patient Led Assessment of the Care Environment (PLACE) evaluated the quality of food on three medical wards at St Mary's Hospital and scored them between 90-96%.
 - Staff assessed and monitored patients' nutritional needs using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition. Nurses completed an admission risk assessment which included the MUST tool to help identify patient at risk of dehydration, poor nutrition or swallowing difficulty. This assessment shows expected actions staff should take following the nutrition assessment scoring and weight recording. During the inspection we saw that staff completed these expected actions.

Patient outcomes

- The trust participated in the 2016 National Diabetes Inpatient Audit. At 20% the trust was above the national average of 17% of NHS trust for inpatient admissions with diabetes. The trust performed significantly worse in audits relating to staff hours for diabetes care, which was below the England average for consultant, dietitian, podiatry, and specialist diabetes pharmacist time. The trust was also in the lowest quartile of NHS trusts in terms of providing a foot assessment within 24 hours of admission or during the patient stay. Patient experience results from the audit also placed the trust in the lowest quartile for timing of meals, and below average for choice of meals. However patient experience suggested the trust was the same as the England average for patients satisfied or very satisfied with their diabetes care.
- The endoscopy unit was accredited by the Joint Advisory Group (JAG) on gastrointestinal endoscopy in January 2017. The JAG Accreditation Scheme is an independent assessment of endoscopy services in the UK, and recognises services that demonstrated it has the competence to deliver care against the Endoscopy Global Rating Scale standards.

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- We noted that the trust was consistently monitoring and improving their mortality rate and remained in the top five lowest-risk acute trust. The trust was the second lowest-risk acute trust in the 2016 Hospital Standards Mortality Ratio (HSMR) and the third lowest-risk acute trust in the Summary Hospital-level Mortality Indicator (SHMI). Staff told us they attended teaching sessions to learn from the death reviews that have taken place in the hospital. The mortality and morbidity meeting were also discussed at the board meeting and the date was compared with the previous months to ensure quality.
- A preliminary audit in December 2016 by the trust of two week wait breaches in time of referral to appointment for cancer waiting times found that all breaches occurred in Endoscopy. The audit stated that although all breaches related to patient choice the trust were not assured that patients were being offered enough choice of dates. The trusts did not have a plan in place to address these concerns.
- In 2014/15 the hospital scored higher than the England average on all standards audited for care of patients with non-ST-elevation infraction (NSTEMI). The Myocardial Ischemia National Audit Project (MINAP) conducted this audit annually. The trust scored 100 % in the number of NSTEMI patients seen by a cardiologist or a member of team and when referred for or had angiography including after discharge. Also, the NSTEMI patient admitted to a cardiac unit or ward was 97% which was better compared to the England average (56%). We saw that the result was also better than the previous year's audit.
- As of March 2017, we were not aware of any instances of CQC outliers within medical wards. CQC Outliers are instances of significant deviation in quality indicators by a service in quality of care from the national average of hospital trusts in England.
- The Division of Medicine and Integrated Care at St Mary's Hospital provided data on length of stay for patients. Between April 2016 and January 2017 the average length of stay was 2.85 days, lower than the England average of 6.9 days. This was notably higher in November, December and January (above three days), which senior staff attributed increased demands during winter. The wards with the longest lengths of stay were care of the elderly wards (12 to 13 days), while the shortest length of stay was in the AAU (.97 days) as patients would be discharged or moved to another ward.
- The trust average length of stay for non-elective patients (8.6) was longer than the England average (6.7) for the same period. We noted that neurology was shorter and while the stroke unit and general medicine were longer than the England average.
- The trust participated in the 2016 Sentinel Stroke National Audit Project (SSNAP) for organisations. Of the ten key indicators which represented an important aspect of acute stroke service organisation, the trust was meeting nine of these indicators including access to a specialist team, availability of therapy, staffing ratios on stroke wards. The trust rated 2nd in all trusts in England for stroke care in the audit. This performance would mostly relate to the Hyper Acute Stroke Unit (HASU) based at Charing Cross Hospital.

Competent staff

- Staff we spoke with stated they received a trust two-week induction programme which they described as positive. This included a large suite of mandatory training before beginning employment, as well as a supernumerary period during which they could shadow more experienced staff on the ward. Staff we spoke with stated the induction prepared them well for the role and they received support from their colleagues when they first started.
- The trust employed several different Clinical Nurse Specialist (CNS) teams who supported staff and provided advice or guidance and training in their area of expertise. This covered specific specialities like respiratory, diabetes, oncology, tissue viability, safeguarding, learning disability, dementia, and critical care. Staff we spoke with stated that CNSs were supportive and easy to access.
- Junior doctors had weekly learning sessions with consultants and received structured training programs through their firms. There had been significant investment in training and education for junior doctors, and staff we spoke with stated that the teaching and opportunities to learn were of a high quality.

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- Staff we spoke with stated the appraisal process was good and they had opportunities to discuss their personal development with managers in the last 12 months. Staff also stated they felt supported to apply for training opportunities and provided examples where they had attended courses to improve their skills. Senior staff told us they identified staff who needed the mentorship training through the appraisal and these staff have commenced the mentorship course.
- Of staff on medical wards at St Mary's Hospital, 88% had completed appraisals with their managers as of February 2017 against a trust average of 87.4%. Most of the staff we spoke to in the hospital during the inspection had their appraisal within the last 12 months. Staff including the doctors we spoke with during inspection told us they had their appraisal and updates with their managers regularly. Staff also told us managers were generally understanding if staff needed protected study time to complete courses
- Clinical practice educators (CPEs) were available to provide support and advice for staff regarding training opportunities and personal development, including in relation to revalidation for nursing staff. This team delivered training once a week on medical wards, where staff to discuss and learn from serious adverse incidents. CPEs also supported managers to complete a learning needs analysis for their wards each year to identify training needs.
- Some staff we spoke with felt there were good opportunities for growth in their roles and felt supported by the trust. Some of the ward managers and matrons had previously been promoted internally. Nursing staff also felt they had good access to developmental training and clinical practice educators. For example, nurse specialists ran weekly sessions, and rotated delivering training on their area of expertise. Nurses we spoke with also stated they felt supported through their revalidation process.
- The trust scheduled protected time for foundation doctors and registrar level doctors to support their professional development. We saw that staff professional development review compliance was similar to national average for December 2016. Trainees on a medical training programme had a Royal College of Physicians e-portfolio, used to record their achievement of competences according to the curriculum for their speciality. A named supervisor reviewed the competencies of trainee doctors on a three monthly basis.
- In some areas, therapists such as occupational therapists (OTs) dedicated to wards provided weekly multidisciplinary teaching sessions to nurses, which helped to build team cohesion and understanding of roles.
- New nurses had a preceptorship programme to accelerate their learning and development during the first few months of their job. They undertook a series of competencies which they had to complete during the preceptorship period. The clinical practice educator or the relevant mentor signed off competencies. Nurses also attended the trusts preceptorship programme and had preceptorship days outside the ward. Healthcare assistants also completed the Care Certificate as part of their induction.
- Doctors told us they had good clinical and educational support from the consultants, which facilitated their learning, practice and development. We saw that some doctors received funding for their PHD programme on the private wards.

Multidisciplinary working

- Medical wards had access to a number of allied health professionals to support the delivery of care, including: occupational therapists, dieticians, physiotherapists, speech and Language therapists, psychiatric liaison, social worker, and palliative care specialists. Staff on the wards stated there was a good range of specialist expertise available when needed for advice to staff and assessments of patient need.
- Multidisciplinary teams were involved in discharge planning and developing community care packages. For example, we observed a discharge officer working closely with nursing staff and a social worker on Samuel Lane to develop a discharge plan.
- A multidisciplinary board round took place on each inpatient ward twice daily, often led by a consultant. The ward round assessed the needs of all patients as a team and included discussions on treatment and discharge plans. We observed a board round in the

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acute medical unit and one care of the elderly ward, which was attended by the ward manager, doctors, nurses, discharge officers and a social worker. Staff discussed each patient in depth and reviewed each patient's current risk status. In both instances staff communicated well, demonstrated a good understanding of each patient and a multidisciplinary focus on discharge plans.

- Medical wards at St Mary's Hospital followed the trust's transfer policy for patients moving between wards and between hospital sites. Staff we spoke with stated that the trust would aim to limit patients to one move between medical wards and would utilise the discharge officers to ensure patients transferred with robust care packages in place. Transfers between wards would also be signed off from consultant to consultant, with no non-emergency patients moved between wards or sites, or discharged, after 5pm.
- Service managers across medical services demonstrated a proactive approach to working together in the best interests of their respective departments. Staff we spoke with stated there was a good working relationship between different healthcare disciplines, and staff could access support from the right clinical staff when they needed to.
- Social workers and discharge officers had good working relationships with community colleagues and we observed instances of positive communication to develop a robust care package for a patient being discharged. Staff we spoke with stated that while there were robust discharge procedures, the quality of care packages available in the community depended a lot on the borough the patient was being discharged to. Several staff stated that discharging patients into Brent in particular could result in delays due to capacity issues.
- Medical wards could refer to the psychiatric liaison team through the electronic records system for support and assessment of mental health patients. The site had two psychiatric liaison teams: one specialising in older people's care, and one for adults. Psychiatric liaison would see patients within one or two days, however patients may also have received psychiatric assessment before being transferred from Emergency Department. Staff we spoke with stated

they would aim to care for mental health patients in side-rooms where possible, and that the team could organise a mental health nurses at short notice to provide more individualised care.

- Staff we spoke with stated that discharge planning was normally well managed. Staff stated the pharmacy team were responsive in providing patients with medication, and having the knowledge and support of the discharge officers and social workers allowed robust discharge packages to be offered to patients going back into the community. We observed ward staff liaising with community providers to provide information on discharges for patients with complex needs.

Seven-day services

- There was consultant cover seven days per week on medical wards between 8am and 8pm, and consultants attended ward rounds and multidisciplinary team meetings. Consultants provided an on call service out of hours and after 8pm covering all the medical wards to support registrars and junior doctors. At night a registrar and four junior doctors covered the medical wards. At weekends two consultants, a registrar and junior doctors were on site to see new admissions and review patients. Junior doctors and registrars supported the consultants and covered seven days through a rota system. Staff we spoke with stated the support from on-call consultants or other medical support was accessible and responsive when needed.
- The hospital discharge team operated a 24 hours a day, seven days a week service to prepare patients for discharge, however patients were not discharged after 5pm. The discharge lounge operated 8am to 8pm weekdays and 9am to 5pm on the weekends. We saw discharge team members working with social workers and nursing staff to arrange for patient discharges.
- Wards had access to direct pharmacy support Monday to Friday between 9am and 7pm, and for five hours on Saturday and Sunday. Pharmacy support was also available between 9am and 1pm on Saturday and Sunday, with the on-call pharmacy available for support out of these hours. Pharmacy did not participate in or undertake weekend ward rounds.

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- Imaging and diagnostic services to medical wards was available 24 hours seven days a week. The imaging team and radiologists were available seven days a week for acute medical patients. The nursing and medical staffs told us scans were available in a timely manner when needed and staff reported no issues in accessing imaging or diagnostic services outside of working hours.
- Physiotherapy, occupational therapy (OT) and SaLT was available Monday to Friday and on call at weekends. Staff could also access physiotherapy and OT support based at other Imperial Healthcare NHS Trust hospitals on weekends if needed.

Access to information

- Staff could access information on other medical patients based at other Imperial Healthcare NHS Trust hospitals using the electronic records system. This meant if a patient was admitted at St Mary's Hospital, staff could access their previous medical records regardless of where they had previously been seen within the trust.
- All wards had computer terminals enabling staff to access patient information such as imaging result, blood results, and medical records through the electronic patient record (EPR).
- All staff received login cards and passwords to access the electronic records system. Agency or bank staff also received a temporary staff card so they could write patient records.
- Some risk assessments continued to be completed on paper copies which meant it may not appear on electronic record systems. Mental capacity act assessments were completed on paper, however the assessment was not always identified on the electronic records system. This meant that some information relating to patient capacity was not accurately reflected in paper and electronic records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found some inconsistency amongst nursing staff and junior medical staff in their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Some staff were not sure when an assessment of capacity would be required for a

patient or when to apply DoLS. Documentation on MCA assessments was also inconsistent on medical wards. In a review of five sets of patient records, we observed patients identified as not having capacity in case notes, but no evidence of the assessment form. This suggested some inconsistency in the assessment and documentation of patient capacity across medical wards.

- Staff in the Medicine and Integrated Care Division at St Mary's Hospital were not meeting the trust targets for training in MCA and (DoLS). Staff had an overall compliance rate of 66% against a trust target of 90%. The trust did not have an action plan in place to address this.
- Staff we spoke with stated that medical staff completed MCA assessments and DoLS with support from the Older People Assessment Liaison Team (OPAL) if needed. Staff told us the psychiatric team reviewed patients subject to DoLS and best interest meetings took place for patients subject to DoLS, MCA and Do Not Attempt Resuscitation (DNACPR). Additional nursing staff could be provided for patients subject to DoLS to deliver more individualised care if necessary.
- Although the trust did not carry out regular standalone DoLS audits, management of the trust's DoLS cases was sub-contracted to a partner foundation trust, which provided oversight to ensure the trust is compliant with current legislation.
- We reviewed the DNACPR documentation in eight patient records on care of the elderly wards and found the forms to be completed comprehensively and available. We did not see any evidence for regular audits of DNACPR documentation
- Staff we spoke with were aware of the need to obtain consent from patients and followed procedures in line with the hospital consent policy. Staff obtained consent from patients prior to the delivery of care and treatment, and we saw this documented in the patient records. We observed staff communicating with patients on the wards regarding the care they would receive and obtaining verbal consent for any care intervention.

Medical care (including older people's care)

Are medical care services caring?

Good



We rated caring as good because:

- Patients we spoke with were very positive about their experiences on the medical wards, particularly regarding their interactions with staff
- We observed positive interactions between staff and patients throughout the medical wards we visited.
- During our observations we saw numerous examples of therapies staff involving patients in their care. Family members we spoke with stated they felt the staff gave them opportunities to be involved in decision making and ask questions.
- The hospital had a multi-denominational chaplaincy service that provided services to patients across the hospital, including bereavement and spiritual support.
- The Patient Advice and Liaison team provided a weekly dementia drop in session for patients and their families who had any questions or wished to receive some support. We also saw posters for various support groups available to patients, carers, friends and family.
- Psychological and emotional support was available to patients following diagnosis of long-term or life threatening condition.

Compassionate care

- The Medicine and Integrated Care Division (which included medical wards) of St Mary's Hospital participated in the NHS Friends and Family Test (FFT), and individual wards were responsible for displaying and acting on results. Between April 2016 and February 2017, the trust reported that a 97% of people would recommend the service to their friends or family members, against the national average of 95%. The directorate also had a response rate of 39% for the same period, against a target of 30%.
- Most of the patients we spoke with were very positive about their experiences on the medical wards. Patients were particularly complementary regarding the staff. One patient said, "Staff were amazing, and always available when I needed them, even at night.

The doctors and nurses explained treatment well, and I was given time to ask questions." Another patient said, "The staff are fantastic. I think they are very competent and involved me in any discussions."

- We observed positive interactions between staff and patients through the medical wards we visited. We observed staff taking the time to reduce patients' anxiety and asking if they needed anything. On the care of elderly ward, staff were seen to be patient in their actions and ensuring the ward was as calm and peaceful as possible. We also observed staff working with disorientated patients and helping to ensure they remained safe on the ward
- Discharge officers were observed to spent time with a patient who did not have a home to be discharged to and discuss their options. Following this, we saw the same staff members working with social workers and nursing staff to arrange for this patient to be discharged into supported accommodation.
- On the wards we saw a number of thank you cards and letters to the staff from patients and relatives. Comments included "thank you for helping to look after me", "I wanted to say thank you for all your support for me and my family", and "Thank you for the wonderful work you do".
- We observed staff being supportive to the needs of patients. When patients rang call bells and appeared to be in discomfort, staff were responsive to their needs. Staff were also aware of patients being cared for in side rooms and regularly checked on them to see if they needed anything.
- The trust participated in the 2015 National Cancer Patient Experience Survey (NCPES). The survey showed that 87% patients said they were treated with dignity and respect which was the same as national average of 87%. 92% also stated staff told them who to contact if worried about their condition or treatment.
- Patient Led Assessments of Clinical Environments (PLACE) in 2016 rated privacy on four medical wards at St Mary's Hospital between 63% and 88% (against a national average of 86%).

Understanding and involvement of patients and those close to them

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- During our observations we saw numerous examples of therapies staff involving patients in their care. This included medical staff on wards discussing treatment options with a patient, and nursing staff talking a patient through each steps of the care and regularly checking if the patient was comfortable to continue. Their caring and compassionate attitude meant they gained the patient's trust, who told us afterwards they felt respected by the member of staff that they spoke to.
 - Patients we spoke with told us staff introduced themselves and explained what they were doing before providing care. Patients felt they were given an opportunity to ask questions about any care and felt staff were patient with them.
 - Family members we spoke with stated they felt the staff gave them opportunities to be involved in decision making and ask questions. We observed interactions on a number of wards between family members and staff that were compassionate, patient and friendly. Family members of end of life patients were particularly positive about how understanding staff were, and felt their family member had been treated with dignity and respect.
 - A number of volunteering staff, particularly on care of the elderly wards, were available to provide recreational or support activities to patients, such as sitting and speaking to them, reading to them, or offering to tidy up around the ward. Volunteering staff we spoke to stated they really enjoyed being able to give something valuable to the patients on the ward and felt they were valued as part of the ward by staff.
 - The service showed understanding of patient needs. For example, further to an incident where a patient was discharged without warm clothing, the service had set up a clothes cupboard to offer clothes to patients who did not have any available. The discharge team also had petty cash available to buy clothes for patients if needed. We observed family members in the discharge lounge who had been contacted by staff and informed of the need to bring warm clothing for patients leaving the hospital.
- including learning disabilities leads, dementia leads, frailty teams, and the palliative care team. Staff we spoke with who work with patients needing end of life care stated that the palliative care team was particularly useful in ensuring patients were made comfortable and that end of life drugs were written up pro-actively to be available as soon as needed.
- The hospital had a multi-denominational chaplaincy service that provided services to patients across the hospital. Staff knew how to contact spiritual advisors to meet the spiritual needs of patients and their families. We also saw posters of the chaplaincy services on all the medical wards inspected. Chaplains were available to provide support for end of life patients and bereavement support for families alongside the palliative care team.
 - Psychological and emotional support was available to patients following diagnosis of long-term or life threatening condition. This service extended to offer counselling, consultations with a psychologist or psychiatrist, specialist nurse or consultant. There was a clinical psychologist service for cancer patients and staff in the hospital. Medical staff told us they had patients on the neurological wards who accessed psychiatric support once a week. Patients were able to self-refer for individual sessions.
 - The Patient Advice and Liaison team provided a weekly dementia drop in session for patients and their families who had any questions or wished to receive some support. The dementia care nurse facilitated the session. We observed there were also other support groups available to patients, carers, friends and family, for some medical specialities.
 - We saw that Macmillan nurses were available to support patients having cancer treatment. There was also Macmillan cancer information and support help desk on the hospital ground floor where patients and relatives can access practical, emotional and social support. Information about the Macmillan leaflets and support were visible on most of the medical wards we visited.

Emotional support

- Services could access a number of clinical nurse specialists to meet the emotional needs of patients

Are medical care services responsive?

Medical care (including older people's care)

Requires improvement



We rated responsive as requires improvement because:

- Staff we spoke stated that discharge forms from the wards could at times be inconsistent or incomplete, and this could delay patients discharge from the discharge lounge.
- Data provided by the trust show patients being discharged out of hours between 22:00 and 07:00, suggesting patients being moved out of the hospital at unsociable hours.
- Staff we spoke with in this area stated that there can be sometimes long delays between patients arriving in the discharge lounge and discharge from the hospital due to issues with transport.
- Patient Led Assessments of the Care Environment (PLACE) in 2016 rated the provision of care of those with dementia on seven medical wards at St Mary's Hospital between 28% and 97%, with four of the wards under 60%.
- Medical pathways at St Mary's Hospital did not meet the NHS England national indicator for 18 weeks referral to treatment (RTT) times.
- The hospital signage is not up to date and does not provide patients or visitors with information how to access the wards.
- Estates in some areas of the hospital were difficult to access for patients with a disability. Elevators were frequently unresponsive during our visit to the hospital.

However:

- There were positive robust measures in place to manage outliers being cared for on other wards. The hospital also had systems in place to increase capacity to meet the needs of the local population during winter pressures.
- The introduction of complaints investigators had much improve response times and the quality of investigations for complaints.

- The learning disability liaison team provided assessment and support for patients with a learning disability and their families, as well as training and advice for staff.

Service planning and delivery to meet the needs of local people

- The hospital recognised public health needs in the local area and had worked closely with local authorities to provide targeted services. The trust had reordered the delivery of speciality medical services across the three trust hospital sites in the last 18 months, with general medicine, respiratory, gastroenterology, endocrine, and care of the elderly delivered at St Mary's Hospital. This meant moving the entire provision of some specialities to other hospitals (acute stroke patients going to Charing Cross Hospital, and cardiology patients going to Hammersmith Hospital) which allowed the medical divisions at each site to deliver care to a smaller number of specialities.
- Senior staff stated they had a good relationship with the commissioners and local stakeholders, who had been supportive of the move. The director of operations had weekly conference calls with sister hospitals and the CCG to discuss any pressing operational issues, such as delayed discharges.
- The hospital had previously been stretched to capacity to meet the needs of the local population during winter pressures. Service managers had developed an escalation procedure to add additional beds to wards and increase the capacity of bays on most wards from four to five. This would be a temporary arrangement for between 6-12 hours, and allowed the wards to alleviate some blockages in assessment units while also keeping the expansion of services under the established ward leadership teams (with expanded staff). The directorate could also utilise the discharge lounge as an additional ward space for general medicine, with the discharge lounge moving to the endoscopy suite. Senior leaders stated any escalation of bed numbers would be discussed with the CCG and measures put in place by Infection Prevention and Control (IPC) nurses to ensure wards were not an additional infection risk.
- Senior staff we spoke with stated they did not have many medical outliers on other wards. However staff

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stated they had a process in place for managing patients, ensuring they remained under the care of a consultant from the appropriate speciality, were included in ward rounds daily, and prioritised for open beds during bed management meetings.

- Patients on the wards we visited were accommodated in single rooms or in single sex bays. We saw there were no mixed sex accommodation breaches on any of the medical wards at St Mary's Hospital during inspection.
- The trust clearly displayed visiting times on any of the medical wards we visited. Family members of patients with complex needs or end of life patients were able to stay overnight on the ward, and chairs were provided for them to sleep in.
- Elevators in the hospital were at times unresponsive or did not leave the ground floor. In addition to some of the narrow corridor of wards or in older parts of the hospital, this made disability access to some areas very challenging. Senior staff stated they were limited in what they could address in terms of the building space, and were looking at ways to improve access to all wards when other current renovations have been completed. PLACE in 2016 rated the provision for patients with a disability on seven medical wards at St Mary's Hospital between 30% and 100%, with four wards under 65%.
- The hospital had a discharge lounge where patients could wait for transport. Patients had access to food and hot and cold drinks. Staff we spoke with in this area stated that there can be sometimes long delays between patients arriving in the discharge lounge and discharge from the hospital due to issues with transport. Staff we spoke with stated transport used to be more closely located to the discharge lounge and had better communication, however as this service had now moved there had been more delays.
- One section of Thistlewayte ward was currently closed and being renovated, with a view to turning the newly refurbished area into a care of the elderly ward.

Access and flow

- Between April 2016 and January 2017, admitted referral to treatment (RTT) times within the Medicine and Integrated Care Division at St Mary's Hospital

varied between 85% and 91% of all patients, with respect to the NHS England indicator of patients being treated within 18 weeks of diagnosis. This did not meet the trust target of 92%. During this time period there was one patient currently waiting more than 52 weeks for treatment.

- Patients were either admitted to the Acute Assessment Unit (AAU) from the St Mary's Hospital Emergency Department (ED) or directly referred to specialist or general medical wards. Bed management arrangements between ED and AAU were managed by the nurse in charge in both departments, who were in regular communication throughout the day. Patients admitted from ED were transferred with an ED exit checklist, which detailed any risk assessments completed and what further tests may be required for each patient. Patients admitted to the AAU would be assessed before being transferred to a speciality medical ward or to a further assessment area. The admitting team was responsible for the patients on their wards, however the OPAL team may take responsibility for elderly patients.
- Medical teams completed ward rounds of their patients, with specialist input from other teams when needed (dementia, psychiatric liaison etc.). The multidisciplinary team that conducted daily board rounds to review patient needs included discharge planning and tasks for completion with each patient. We observed positive examples of this on the acute assessment unit, where there was a multidisciplinary approach to discharge planning from the point of admission. Discharge arrangements include input from medical staff, nurses, therapies, social workers, and discharge officers.
- Data provided by the trust on out of hours discharges show 25 patients discharged between 10pm and 7am in February 2017 alone (20 in General Medicine and five in gastroenterology), suggesting patients being moved out of the hospital at unsociable hours. Staff stated they tried to discharge patients as early in the day as possible to ensure patients were not on the ward unnecessarily and beds were available for new admissions. Staff we spoke with across wards stated they did not discharge patients after 5pm, however this conflicts with the data provided by the trust. Data

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from the St Mary's Hospital acute and specialist medicine scorecard show that in the 10 months between April 2016 and February 2017, 11.5% of patients were discharged before noon.

- Ward staff arranged discharge medication with the pharmacy team, and the patient would be transferred to the discharge lounge to await transport. Staff we spoke with that discharge forms from the wards could at times be inconsistent or incomplete, and this could delay patients discharge from the discharge lounge. Discharge staff stated that the main delays for get people home were delays in the provision of transport, or incomplete information on discharge forms from the wards.
- The trust provided data to NHS England on bed occupancy across General and Acute Care (which includes all medical beds). From October to December 2016, the trust had an overnight bed occupancy rate of 89%, compared to an England average of 91%. This is an increase in the occupancy rate of 83% from the previous reporting period (June to September 2016). The ratio between delayed transfers and bed occupancy for the trust for the period of June to September 2016 was 0.01 which was better than the England average of 0.03. This information suggests that the trust was managing their capacity and beds on the ward well.
- Staff we spoke with stated that patients would try to be limited to only one move following admission to the acute assessment unit (AAU), however the trust stated patient moves per admission are not monitored and were unable to provide supporting data. Staff stated that medical outliers were rare, however there was a process in place for managing these patients, ensuring they remained under the care of a consultant from the appropriate speciality, were included in ward rounds daily, and prioritised for open beds during bed management meetings.
- The Medicine and Integrated Care Division had an escalation protocol, in line with their operational policy, to address bed availability issues when the division had reached full capacity. At amber alert, medical patients could be admitted to beds on surgical wards. For red alerts, suitable patients would be transferred to vacant beds at Hammersmith Hospital. For a black alert, the division would place

additional beds in designated rooms on the 1st floor and consider use of the discharge lounge as another ward space. Senior staff we spoke with stated that the services had to use these protocols during spells of winter pressures, however it had now been over three weeks since they had to escalate the bed capacity situation to red or above.

- The trust medical and integrated team performed better than the England average for the patients waiting longer than six weeks for diagnostic test in December 2016.
- For the period of December 2016, the two weeks GP referral to the first outpatient appointment for cancer patient was 93% (similar to the England average). The 31 days wait from diagnosis to first treatment for the same period was 97% (higher than the England average of 96%). The trust also scored higher or similar to the England average on 31 days second or subsequent treatment (100%), 62-day urgent GP referral to treatment (82%) and 62 days urgent GP referral to screening (93%).

Meeting people's individual needs

- The hospital signage was not up to date and did not provide patients or visitors with information on how to access the wards. Some of the signs in the hospital made no mention of how to access wards and there was no signage in languages other than English. Some patients we spoke with stated it can be confusing to find your way around the building, particularly if you came through one of the older entrances to the hospital. There was also no reception areas at some of the entrances to the hospital, which visitors we spoke to found confusing.
- The trust had access to interpreters if needed and this could be booked through the ward. However staff stated they would first attempt to find a staff member on one of the wards who may be able to speak the same language. Staff also stated that the provision for interpreting services had recently changed, and they were not familiar with booking arrangements for the new service.
- The hospital offered a number of alternate choices to meet the religious and cultural needs of those using the service. Patients were able to have individual meals that met their dietary, cultural, religious or

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medical needs if they informed staff of their preferences. The variety of food also included special dietary needs such as gluten intolerance, Asian or Afro-Caribbean food and vegetarian options. The service could also provide multi-faith room or religious texts for prayers, as well as access to local spiritual leaders as required.

- We saw a number of leaflet racks around services displaying information on how to access support; however we also saw instances of empty racks on wards with not many leaflets or duplicate information. Information available on the wards included complaints leaflets, bereavement and chaplaincy contact details, information on MRSA screening and other risk assessments, and leaflets for patient support groups.
- The learning disability liaison team provided assessment and support for patients with a learning disability and their families, including communication aids and support. The team received alerts on any familiar patients using the service through the electronic record system. The team also provided advice, training, and policy updates to frontline staff on best practice in working with learning disabilities patients. Learning Disability (LD) nurses had also developed communication aids for staff working with learning disabilities in maternity, emergency, inpatient, and outpatient services.
- The learning disability and inclusion staff recently had a two day MENCAP training which was inclusive safeguarding, consent, deprivation of liberty safeguards, autism and learning disability which has helped improved their competency, skills and development. The training has helped developed their competency and help support staff and patients.
- The trust had introduced Side by Side for Alzheimer's patients, an initiative by the Alzheimer's Society service which helps people with dementia to access recreational activities. This included arts and crafts, harmony singing and Friday afternoon tea parties.
- The dementia team was available to provide advice and support for patients and staff. Dementia nurses has developed the NOSH project to support assisted eating and therapeutic meal times for dementia patients, and also ran drop-in sessions weekly for

family members to ask questions or get support. Staff also stated they had accessed support for advice on working with patients with dementia in the past, and the dementia nurses had recently delivered one day training courses on a number of wards to improve staff understanding of dementia.

- An external organisation provided the food for the wards. Food was delivered to the ward and heated in the ward kitchen. Patient told us they "the food was very good", "there were nice options to choose from", and "food was tasty".
- Patient Led Assessments of the Care Environment (PLACE) in 2016 rated the provision of care of those with dementia on seven medical wards at St Mary's Hospital between 28% and 97%, with four of the wards under 60%, which was lower than the national average of 74%. The trust had developed an action plan to address the findings of the PLACE report.
- The Older People Assessment Liaison team (OPAL) was a consultant-led team which provided support on risk assessments and adjustments for patients using elderly care services, and the frailty team provided additional support and oversight of patients with increased risk due to frailty. Senior staff stated they hoped to merge these two teams in the future to deliver more bespoke care to elderly patients. Staff feedback on support they received from OPAL and the frailty team was very positive.
- Patients who had any concerns or issues relating to their clinical care were also able to access the Patient Affairs team, who aimed to resolve any issues the patient had on their behalf.

Learning from complaints and concerns

- Data provided by the trust showed there were 40 complaints between April 2016 to January 2017 for the medical wards at St Mary's Hospital, which was lower compared to the England average of 100. The data showed that all the complaints were dealt within the trust target time frame of less than 40 days.
- Complainants received support from the patient advice and liaison service (PALS). PALS also helped to arrange meetings with patient and family if requested. Staff were aware of the PALS services and their role in the complaint process, however staff stated they rarely

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had any contact with the PALS service or saw them on the wards. Staff stated they would try to handle any concerns that patients had on the ward informally, particularly if they could give the complainant immediate action.

- The trust has employed four band 7 complaint investigators prior to our inspection to deal with complaints received by the trust. The complaints investigator handled complaints received along with support from the area manager or divisional lead. Senior staff we spoke with stated it had previously been difficult to respond to patients within the target time. However, the introduction of complaints investigator had much improved response times and the quality of investigations. The hospital now also collects compliments from service users, with a view to examining the data for any themes. No complaints were referred to the Parliamentary & Health Service Ombudsman (PHSO).
- Patients we spoke with stated they would be confident any complaint they made to the trust would be taken seriously.

Are medical care services well-led?

Good 

We rated well-led as good because:

- The Medicine and Integrated Care Division at St Mary's Hospital had also published local objectives for review by staff and the public in 2018, as well as clinical and estate strategies for the future.
 - The trust had a number of initiatives under way to involve member of the community in decision making processes for the future development of services.
 - There were robust governance and risk management structures in place across medical wards and within the hospital.
 - Staff we spoke with stated that management were accessible and supportive. Some of the managers we spoke with had been promoted internally to their management roles and feel encouraged to develop professionally.
- Staff we spoke with stated that morale was positive amongst the nursing and medical staff. Staff stated that the culture at the service was very positive and they enjoyed working there.
 - There were a number of engagement opportunities and roles within the hospital for members of the public, and the hospital held public consultations for any future developments.
 - Medical trainees we spoke with stated that medical leadership within the directorate was well managed and offered good communication throughout the discipline.

However:

- Some of the risks we identified on inspection were not identified on the directorate's risk register.

Leadership of service

- Medicine and specialist medicine at St Mary's Hospital sat under the directorate of Acute and Speciality Medicine under the Medicine and Integrated Care Division. The divisional director for medicine and integrated care covered all directorates in this division and reported directly to the trust chief executive. The medical oncology speciality was under the Oncology and Palliative Care division. We saw that all the clinical divisions had a triumvirate of clinical director, director of operations and divisional director of nursing, with all posts filled.
- Staff we spoke with stated that management and the executive team were accessible and supportive. Staff stated that service managers were very visible around the service and that external executive members of the wider organisation would often visit. Staff also stated that the management team operated an "open door" policy and that they could bring any problems to their line managers.
- Senior staff told us the operational leaders used to be based at different sites and this has now been changed and they were now all based on one site. This change has brought "more local leadership, team working and more responsiveness". Senior staff said they had changes in practice and care since this change, for example, the sharp bins compliance have improved with the walk rounds.

Medical care (including older people's care)

- Medical trainees we spoke with stated that medical leadership within the directorate was well managed and offered good communication throughout the discipline. Nursing staff we spoke to stated that the divisional director of nursing was also very accessible and offered direct support to managers throughout medical wards. Staff in both disciplines stated regular meetings took place for medical staff and nursing staff to discuss issues and future plans within the discipline.

Vision and strategy for this service

- The trust published their clinical strategy in 2014 and due to finish in 2020. The main areas of focus were to create more local and integrated services, reorganising the delivery of specialist services, to improve patient experience as well as clinical outcomes, and continue to develop research opportunities within the trust. Inspectors recognised that the medical departments at St Mary's Hospital had made significant improvements since the time of their last inspection.
- The Medicine and Integrated Care Division at St Mary's Hospital also published local objectives for review in 2018, which linked into the trust objectives. This included expansion of the fibro-scan service, improving diagnostic waiting times and Referral to Treatment (RTT), complete a demand and capacity review of acute admissions, and review the flow of patients through the department to improve discharge times.
- The trusts had developed a ten year estates plan, due for completion in 2016, which complements the current redevelopment of medical services and aligns with the clinical strategic goals set by the trust. The estates strategy suggests further specialisation for the three main trust hospital sites, with St Mary's becoming the acute centre and specialist emergency service site.
- Staff we spoke with felt they were well informed about the future goals of the directorate and the strategic vision for the trust. Staff stated they felt communication from the executive staff regarding future plans was positive and that any strategies were made available for review and comment.
- The trust values were "kind, collaborative, expert and aspirational" which were developed out of a leadership project to instil positive attitudes in staff. Working as a team, adaptable, open and approachable were embedded within the collaborative values. Staff we spoke with showed aware of the trust values and stated they incorporated these values into their work.

Governance, risk management and quality measurement

- Divisional management for medicine and integrated care set the divisional strategy and had overall responsibility for quality, finance and performance of the services they delivered. They also oversee the delivery of the divisional annual business plan, and also agreed, monitored and controlled the implementation of policy, plans and strategy. Divisional management had oversight of implantation and performance quality through the monthly Divisional Quality and Safety Committee Meeting. This committee reported into the trust executive committee through the divisional directors.
- The trust provided six months of minutes from the Divisional Quality and Safety Committee Meeting. Attendance included the divisional triumvirate, as well as leadership teams from each medical speciality and representatives for therapies staff. Standing agenda items included safety and effectiveness (which look at incidents, complaints, risk registers, and infection control), compliance and improvement (which reviewed minutes of monthly medical speciality quality and safety minutes), and review of any notable audits or documents recently finalised.
- Directorate leadership at St Mary's Hospital also met at monthly directorate management committee meetings to discuss implementation of clinical strategy and provide oversight of risk and performance at a local level.
- The trust provided minutes from the monthly directorate management committee. Attendance included the Clinical Director, General Manager, and Deputy Divisional Director of Nursing, as well as medical speciality leads at St Mary's Hospital. The minutes of the meetings detailed discussions on quality performance and safety oversight, as well as review of performance metrics collected by the trust.

Medical care (including older people's care)

- The Medicine and Integrated Care Division at each hospital site maintained a divisional scorecard which was made available with updated metrics each month. The scorecard corresponded to the five key domains of the CQC, and was used to identify areas of quality or safety performance that were significantly changed in the data.
- The Medicine and Integrated Care Division employed a Clinical Governance Lead who reported directly to the Divisional Director. The governance leads role was to ensure information drawn from the various medical specialty and hospital site meetings was accurate and up to date, and that reporting structures allowed information on risk and performance to be shared from management through to frontline staff.
- The divisional director, serious incidents investigator and governance leads met weekly to discuss incidents, complaints, performance indicators and other issues. Senior staff used these meetings to decide the severity of incidents and how they should be investigated.
- The trusts employed a Quality improvement team who sat within the medical director's office. Their aim was to develop training and awareness which has increased quality and safety from the bottom up. The quality improvement team had identified nine themes, such as hand hygiene, that they would focus on through as part of the trust quality improvement strategy.
- As of March 2017, the acute medicine and integrate vision had a risk register which highlighted 33 divisional risks. We saw that the division risk register were reviewed regularly and included risk we have identified during the inspection. Leads for different medical specialities also maintained local risk registers, which were used to inform site and directorate risk registers. Risk were categorised into green, yellow, amber and red.
- The division appeared to have a good understanding of the risks facing the delivery of care from the risk register. This included risks relating to the environment (such as refurbishment or wards or shortage of equipment), capacity (including meeting national waiting times indicators and RTT), staffing issues (such as recruitment and retention of middle grade medical staff), and complexity of care (such as vulnerable patients in acute settings). All risks on the register had been reviewed in the last three months.
- Some of the risks we picked up on inspection were not identified on the directorate's risk register. This included staff not meeting trust targets for resuscitation training, not meeting MRSA screening targets, and discharging patients out of hours.
- The trust had developed a quality accounts strategy due for completion in 2018, with a view to improving quality and safety monitoring throughout the trust. The strategy corresponded to the CQC five key domains, and contained measurable targets to be reached over the next two years.

Culture within the service

- The 2016 staff survey included some questions relating to the culture of services. The number of staff responding positively to the statement "I would recommend my organisation as a place to work" increased from 57% in 2015 to 62% in 2016 (compared to 60% nationally). Staff responses had also improved for the statement "I am satisfied with the support I get from my work colleagues" from 73% in 2015 to 76% in 2016.
- Staff we spoke with stated that morale was positive amongst the nursing and medical staff. Most of the staff we spoke with stated they enjoyed working for the trust and they felt well supported.
- We saw several examples of staff receiving promotions internally into management roles, and stated they had been encouraged to apply for management posts and progress their careers. Staff we spoke with stated they felt there were good opportunities for development within the service and that their professional development was nurtured. This was further supported by the trust through available mentorship programs.
- Staff we spoke with stated that the culture at the service was very positive and they enjoyed working there. Staff stated there was a good relationship between the various disciplines of healthcare

Medical care (including older people's care)

professionals, and that staff were very welcoming to newly recruited members of the team. Staff also stated they felt their colleagues offered excellent informal support and guidance when needed.

- The staff on medical wards worked collaboratively with other staff across the trust, and stated they had a good relationship with other disciplines and staff outside the directorate. We observed several examples of positive interactions between medical staff and staff from other directorates or departments in the hospital.
- We heard no reports of staff bullying or harassment within medical wards at St Mary's Hospital. The number of staff across the trust stating they had experienced bullying or harassment in the 2016 NHS staff survey was 31%, worse than the national average of 25%.
- Staff stated they could access psychological support through the trust if they felt they needed to, and could self-refer to the service. Staff stated that when there had been difficult incidents, managers and other staff provided informal emotional support.

Public and staff engagement

- The trust had a patient and public involvement (PPI) strategy for 2016-2017. The trust board ratified this strategy with a view to obtaining more feedback and involvement from the public in order to better shape services. The PPI strategy includes the development of bi-monthly strategic lay forum with 12 lay representatives from the community, collation of other PPI activities currently underway within the trust, supporting staff to deliver quality improvement projects with support from public stakeholders.
- The trust advertised any opportunities for public engagement on the trust website and on public information boards throughout the trust. The website had a regularly updated calendar of all available open events and PPI opportunities, as well as information on how to join improvement programmes or volunteer at the trust.
- The trust had frequently offered public consultations on future developments or changes to the delivery of services, to ensure the community members and locals can have their opinions heard. Senior staff stated they conducted notable consultations on the

refurbishment plans for St Mary's Hospital and on the redevelopment of medical services across the trust. This was reflected in minutes of monthly trust board meetings.

- The hospital recently featured in a new TV documentary, where staff and patients were followed across five of the trust hospital sites. The documentary aimed at showing the complexity of the NHS in action, including how staff managed competing with pressures and demands to ensure patients received the care they needed, as well as working to transform services to respond to changing needs.
- Staff told us the Chief Executive Officer (CEO) held monthly 'open door' sessions and all staff were encouraged to attend. A staff member we spoke with stated they had attended this session once and found it to be very informative. Staff told us the chief executive also sent a regular email update to staff on developments at the trust. Staff told us they received and read the email updates from the chief executive.
- The hospital had an award initiative for staff called 'make a difference award', where nominations were made by staff, patients and relatives. Staff received a certificate during the 'make a difference award' ceremony with a monetary prize. Some of the staff we spoke to during inspection had won this award and felt proud to be nominated. Award winners were announced to staff on the weekly staff message.
- The trust's staff engagement score for the period of July to September 2016 was 77% with a 33% response rate (compared to 70% nationally). The 2016 staff survey result showed that 78% of staff felt they were engaged by the trust in their work, 72% of staff were satisfied with their job and 71% felt recognised and valued.

Innovation, improvement and sustainability

- The trust developed a nutrition pathway called the Nutrition Support in Hospital (NoSH) which was designed to ensure patients, particularly people with dementia, received the food and drink they need while in hospital without losing the independence they had before admitted to the hospital.

Medical care (including older people's care)

- The trust had introduced Side by Side for Alzheimer's patients, an initiative by the Alzheimer's Society service which helps people with dementia to access recreational activities. This included arts and crafts, harmony singing and Friday afternoon tea parties.
- The Medicine and Integrated Care Division introduced a nurse-led cirrhosis clinic offering improved screening to patients at high risk of developing of severe complications from substance misuse, such as liver cancer. The clinic recently won the "Innovative Project of the Year" award from St Mungo's homelessness charity.

Outstanding practice and areas for improvement

Outstanding practice

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Areas for improvement

Action the hospital **MUST** take to improve

- The maternity and medical service must ensure that they always follow the trust's medicine management policies so that medicines are safe for administration to patients. In particular for date checking medicines and storing medicines in refrigerators.
- The trust must improve compliance with its mandatory training for all staff groups
- The maternity service must ensure there is comprehensive oversight of problems and that the risk register is reflective of all risks within the directorate.
- The maternity service must improve the management of CTG monitoring. This should include improving CTG training rates for relevant maternity staff and improvements in the "Fresh Eyes Buddy System" to ensure standards are met.
- The trust must ensure they implement the recommendations made in the Royal College of Obstetricians and Gynaecologists (RCOG) report from April 2017, 'Review of Maternity Services at Imperial College Healthcare NHS Trust, St Mary's Hospital site'.
- The trust must take action to ensure medical wards are meeting resuscitation training requirements for their staff.

Action the hospital **SHOULD** take to improve

- The maternity service should ensure that up to date safety thermometer and key relevant information are displayed on the quality improvement boards.
- The maternity service should ensure that second theatre and emergency theatre lists are appropriately staffed.
- The maternity service should ensure that all clinical guidelines are up-to-date.
- The trust should ensure that there is more visibility of executive and senior leadership team on the ground floor in particular for maternity services.
- The maternity service should ensure a consistent approach and more user friendly patient information available and displayed in wards including information about PALS.
- The service should urgently review and improve the signage for the various maternity wards and department, particularly for foetal medicine unit.
- The maternity service should address the estates issues related to kitchen and patient shower area.
- The trust should improve performance of the number of staff on medical wards completing mandatory training in relation to trust targets.

Outstanding practice and areas for improvement

- The trust should ensure medical wards are meeting targets for MRSA screening set by the trust.
- The trust should ensure there is a clear process for a timely response from hospital security to incidents or staff being exposed to violence and aggression.
- The trust should ensure staff have a clear understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The trust should improve the consistency and completeness of discharge information for patients transferred to the discharge lounge.
- The trust should improve hospital signage, ensure it is up to date and provides clear information for visitors on how to access the wards.
- The trust should ensure that patients are not discharged out of hours (between 10pm and 7am), without a clear reason for doing so, a robust discharge plan in place, and a safe place to discharge patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>(1) Care and treatment must be provided in a safe way for service users.</p> <p>(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—</p> <p>(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.</p> <p>Staff compliance with trust mandatory training was low and below trust target of 95%.</p> <p>CTG training rates were low for relevant maternity staff.</p> <p>The "Fresh Eyes Buddy System" for reviewing CTG was not consistently used.</p> <p>Resuscitation training requirements for staff were not met on medical wards.</p> <p>The Royal College of Obstetricians and Gynaecologists (RCOG) report from April 2017, 'Review of Maternity Services at Imperial College Healthcare NHS Trust, St Mary's Hospital site' made 27 recommendations to improve practice.</p>
Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>(1) Care and treatment must be provided in a safe way for service users.</p>

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Requirement notices

(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—

(g) the proper and safe management of medicines;

Staff did not always follow the trust's medicine management policies.

Regulated activity

Maternity and midwifery services

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(d) maintain securely such other records as are necessary to be kept in relation to—

(i) persons employed in the carrying on of the regulated activity, and

(ii) the management of the regulated activity;

Requirement notices

(e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

There was a lack of comprehensive oversight of problems and the risk register did not reflect all existing risks.

Not all staff were able to give examples of learning from incidents or changes that had occurred as a result.

An audit of Intrapartum CTG “Fresh Eyes Buddy System” demonstrated that 87.5% of the notes were not meeting the standard.

Some clinical guidelines were out of date.

The Royal College of Obstetricians and Gynaecologists (RCOG) report from April 2017, 'Review of Maternity Services at Imperial College Healthcare NHS Trust, St Mary's Hospital site' made 27 recommendations to improve practice.