

Barts Health NHS Trust

St Bartholomew's Hospital

Quality Report

West Smithfield

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

Ratings

Overall rating for this hospital

Good



Medical care

Good



Surgery

Good



Critical care

Good



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

St Bartholomew's Hospital is a teaching hospital in the City of London and part of Barts Health NHS Trust.

St Bartholomew's Hospital is the oldest hospital in Britain, occupying the site it was originally built on. The hospital provides a range of local and specialist services: including treatment of heart conditions, cancer, fertility problems, endocrinology and sexual health conditions. The hospital has a minor injuries unit and a specialist Heart Attack Centre, but does not offer A&E services.

The hospital has recently seen much building redevelopment, including the demolishing of parts of the site to make way for a new PFI funded building that houses the trusts specialist cancer and cardiac services. This includes the Barts Heart Centre (BHC), formed by the merger in 2015 with staff and services at the London Chest hospital and the Heart Hospital (University College Hospital).

The hospital has 365 inpatient beds and 108 day case beds, and employs 870 nursing and medical staff.

The BHC is Europe's largest specialised cardiovascular centre, covering a population of three million people across north and east London, west Essex and beyond. The facilities include: 10 theatres, 10 catheterisation labs, 250 general cardiac beds and 58 critical care beds, delivering specialist cardiac and respiratory services. The BHC aspires to perform more heart surgery, MRI and CT scans than any other centre in the world.

We inspected four core services: medical care, incorporating oncology and cardiology services; surgery, including theatre and recovery; critical care, including the specialist intensive care facilities the hospital provides; outpatients & diagnostic imaging, including radiotherapy. We did not inspect end of life care services.

We rated the well led domain in surgery and critical care as outstanding. Overall, we rated St Bartholomew's hospital as good.

Our key findings were as follows:

Safe

- There was a good incident reporting culture and learning from incident investigations was disseminated to staff. Staff were able to tell us about improvements in practice that had occurred as a result.
- Staff had an understanding of safeguarding systems and there was a safeguarding team within the trust. We found deprivation of liberty and mental capacity was assessed in line with trust policy and legislation.
- The surgery service had significantly reduced the number of surgical site infections in the last 12 months.
- Most clinical areas were clean, well maintained and free from clutter.
- We predominantly observed good adherence to infection control protocol.
- We observed good medicines management, including safe storage of medications and controlled drugs.
- Clinical practice was evaluated and benchmarked through an on-going programme of local and national audits, peer reviews and service development.
- There had been a sustained investment in recruitment of nursing staff.

However, we also found:

- Understanding and implementation of sepsis six (a procedural guideline designed to reduce the mortality of patients with sepsis) was variable among staff, and an action plan had been introduced to improve this.
- Understanding and learning from never events was not consistent across services.
- Nursing care bundles and documentation were not always completed consistently, and we found gaps in the recording of risk assessments and safety observations across medical inpatient areas.
- Nursing vacancies across some services remained above the trust target: bank and agency staff usage was high in some clinical areas, although this had had minimal impact on patient care.

Summary of findings

- Mandatory training rates across services were variable.
- Medicines fridge temperatures were not always consistently monitored in some clinical areas.
- There was limited signage in the x-ray department informing patients of the dangers of radiation, and the signage did not carry the radiation protection supervisors' details.
- Risks associated with the storage of chemicals, sharps and hazardous waste were not consistently managed in line with national and international guidance.

Effective

- Patient care was delivered in line with national clinical guidance and best practice.
- Pain was well managed across the services we inspected.
- There was effective multi-disciplinary team working in place within and across services.
- The heart centre demonstrated an average 'door to balloon time' of 60 minutes, which was better than the national average of 90 minutes.
- The average length of stay for elective and non-elective medical inpatients, with the exception of clinical haematology patients, was shorter than national averages.
- Results from the national lung cancer audit indicated the hospital performed better than the national average in every indicator.
- Clinicians demonstrated an on-going commitment to developing pathways that improved patient outcomes.
- Consultants were participating in a multi-partner heart improvement programme to reduce late admissions and improve patient outcomes.
- A nurse education team and specialist educators were in post in each clinical area to lead on staff development and training.
- There were effective training opportunities available for clinical staff.
- A rehabilitation support team and multidisciplinary therapy team supported cardiac patients with rehabilitation goals and strategies to improve their recovery. This was part of a broad multidisciplinary approach to care and treatment that ensured patients received a holistic and individualised recovery plan.
- Surgery patients that we spoke with felt they had been well informed regarding their treatment and that consent had been well explained in pre-admission and pre-operatively

However, we also found:

- The critical care service did not fully participate in providing data to Intensive Care National Audit and Research Centre (ICNARC), which was an expectation for critical care services.
- There was not daily on-site cover from a tissue viability nurse and ward nurses told us they did not feel confident in identifying or treating pressure sores. This was reflected in the number of hospital-acquired pressure sores in the previous 12 months.
- There were gaps and inconsistencies in staff knowledge with regards to the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. We found insufficient and inappropriate documentation and records of monitoring with regards to this in two medical wards.
- We found 15 policies in radiotherapy that were not up to date.

Caring

- We saw examples of staff providing compassionate care with dignity to patients across the services we inspected. Staff took time to discuss care and treatment with patients and relatives and kept them well informed.
- Patient survey results were consistently good and there was evidence staff used narrative feedback to improve and develop services.
- We observed staff in each clinical area providing emotional support based on the needs of their patients.

However, we also found:

Summary of findings

- NHS Friends and Family Test response rate was lower than the national average in medical services. However, ward managers demonstrated how they were working to improve this.
- Results from the 2016 cancer patient experience survey indicated there was room for improvement in how patients accessed private discussions with staff and in the sensitivity of staff when communicating.

Responsive

- Flow through surgery services was well managed.
- The specialised cardiovascular surgery service provided inter-hospital support for a number of district general hospitals in the north and east London area. Emergency on-call surgeons were available 24/7 to treat complex aortovascular patients.
- Recruitment of Clinical Nurse Specialists provided addition support for patients with specific clinical needs.
- The sexual health service had adapted to the needs of the local population including through the provision of a team of consultants, nurse practitioners and sexual health technicians who provided targeted support for patients with specific sexual risks.
- A new neuro-oncology rehabilitation service had been implemented to support patients with complex rehabilitation needs relating to cancer.
- A specialist team of nurses had developed an apheresis clinic in the chemotherapy day unit, which had expanded the range of specialist services available.
- Patients referred to cancer services were seen within two weeks of referral in 99% of cases and 98% of patients began their first treatment within 31 days. In addition 92% of patients were seen within 18 weeks of referral across all specialties, which met the national target.
- Clinical services had adapted access times and pathways to provide a safer and more responsive service. This included a two-week wait for angiograms and angioplasty after a cardiac inpatient stay in the heart centre.
- Specialist nurses led a 24-hour chemotherapy advice line, which patients could use during their treatment to ask questions or to access emergency admission pathways.
- The outpatients department had developed some nurse-led clinics; there were also rapid access clinics for patients experiencing conditions such as asthma and chest pain.
- The access issues resolution service (AIRS) was a dedicated helpline offering patients and GPs fast resolution of all booking and scheduling issues.
- Diagnostics and imaging services were meeting waiting time performance criteria.
- Medical wards had private space for patients and relatives to relax, socialise or talk privately. This included libraries, TV rooms and kitchens to make drinks and snacks. Hospital volunteers also provided daily snack and toiletry services on inpatient wards.
- A new catering contractor had improved the food service to patients and we saw an individualised service was now provided.

However, we also found:

- There were capacity issues in some outpatient clinics that meant there was insufficient number of clinics to deal with demand. Clinic rooms were booked up quickly and there was limited spare room capacity.
- Signage in some medical areas was difficult to identify and did not support easy navigation.

Well-led

- There was strong medical and nursing leadership and achievable strategies were in place to develop services.
- The senior leadership operating model allowed for good lines of governance and communication.
- Staff stated that the transition of services during the merger and formation of the Barts Heart Centre had run relatively smoothly, with minimal impact to the quality of patient care.
- Staff we spoke to across services emphasised the positive and collaborative culture following the merger.
- There was a high priority on research and senior clinical teams provided dedicated time for this.

Summary of findings

- Clinical teams used dashboards and risk registers effectively to review incident investigations and track the level of risk presented to patients, staff and services.
- Staff across services demonstrated that contingency planning worked well to minimise disruption during a prolonged IT failure.
- We saw innovation in clinical areas aimed at future service sustainability and the development of research
- Cardiothoracic surgery services were leading a number of innovations both within the UK and internationally.

However, we also found:

- Staff in sexual health services said human resources or occupational health had not supported them during a period of unpredictable change.
- The risk register in outpatients and diagnostic imaging did not contain action plans to explain what actions had been taken to mitigate identified risks or identify timescales for completion of actions to mitigate risks

We saw several areas of outstanding practice including:

Medical Care:

- Senior teams encouraged staff to participate in research and develop innovative projects to improve care in their clinical area. For example, staff in ward 6 had been recognised as finalists for a Health Service Journal award in November 2016 for their work in redesigning a specialist service. In addition, staff teams from wards 4C, 5D and 6D had conducted falls prevention research that led to the introduction of falls champion badges for staff who had demonstrated skills development in falls prevention and who could train or coach colleagues. A research ambassador group supported staff to engage in research in line with national ethics guidance.
- Staff in the sexual health clinic were encouraged to apply to present their work at the annual British Association of Sexual Health and HIV conference as a strategy to share best practice and new learning. For example staff had attended a 2016 conference to present a reflection on their clinical practice in the management of syphilis and to present the work of a satellite screening partnership clinic with a nearby private pharmacy.
- The trust was participating in the East London Cancer Board initiative. This was collaboration between 20 organisations and 50 professionals who sought to agree priorities for improvements and drive positive change in local cancer services. In January 2017 the board announced its key areas of focus and planned work together including incorporating patient experience narratives and identifying opportunities for new care pathways such as for prostate cancer follow-up care.
- An experimental medicine cancer centre had recruited 934 patients to trials developing practice-changing medicine for four cancer types.
- An international cancer specialist organisation had selected the hospital as one of 20 global sites of excellence in immune-oncology to advance the development of cancer immune therapy.
- Staff in the chemotherapy assessment unit provided a 24-hour telephone triage and advice service for patients who were feeling unwell during their treatment and patients who had completed a course of treatment within the previous six months.
- The heart centre demonstrated an average 'door to balloon time' of 60 minutes, which was significantly better than the national average of 90 minutes.

Surgery:

- Staff we spoke with stated they felt it had been a significant achievement by the leadership of surgery to bring three services together into one organisation, standardise processes efficiently, and continue to maintain the quality of care while doing so. Staff stated that the move into surgery services at St Bart's Hospital had been well managed and the transition was relatively smooth.

Summary of findings

- Surgery services were in the process of introducing a robotic surgical team with a fully adapted robotic surgery theatre. This would allow the surgery services to offer less invasive cardiothoracic surgery procedures, which led to faster recovery times, minimised trauma, and reduced pain. The robotic surgical programme would be the only dedicated cardiothoracic robot in the UK. The Robotic Epicentre for teaching and training in the UK will move to St Bart's Hospital in 2017.
- Surgery services had clinical research collaboration with a leading electronics company to develop visual applications for thoracic surgery. To support this, surgery services had developed a hybrid theatre, which could allow on-table visualisation of very small cancerous lesions, allowing more precise excision and reducing loss of health lung tissue.
- St Bart's Hospital was the first site in Europe to perform Electromagnetic Navigation Bronchoscopy, and was the only centre offering this in the UK as a routine service. Surgery services are also a training centre for this procedure in Europe.
- The hospital's Grown Up Congenital Heart disease (GUCH) programme had recently received national accreditation and is one of the largest in the world. The service provides supported transition from childhood to adulthood for those born with heart disease via a well-established transition programme with a leading London paediatric hospital.

Critical Care:

- The service had set up a well-governed and safe Extracorporeal Membrane Oxygenation (ECMO) service to provide both cardiac and respiratory support for patients and had put in a bid to become a national funded service.
- Since the merger of the three hospitals the service had developed a well governed critical care service with excellent medical and nursing leadership.

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

Medical Care:

The trust should:

- Ensure that nursing care bundles, including patient risk assessments, are completed consistently and without omissions.
- Ensure that adequate contingency plans are in place to reduce the risks of medicines management errors in the absence of pharmacy support.
- Ensure all teams meet the 90% target for completion of safeguarding training.
- Ensure all teams meet the 90% target for completion of mandatory training.
- Ensure there is adequate expertise on-site to ensure patients at risk of conditions associated with tissue breakdown or pressure sores receive appropriate care and treatment.
- Ensure further emphasis on making sure that all staff accurately and appropriately use the national early warning scores (NEWS) when assessing patients.
- Ensure staff working in laboratories have appropriate training in using personal protective equipment and protecting themselves from the risks associated with coming into contact with infectious material.
- Ensure FP10 prescription pads in the sexual health clinic are stored and managed in line with NHS Protect security of prescription forms guidance 2015.

Surgery:

The trust should:

- Ensure there are processes in place to monitor consistent recording of temperatures for medication refrigerators on surgery wards.
- Ensure NEWS scores are correctly scored and there are sufficient structures in place to frequently monitor performance in this regard.

Summary of findings

- Ensure patients who have appointments cancelled are offered an alternative.
- Ensure there is screening for patients who may have dementia, and that additional support is available for patients with dementia or other complex needs.
- Improve communication with patients regarding their discharge planning from surgery wards.
- Improve signage in the outpatients building for pre-admission appointments.
- Ensure they are meeting the trust target for appraisals of non-medical staff within surgery services.

Critical care:

The trust should:

- Ensure sepsis six pathway is fully integrated into practice and staff are educated appropriately.
- Ensure the first floor critical care units submit data to the Intensive Care National Audit and Research Centre (ICNARC) dataset to ensure patient outcomes are benchmarked against similar services nationally.
- Consider increasing the number of dieticians to meet national guidelines.

Outpatients and Diagnostic Imaging:

The trust should:

- Ensure clinics running late are reported as incidents in line with trust policy.
- Ensure clinic 5 has access to a sluice facility.
- Improve signage in the x-ray department informing patients of the dangers of radiation.
- Record ambient room temperatures are recorded in all rooms where medicines are stored.
- Ensure risk registers are fit for purpose and record actions and timescales to mitigate risks

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating

Good



Why have we given this rating?

An incident reporting system was embedded into the operation of the hospital and staff at all grades told us they felt confident in escalating concerns and mistakes. We saw evidence senior staff consistently investigated incidents and learning was broadly disseminated and shared, and we saw changes in practice and policy occurred as a result.

Infection prevention and control processes were effective and we saw staff consistently adhered to these. Staff adhered to good medicines management protocols that ensured patients were safe from the risks associated with improper storage and documentation. Pharmacy teams were proactive in identifying areas for improvement in medicines management and worked with clinical teams and senior leadership teams to implement safer practices.

Staff at all levels demonstrated a consistently proactive approach to reporting safeguarding concerns and working within multidisciplinary teams to keep people safe.

Senior clinical staff had adapted services provided to patients in response to identified risks, including the introduction of a consultant of the week model and emergency transfer care pathways.

An improved recruitment strategy and the implementation of nurse development pathways had led to lower vacancy rates and consistent nurse to patient ratios. An action plan was in progress to reduce vacancy rates further through international recruitment and internal development of existing nurses.

Each clinical area demonstrated improvements to patient outcomes through service developments and staff initiatives. This included a reduction in falls in the cancer wards through the introduction of a falls prevention competency framework.

Multidisciplinary working with internal and external colleagues resulted in better patient care.

A structured multidisciplinary education programme and the development of a junior doctor education hub had improved training and development opportunities.

Summary of findings

Clinicians had established multidisciplinary pathways and structures that meant patients treated at more than one of the trust's hospitals received coordinated, continual care.

Patients and relatives we spoke with provided consistently positive accounts of their care experiences. Good survey results and the demonstrably caring and compassionate approach of all staff we observed supported this.

Clinical processes were structured to ensure patients were included in their assessment, care and treatment. We saw evidence of this through observing ward rounds, speaking with patients, looking at patient records and looking at survey results.

Staff in each area demonstrated how they engaged patients in the service, both for improvement and to gather informal opinions and feedback.

There was evidence of innovation and a drive towards service development and sustainability in each clinical area. This included through research and the implementation of new and experimental services and treatments based on new guidance and evidence.

We also found:

Although there was consistent pharmacy support and cover in most clinical areas, there was a lack of contingency planning and elevated risks when this was not available.

Nursing care bundles and documentation were not always completed consistently and we found gaps in the recording of risk assessments and safety observations across inpatient areas.

We saw good infection control and hand hygiene practice during our inspection but this was not always supported by good long-term audit data. For example, the infection control team reported avoidable instances of hospital-acquired methicillin resistant *Staphylococcus aureus* (MRSA) and inconsistent hand hygiene compliance.

Risks associated with the storage of chemicals, sharps and hazardous waste were not consistently managed in line with national and international guidance.

Completion of mandatory training was variable and no single group of staff had full compliance with the trust's minimum 90% completion rate.

Summary of findings

We found overall inconsistency in how staff assessed and recorded patient mental capacity in some inpatient areas. This included for one patient with a Deprivation of Liberty Safeguards authorisation in place.

Staff in the sexual health service described a lack of engagement or support from the trust, human resources and occupational health during a time of uncertainty.

Surgery

Good



Staff we spoke with felt there was a good attitude from managers towards reporting and learning from incidents within surgery, and they felt encouraged to report concerns or issues. Root-cause analysis of the never events resulted in review of standard operating procedures, and the introduction of Local Safety Standard for Invasive Procedures (LocSIPP) to minimise the risk of a repeat incident.

The service had significantly reduced the number of surgical site infections (SSI) in the last 12 months.

Most of the surgery wards and theatres we visited were clean and well-maintained.

There were a number of audits in place to monitor performance of medicines administration and management.

Surgical pathways were delivered in line with national clinical guidance and best practice

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

Staff we spoke with stated they found the appraisal process useful, and felt there were good opportunities for professional development with the trust. Surgery staff were meeting most of the mandatory training targets for the trust.

There was effective multidisciplinary team (MDT) working in place. We attended a number of ward meetings attended by medical, nursing, and MDT staff, and found communication to be effective and well managed.

Patients we spoke with gave us positive feedback on the quality of care they received. Positive interactions between staff, patients and their families was observed. Patients and family we spoke with felt they had been well involved in their care.

Feedback from the Family and Friends Test (FFT) was consistently good across surgical wards, with an average of 98% for the period between April 2016 and February 2017.

Summary of findings

Flow through surgery services was well managed and efficient.

The specialised cardiovascular surgery service provided inter-hospital support for a number of district general hospitals (DGHs) in the north and east London area. Emergency on-call surgeons were available 24/7 to treat complex aortovascular patients.

Surgery services had access to a number of Clinical Nurse Specialists who could provide additional support for patients with any additional clinical needs.

There were a number of post-discharge wound clinics available to support patients with their recovery.

There was a positive culture within surgery services at the hospital. The leadership team was well established and there were good connections throughout the service. The team were managing a very complex critical care environment in a very integrated and seamless way.

The senior leadership team within surgery had effectively overseen the joining of three separate specialist surgery services into one organisation since 2015. This included standardising process, developing a unified culture and identity for surgery services, and maintaining quality of care for patients.

Surgery services had divisional level business plans and strategies for developing the service within each area of clinical speciality for the next one to five years, which aligned with the hospital-wide priorities for the future.

There were effective governance arrangements in place and senior staff had a good understanding of risks facing the service.

There were a number of leadership development courses available to staff who wished to have more responsibility.

Cardiothoracic surgery services were leading a number of innovations both within the UK and internationally.

We also found:

We found examples of National Early Warning Scores (NEWS) being incorrectly scored for patients on surgical wards.

There were significant vacancies in the nursing and medical teams, however this was mitigated by the use of regular bank staff. Surgery services also had a robust recruitment programme with a number of new staff due to start.

Refrigerators for medication on surgery wards did not have their temperatures checked consistently.

Summary of findings

The trust had recently had a major IT shortage prior to the inspection, which had resulted in severe disruption to accessing electronic images and blood results. Some of the policies we reviewed on the trust intranet for surgery services had passed the date from review. Surgery services were not meeting the trust target for appraisals for non-medical staff. There was variable performance in surgery services relating to care for dementia patients. Patients stated that communication from staff regarding discharge planning could be inconsistent. There was limited signage in the outpatients building for pre-admission appointments.

Critical care

Good



There was a good incident reporting culture and learning from incident investigations was disseminated to staff in a timely fashion. Staff were able to tell us about improvements in practice that had occurred as a result.

The environment was suitable to provide effective care and treatment and equipment was available and safe for use. Required checks were completed in most cases and we observed good infection prevention and control practice.

Staff had an understanding of safeguarding systems and there was a safeguarding team within the trust. We found deprivation of liberty and mental capacity was assessed in line with trust policy and legislation. Care and treatment was delivered using up to date evidence based practice.

We saw examples of staff providing compassionate care to patients. Staff took time to discuss care and treatment with patients and relatives and kept them well informed.

Patient and relative feedback was very positive about the care provided across the critical care services. Staff were described as caring and compassionate.

There was good access and flow within the critical care service. Delayed discharges on the general critical care unit were below the national average and minimal elective surgeries were cancelled due to a lack of critical care bed.

There was strong medical and nursing leadership and the service had a strategy in place to develop the service, which was achievable.

Summary of findings

The leadership team were well established and there were good connections with all staff throughout the service. The team were managing a complex critical care environment in an integrated and seamless way. The leadership team had a good oversight of local risks and risks were fully documented, discussed and we saw appropriate mitigation to reduce risks. There was an open and positive culture within the unit. Leaders were visible, supportive and approachable. We also found: We were not assured sepsis six and the new sepsis pro forma was fully integrated into practice as staff knowledge was varied. The first floor did not participate in the Intensive Care National Audit and Research Centre (ICNARC) dataset. We were told there were plans to include the first floor in the future. The service was not meeting national guidance for dietician and occupational therapy input. Visiting times were not always responsive to the needs of relatives and patients. Whilst we saw some examples of flexibility, this was not consistent.

Outpatients and diagnostic imaging

Good



Outpatients and diagnostic imaging staff had completed mandatory training and rates were 100% in most teams. Staff were clearly able to explain their role in raising safeguarding concerns and how they would escalate concerns in this regard. There was evidence of the WHO checklist being completed and audited. Patient protocols were in place in radiology. There was effective use of the national early warning score (NEWS) to identify a patient who might be deteriorating. Patients received care and treatment that was evidence-based and in accordance with national guidance. However, we found 15 policies in radiotherapy that were not up to date. There was compliance with the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER). Staff worked together in a multidisciplinary environment to meet patient's needs. There was a range of audits in place across outpatients, diagnostics and imaging to monitor patient outcomes.

Summary of findings

Consent was sought from patients prior to their receiving care or treatment. Staff received training in the Mental Capacity Act (2010) (MCA) and Deprivation of Liberty Safeguards (DoLS).

The outpatients department had developed some nurse-led clinics; there were also rapid access clinics for patients experiencing conditions such as asthma and chest pain.

The access issues resolution service (AIRS) was a dedicated helpline offering patients and GPs fast resolution of all booking and scheduling issues.

Interpreters were available to enable staff to communicate with patients where English was not their first language.

Between February 2016 and January 2017 the percentage of patients waiting more than six weeks to see a clinician was mostly lower than the England average.

St Barts had introduced a call reminder service to remind patients of their appointments.

Outpatients' managers told us they had not had to cancel any clinics as a result of the IT failure on 20 April 2017.

The trust had consistently performed better or similar to than the operational standard and England average for cancer waiting times.

Diagnostics and imaging services were meeting waiting time performance criteria.

Staff offered care that was kind and promoted people's dignity. We saw relationships between people who use the service and those close to them and staff were strong, caring and supportive.

Most patients and relatives we spoke with told us they were involved in decision making about their care.

Patients and those close to them also understood their treatment and choices available to them.

There was a range of emotional support options for people to talk about their condition, including access to chaplains, social workers and community support staff. Interpreters were available to enable staff to communicate with patients where English was not their first language.

Staff told us there had been improvements in leadership at both an executive and local level in outpatients, diagnostics and imaging. Local leaders were visible and staff felt that concerns they raised would be addressed.

Summary of findings

Quality reports and dashboards were sent to the managers and matrons of outpatients and diagnostic imaging on a monthly basis; this included reviews of key performance indicators (KPI).

Governance systems internally within outpatient and diagnostic imaging services demonstrated information was shared and lessons were learnt about events. However, shared learning across the divisions was more limited.

Most staff knew about the trust's values and could explain what these meant to their role.

Staff told us relationships between outpatients and diagnostic imaging had improved. Staff felt that there was an open culture within services.

We also found:

Incidents in regards to clinics running late were not always reported in accordance with trust policy.

Clinic 5 did not have a sluice and staff were emptying urine into a toilet. This created an infection risk of bodily fluids splashing in the toilet area.

There was limited signage in the x-ray department informing patients of the dangers of radiation, and the signage did not carry the radiation protection supervisor's details.

Staff could not be assured that medicines were stored within the required temperature for the safe storage of medicines in clinic 1 as ambient room temperatures were not recorded.

There was an identified risk as a result of the age of the ultrasound machines and the potential to produce suboptimal images. Although there had been no incidents of this.

IT failures on 20 April 2017 and 30 May 2017 had led to clinicians having to leave their clinical areas to view images in the imaging department. Work was in progress on an investigation and a clinical harm review. There was a risk to ongoing service development in regards to the rolling out of a paperless records system due to the reliability of the trust's IT systems.

The risk register did not contain action plans to explain what actions had been taken to mitigate identified risks or identify timescales for completion of actions to mitigate risks.

Between December 2015 and November 2016 the 'did not attend' (DNA) rate was mostly higher than the England.

Summary of findings

There were capacity issues in some clinics. Clinic rooms were booked up quickly and there was limited spare room capacity.

There was a risk to ongoing service development as clinic space was at a premium and as demand increased, the outpatients' model may make meeting the demand unsustainable.

St Bartholomew's Hospital

Detailed findings

Services we looked at

Medical care; Surgery; Critical care; Outpatients and diagnostic imaging;

Detailed findings

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Background to St Bartholomew's Hospital

St Bartholomew's Hospital is a teaching hospital in the City of London and part of Barts Health NHS Trust.

St Bartholomew's Hospital is the oldest hospital in Britain, occupying the site it was originally built on when founded in 1123. The hospital provides a range of local and specialist services: including treatment of heart conditions, cancer, fertility problems, endocrinology and sexual health conditions. The hospital has a long history over the centuries of innovation and development. In the 1990's the hospital was threatened with closure. The accident and emergency department was eventually closed in 1995 and services transferred to the nearby Royal London Hospital. However eventually, a plan was formulated to develop St Barts as a centre of excellence for cardiac care and cancer.

The hospital had recently seen much building redevelopment, including the demolishing of parts of the site to make way for a new, PFI funded building that houses the trusts specialist cancer and cardiac services. Some of the estate that remains dates back to the 1700s.

The Barts Heart Centre (BHC), formed by the merger in 2015 with staff and services at the London Chest hospital and the Heart Hospital (University College Hospital), is Europe's largest specialised cardiovascular centre, covering a population of three million people across north and east London, west Essex and beyond. The facilities include: 10 theatres, 10 catheter labs, 250 general cardiac beds and 58 critical care beds, delivering specialist cardiac and respiratory services. The BHC aspires to perform more heart surgery, MRI and CT scans than any other centre in the world. The service plans to be the biggest centre of excellence for adults with congenital heart disease.

The hospital had 365 inpatient beds and 108 day case beds, and employed 870 nursing and medical staff.

Our inspection team

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Nicola Wise, CQC

Inspection manager: Max Geraghty, CQC

Our inspection team included CQC inspectors and analysts, doctors, nurses, allied health professionals and a specialist in clinical governance.

Detailed findings

How we carried out this inspection

We spent two days visiting St Bartholomew's Hospital as part of our announced visit. We also returned to some services to carry out further unannounced inspection activity. We spoke with patients and their relatives, carers and friends and staff. We observed care and inspected the hospital environment and equipment. We also liaised with local bodies, such as clinical commissioning groups.

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

- Is it safe?

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

The inspection team inspected the following core services at this location:







- Medical care
- Surgery
- Critical Care
- Outpatients and diagnostic imaging.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	 Outstanding	Good
Critical care	Good	Good	Good	Good	 Outstanding	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	 Outstanding	Good

Medical care

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

Information about the service

The cancer and cardiology clinical academic groups, or divisions, at St Bartholomew's Hospital have 300 beds across five core specialty areas; interventional cardiology, electrophysiology, specialised cardiology, cancer and respiratory.

Barts Heart Centre has 10 theatres, 10 catheter labs and 250 general cardiac beds and the Barts Cancer Centre has two oncology wards and two haematology-oncology wards. Cardiology services are provided through an emergency pathway or an interventional pathway and there are multiple specialities including valve implantation, cardiomyopathy, general heart failure and grown up congenital heart.

The chemotherapy assessment unit has 32 solid oncology chairs, 1 bed for peripherally inserted central catheter (PICC) line placements and a dedicated apheresis unit which has capacity for 2 patients at any one time as well as 29 haematology-oncology chairs and a four-bedded assessment unit.

During our inspection we visited all of the medical care areas, including the catheter laboratories, sexual health service and a hostel used for relatives to stay overnight.

The trust had 79,367 medical admissions between December 2015 and November 2016. Emergency admissions accounted for 39,735 (50%), 34,699 (44%) were day case, and the remaining 4,933 (6%) were elective. Between April 2016 and March 2017, 22,049 patients used the sexual health clinic.

To help us understand the quality and safety of medical care services, we spoke with the senior clinical and leadership teams responsible for cardiology, cancer care, sexual health services and the catheter laboratories. We spoke with lead pharmacists and 27 members of clinical and non-clinical staff. We also spoke with 15 patients, observed care in all clinical areas and looked at over 80 individual pieces of evidence including 23 prescription records and 20 care and treatment plans. Our inspection included sexual health, genitourinary medicine and HIV services, which are provided from the Barts Sexual Health Centre in the Kenton and Lucas Wing within the acute and emergency medicine division.

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Summary of findings

We rated this service as good because:

- An incident reporting system was embedded into the operation of the hospital and staff at all grades told us they felt confident in escalating concerns and mistakes.
- We saw evidence senior staff consistently investigated incidents and learning was broadly disseminated and shared, and we saw changes in practice and policy occurred as a result.
- Infection prevention and control processes were effective and we saw staff consistently adhered to these.
- Staff adhered to good medicines management protocols that ensured patients were safe from the risks associated with improper storage and documentation.
- Pharmacy teams were proactive in identifying areas for improvement in medicines management and worked with clinical teams and senior leadership teams to implement safer practices.
- Staff at all levels demonstrated a consistently proactive approach to reporting safeguarding concerns and working within multidisciplinary teams to keep people safe.
- Senior clinical staff had adapted services provided to patients in response to identified risks, including the introduction of a consultant of the week model and emergency transfer care pathways.
- An improved recruitment strategy and the implementation of nurse development pathways had led to lower vacancy rates and consistent nurse to patient ratios. An action plan was in progress to reduce vacancy rates further through international recruitment and internal development of existing nurses.
- Each clinical area demonstrated improvements to patient outcomes through service developments and staff initiatives. This included a reduction in falls in the cancer wards through the introduction of a falls prevention competency framework.
- Multidisciplinary working with internal and external colleagues resulted in better patient care.

- A structured multidisciplinary education programme and the development of a junior doctor education hub had improved training and development opportunities.
- Clinicians had established multidisciplinary pathways and structures that meant patients treated at more than one of the trust's hospitals received coordinated, continual care.
- Patients and relatives we spoke with provided consistently positive accounts of their care experiences. Good survey results and the demonstrably caring and compassionate approach of all staff we observed supported this.
- Clinical processes were structured to ensure patients were included in their assessment, care and treatment. We saw evidence of this through observing ward rounds, speaking with patients, looking at patient records and looking at survey results.
- Staff in each area demonstrated how they engaged patients in the service, both for improvement and to gather informal opinions and feedback.
- There was evidence of innovation and a drive towards service development and sustainability in each clinical area. This included through research and the implementation of new and experimental services and treatments based on new guidance and evidence.

However:

- Although there was consistent pharmacy support and cover in most clinical areas, there was a lack of contingency planning and elevated risks when this was not available.
- Nursing care bundles and documentation were not always completed consistently and we found gaps in the recording of risk assessments and safety observations across inpatient areas.
- We saw good infection control and hand hygiene practice during our inspection but this was not always supported by good long-term audit data. For example, the infection control team reported avoidable instances of hospital-acquired methicillin resistant *Staphylococcus aureus* (MRSA) and inconsistent hand hygiene compliance.

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- Risks associated with the storage of chemicals, sharps and hazardous waste were not consistently managed in line with national and international guidance.
- Completion of mandatory training was variable and no single group of staff had full compliance with the trust's minimum 90% completion rate.
- We found overall inconsistency in how staff assessed and recorded patient mental capacity in some inpatient areas. This included for one patient with a Deprivation of Liberty Safeguards authorisation in place.
- Staff in the sexual health service described a lack of engagement or support from the trust, human resources and occupational health during a time of uncertainty.

Are medical care services safe?

Good



We rated safe as good because:

- There was an effective and open incident reporting culture and staff could demonstrate how this contributed to improved patient safety and outcomes.
- Established safety processes were in place, which included monthly morbidity and mortality meetings and audits in each clinical specialty.
- Staff demonstrated hand hygiene and infection control practice in line with trust standards and national best practice guidance. However, this was not always supported by consistently good audit results.
- Medicines management in most clinical areas met trust and national best practice guidance, including in the safe storage of controlled drugs and the monitoring of medicine storage temperatures.
- Staff acted proactively when they had safeguarding concerns and both clinical and non-clinical teams demonstrated appropriate and rapid escalation of these to the safeguarding team.
- Clinical staff managed risks to patients by improving the services available, such as the implementation of a consultant of the week model and emergency admission pathways.
- Nurse to patient ratio were maintained at recommended trust levels in accordance with safer staffing tools and senior staff monitored these at several points each day as part of safety meetings. Bank and agency nurses were appropriately trained and experienced.
- Overall turnover of medical staff was better than the trust target in the 12 months prior to our inspection.

However:

- There was a lack of pharmacy support for staff in the sexual health clinic following an incident relating to medicines management. There was evidence in other clinical areas that risks associated with a lack of pharmacy cover were not managed by contingency plans.

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- Nurse-led care documentation and patient records were not completed consistently and we found significant gaps in the recording of observations and risk assessments.
- The infection control team found three cases of hospital-acquired methicillin resistant *Staphylococcus aureus* (MRSA) could have been avoided and implemented an improvement plan as a result.
- Hand hygiene audit results were variable and were inconsistently reported.
- There was inconsistent compliance with national and European regulations on the management of chemicals, sharps and hazardous waste. This included incorrect use of equipment.
- Nurses and medical staff did not meet the trust's minimum 90% completion rate for mandatory training, including all modules of safeguarding training and basic life support.

Incidents

- 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.
- Between March 2016 and February 2017, medical care services reported one incident which was classified as a never event. This involved a retained guide wire from a peripherally inserted central catheter (PICC) line insertion that was identified after the patient reported swelling and discomfort. A senior clinical team conducted a root cause analysis (RCA) after this event and identified a number of areas of learning for the team including a new clinical safety checklist and multidisciplinary safety checks during medical procedures. Staff also documented their use of the Duty of Candour (DoC) as part of the RCA, including discussions with the patient on how the incident occurred and what had been done to prevent future instances.
- In accordance with the Serious Incident Framework 2015, St Bartholomew's Hospital reported five serious incidents (SIs) in medicine that met the reporting criteria set by NHS England between March 2016 and February 2017. Each SI related to a different type of incident and staff did not identify any trends in risk or occurrences. Serious incidents were attributed to one occurrence each of self-inflicted harm, medical equipment, a pressure ulcer, a fall and an invasive procedure. We found evidence that staff implemented improvements following the outcomes of SI investigations. For example following an incident involving a member of staff on a cancer ward staff on night shift were allocated breaks in pairs. Another incident involved potential serious harm to a patient when a nurse administered an incorrect fluid. Senior staff found that similar fluids were stored together, which contributed to the error. As a result the trust implemented new storage guidance.
- In the year prior to our inspection staff in sexual health services reported two SIs. One related to the overheating of the medicines room and another related to a miscarriage after a patient received an implant. In both cases the senior team completed an RCA to identify opportunities for learning.
- Staff we spoke with demonstrated understanding of the outcomes and learning from never events and SIs from other clinical areas, which demonstrated an effective system for learning and improvement across clinical specialties. For example, when an incident occurred in surgery or gynaecology, clinical leads shared learning between them.
- Between March 2016 and February 2017, cancer services reported 131 clinical incidents, of which 45 were medicine errors and 12 related to patient falls. In the same period cardiology services reported 447 incidents, of which 106 were related to medicine and 27 related to patient falls. In respiratory medicine, staff reported 208 incidents including 79 medicine errors and 14 patient falls.
- During the same period staff in sexual health services reported three incidents. None of the incidents resulted in patient harm and where a patient was affected we saw the senior team contacted them to resolve the situation. As part of the investigation the senior team also provided staff with more training, such as where a mislabelling error meant a patient experienced a delay in obtaining the results of a sexual health screen.
- Consultants in each clinical division led monthly morbidity and mortality (M&M) meetings to review specific patient outcomes and clinical safety processes associated with these. Clinical teams in each specialty area attended monthly audit days to review M&M findings and patient complications, which they also

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discussed in team meetings. Senior clinical staff we spoke with said they felt there was a good openness to learning and sharing learning. For example, as a result of learning from M&Ms in the heart centre, 60% of cardiac catheterisation procedures were subsequently completed through the wrist as a strategy to lower mortality rates.

- We looked at a sample of minutes from M&M meetings between June 2016 and February 2017. The meetings were always consultant-led although attendance was sporadic. However, we saw the attending team discussed each case in detail and included wider multidisciplinary teams and other providers in their findings and action points. For example findings from one patient death was shared with consultant colleagues at another hospital and with a local ambulance service to improve referral criteria for emergency pathway patients. Another review resulted in closer working with arrhythmia nurse specialists following an unexpected death.
- There was a positive culture of incident reporting in all areas and staff told us they were encouraged to submit reports. In addition, all of the staff we spoke with said they felt supported by their senior team when they were involved in an incident and demonstrated understanding of the DoC.
- Each inpatient ward manager maintained an incident folder so staff could read updates, outcomes and learning from previous incidents. We saw senior nurses discussed these during daily handovers and staff were given the opportunity to ask questions.
- Staff in all areas demonstrated knowledge of improvements to practice as a result of incident investigations. For example, staff in a cancer ward gave one example of a patient receiving the wrong chemotherapy treatment within the last 12 months. On investigation, it was identified that staff had been working under pressure due to staffing issues. There were not always two people in the bay therefore although two nurses checked chemotherapy; it was not always started immediately. This resulted in increased recruitment and staffing. Following incidents whereby patient samples had been lost in the laboratory, staff in the sexual health clinic had implemented a new labelling and signing in and out system for samples. We asked staff about this. One nurse said, "There is not a

blame or fear culture here. Our [manager] encourages us to submit reports for anything that goes wrong and I think they go out of their way to make sure we're supported to speak up."

- Nurses proactively used 'near misses' or trends in incidents to improve the care they provided. For example, nurses on ward 4D identified a need for improved practice with how nasogastric tubes were used. As a result, a nurse took the lead in improving knowledge and displayed the hospital policy on this and introduced safety briefings during daily handovers. In addition staff in this ward recognised the risk of patients developing pressure areas around their noses from breathing equipment used. To reduce the risk of pressure sores developing, nurses introduced more frequent checks and care of the position of nasal ventilation masks. The ward manager was working with the tissue viability nurse to develop a standard operating procedure for the prevention of pressure sores caused in this way.
- We looked at the outcomes of 20 incidents reported in medical care services and found there was evidence of appropriate investigations with learning outcomes disseminated to staff. For example, following a documentation error involving prescribed medicine on ward 4E; two nurses checked stock levels and reviewed how medicine administration took place. The nurses involved completed a reflective exercise and the incident was discussed during a ward safety briefing.

Safety thermometer

- The NHS Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place on one day each month. Data must be submitted within 10 days of suggested data collection date.
- Data from the Safety Thermometer showed that the trust reported 116 new pressure ulcers, 41 falls with harm and 31 new catheter urinary tract infections (CUTIs) between February 2016 and February 2017 for medical services[MG1]. Monthly prevalence of each

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condition varied broadly during this period. For example, the prevalence of falls per 100 patients varied from no instances in March 2016 to 0.75 in September 2016.

Cleanliness, infection control and hygiene

- Between April 2016 and January 2017 staff reported 10 cases of *Clostridium difficile* (C.Diff) in patients later than 72 hours after admission. In each case staff conducted a root cause analysis to identify contributing factors to the infection and measured this against national Department of Health targets. For example, the trust as a whole had a target of no more than 82 C.Diff cases across all of their hospitals between April 2016 and March 2017. The infection control team implemented a number of strategies to reduce future C.Diff cases and manage related infection control policies. These included weekly C.Diff clinical reviews led by a microbiology consultant, pharmacist and the infection control team (ICT) to review and monitor the diarrhoea protocol. The ICT also prepared a monthly site report for site leads and introduced a new medicine for C.Diff treatment to be used with the guidance of the consultant microbiologist.
- Between April 2016 and January 2017 staff reported three cases of methicillin resistant *Staphylococcus aureus* (MRSA) that occurred more than 48 hours after admission. This means the cases could be apportioned to the hospital. In each case the ICT conducted an RCA of the infection and found that all three had been avoidable had more stringent infection control procedures been followed in relation to intravenous line management. Learning from each incident was communicated to the staff in the clinical areas responsible for each patient and to medical teams across the hospital.
- The ICT implemented closer working with the housekeeping team to ensure cleaning protocols and practice on the wards were sufficient to reduce the risk of C.Diff cases.
- The ICT and senior ward nurses led monthly hand hygiene audits in each clinical area. Between April 2016 and February 2017 medical care services achieved 92% compliance overall, which met the trust's minimum target of 90%. This was an average figure and included seven instances of missing monthly data across five wards including two months' of missing data from ward 3D and two months' of missing data from ward 5D. In the months data was available, individual performance ranged from 67% on ward 5D in February 2017 to 32 instances of 100% across eight of the nine wards included. Ward 3A west did not achieve 100% in any month during this period and results ranged from 73% in May 2016 to 91% in November 2016, January 2017 and February 2017. Ward 6D achieved 100% compliance in every month during this period.
- The sexual health clinic did not consistently contribute results to monthly hand hygiene audits. Between April 2016 and February 2017 audits took place in only two months although the unit achieved 100% in both months. The chemotherapy day unit met or exceeded the trust's 90% target in every month during this period and achieved 100% in 13 of the 22 audits that took place. Ward 7A in the day unit did not submit data for two months during this period. The trust identified improvements in the collection, submission and analysis of data as part of its 2017-2019 planned priorities in a number of areas.
- Infection control nurses conducted an annual audit of each medical inpatient ward and issued action plans for improvement in each case. We looked at the audits for each medical ward for the year previous to our inspection and found that all actions had been signed off. We confirmed this by speaking with staff and visually inspecting ward areas.
- Staff used 'I'm clean' stickers to indicate when an item of equipment had been cleaned and decontaminated and was ready for use. Although we saw staff used this system consistently in most areas we looked at, there was room for improvement. For example, we found a member of staff had labelled a commode with an 'I'm clean' sticker but we found the item was soiled. We spoke with the nurse in charge about this who arranged for the commode to be cleaned immediately.
- Despite inconsistent audit results, during all of our observations we saw staff observed good infection control practice, including in hand hygiene and the use of personal protective equipment (PPE). Patients we spoke with said they noticed staff always wore gloves when providing care and said they noticed staff washed their hands frequently.
- We saw that staff working in the laboratory in the sexual health clinic did not always use personal protective equipment or follow appropriate safety measures. For example, we observed a technician handling chemicals and bodily fluids without wearing a lab coat over their

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own clothes. The technician was not able to locate PPE goggles when we asked if they were available and said they had previously splashed chemicals on their own clothes without reporting this as an incident. This presented a significant risk of personal injury and cross-contamination. We looked at training records for infection control for this team and found only 71% of staff were up to date with this mandatory programme.

- During all of our observations staff adhered to the trust's 'bare below the elbow' policy. We also saw staff challenge people who tried to enter clinical areas wearing long sleeves, including an agency nurse and a bank nurse who both demonstrated attention to detail in this area.
- Between March 2016 and February 2017, staff in medical care services reported 20 incidents relating to infection control. We looked at each incident and found investigating staff had taken appropriate action in each case including staff education and safety briefings. However, it was not always evident from incident reports that sufficient protocols were in place at ward level to prevent future recurrences. For example, one patient on ward 4A experienced a delay in the commencement of MRSA decolonisation treatment due to a lack of communication between nurses and junior doctors despite instruction from an infection control specialist on two occasions. Although the incident resulted in improved guidance to staff there was no evidence a review of policy for MRSA treatment took place.

Environment and equipment

- The hospital participated in the national patient-led assessment of the care environment (PLACE). PLACE enables staff to assess the environment from the perspective of patients against six key measures including against cleanliness, quality of food and accessibility for patients with a disability or living with dementia. The 2016 PLACE scores were assessed in medical wards 3A, 5A and 5C. All three wards scored 100% for their cleanliness, condition, appearance and maintenance.
- Not all areas were compliant with the Control of Substances Hazardous to Health (COSHH) Regulations 2002. For example, we saw a container of chlorine tablets was stored in an unlocked cupboard on one day of our inspection in ward 6D. We also saw a 22-litre sharps bin with an orange lid used for hazardous waste

that should have been stored in a sharps bin with a yellow lid. This meant the ward did not fully adhere to the Department of Health (DH) Waste Regulations Health Technical Memorandum (HTM) 07/01 2013 or the European Union Waste Directive 2008/EC/98 in relation to the safe segregation and disposal of waste. We spoke with the nurse in charge who said the ward had run out of yellow lids and so this was a temporary measure. All other medical inpatient areas were in line with waste regulations and demonstrated appropriate waste streaming processes, including for cytotoxic waste.

- Staff used a daily bedside safety checklist to ensure essential equipment such as monitors and gases were working properly and were appropriately maintained. We looked at a sample of 13 checklists in the heart centre and cancer centre wards and saw staff had completed them consistently in the month prior to our inspection.
- Not all areas we observed always followed EU directive 2010/32/EU or the DH HTM 07-07 in relation to the prevention of sharps injuries. For example, we found sharps bins in use on wards 4D and 4E where staff did not use the temporary lid apertures to prevent avoidable injuries.
- The environments of all of the cancer wards and heart centre wards met the DH Health Building Notes (HBNs) 00-09 and 00-10 in relation to infection control in the built environment and the condition of flooring. Although handwashing sinks in each area met HBN standards, hand hygiene technique posters were not displayed at every sink.
- Six negative pressure rooms and an anteroom were available in the heart centre. We found staff operated these in line with manufacturer's best practice guidance, including in the scheduled maintenance of filters and contingency plans for equipment failure.
- The equipment manufacturer monitored the negative pressure in rooms used for chemotherapy remotely to ensure it operated at safe levels. This was a 24-hour service and the monitoring team could contact hospital staff immediately if there was a need for urgent maintenance or to suspend treatment.
- Four cancer wards were situated on a single floor of the main hospital clinical building. This ward had a high efficiency particulate air (HEPA) filtration system installed, which removed particles from the air and helped to prevent the spread of airborne bacteria and viral organisms.

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- There were several areas of disused reception desks or unmonitored waiting areas on each floor of the main hospital building. Although staff controlled access to wards, it was not immediately clear how the security of staff and patients was monitored or how they were protected from unauthorised visitors. For example a meeting room was available in an unsecured area of the level five landing and we saw this was not always kept locked. We also saw a visitor had accessed a disused reception desk as an area for personal prayer without being challenged or authorised by staff. We asked ward staff about their safety and security. None of the staff we spoke with were aware of specific security risks, policies or procedures but knew how to contact the 24-hour security team.
- A multidisciplinary team met weekly to review medicines incidents. We found this ensured incidents were investigated and staff from different specialist areas contributed to improvements to practice as a result. For example, pharmacists noticed a trend in medicines errors relating to opiate prescribing. They investigated and found the issue was related to inappropriate conversion from one opiate to another. As a result the pharmacy team updated the trust opiate conversion guidelines, which the pain team shared across departments. The pharmacy team also worked with the palliative care team to improve the prescribing and safety of opiates in cancer services. Pharmacists felt the lack of a specialist palliative care pharmacist meant this remained an unresolved risk.

Medicines

- Staff ensured fridges used to store chemotherapy and generic medicines were kept locked, which we confirmed by checking on each day of our inspection in each clinical area.
- Staff documented the daily temperatures of fridges used to store medicine. They used this check to ensure medicines were stored within the safe temperature range set by pharmaceutical manufacturers. We saw staff documented checks consistently and that in the three months prior to our inspection safe temperatures had been maintained. However when we checked one fridge during our inspection it showed temperatures up to 22°C. Staff were not able to explain this.
- We found one cupboard in a cancer ward that had 'to take away' (TTA) medicines that had been dispensed over four weeks previously. We asked the lead cancer pharmacist about this who told us the team has already identified that this is an area for improvement and they had identified a cause as over-ordering of TTAs by staff on the ward. To more effectively manage this, the senior pharmacy team had submitted a business case for two additional technicians who would be dedicated to managing medicine stock levels and prescriptions on the wards, which would help to identify the medicines needed and ensure returns were completed more efficiently.
- Controlled drugs (CDs) and resuscitation drugs were stored and managed appropriately in all wards in which they were stored. This included locked and controlled access, signed checks of stock every day and appropriate documentation when medicine was used.
- Between March 2016 and February 2017 staff reported 305 incidents relating to medicine, which represented 25% of all reported incidents. In each case an appropriate investigation had taken place and pharmacy staff had been involved with supporting ward staff. Although there was evidence of learning and changes in practice in most incidents we looked at, it was not evident that adequate contingency plans were in place to mitigate risks during staff shortages. For example, one incident related to a shortage of a prescribed antibiotic for a patient on ward 4E. The ward had a vacant pharmacy technician post, which meant that staff had not ordered the 30 vials of medicine needed. This compromised patient safety, as staff discovered there was a national shortage of the antibiotic after stocks had already been depleted. This resulted in changes to prescriptions for patients at short notice. Although no harm occurred to patients, staff identified the resolution as recruitment to the vacant post but did not identify how this situation could be avoided in future if technicians were unavailable.
- Staff in the sexual health clinic responded appropriately when an air-conditioning failure meant a storage room reached 40°C. A senior nurse reported this as an incident and quarantined the affected medicines. The pharmacy provided new stock of medicines whilst the medicines management team investigated and reported which medicines were no longer safe for human consumption. The clinic had limited facilities to store medicine securely and that some medicines were stored in a room that did not have restricted access. We brought this to the attention of staff who resolved the situation.

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We saw from the incident investigation that senior staff followed hospital procedure to obtain air conditioning equipment, which the trust had not adequately responded to.

- Staff in the sexual health clinic used FP10 prescription pads for issuing out prescription. This is controlled stationery that requires auditable record keeping and access restriction. However, staff did not adhere to this requirement. For example, FP10 pads were kept in an unlocked cupboard in the clinic to which access was not restricted solely to prescribing staff. We saw a number of voided prescriptions (three in the previous two months) and a staff nurse we asked was not able to account for these as staff had not retained the prescriptions. According to best practice guidance all voided prescriptions should be recorded retained for 18 months and destruction witnessed. Although staff told us pharmacist input into the clinic was not routine, after our inspection a pharmacist responsible for networked sexual health services implemented an action plan for improvement.

Records

- Nurses used a 'nurse toolkit' for each patient on admission to document observations and risk assessments for pressure sores and tissue viability, falls risks and social care needs.
- Staff used a combination of paper notes and electronic notes for patient observations and risk assessments. Although staff told us this system worked well a serious incident had occurred resulting in a patient's death because staff had performed an unnecessary procedure when they could not find previous important notes as a result of the dual system. The senior divisional team had investigated this incident and reported it as resolved but this had not resulted in a defined change to the dual notes system.
- We looked at four sets of patient records on ward 3A and four sets on ward 5C and found standards of information and risk assessments to be variable. For example, on ward 5C one patient's records had no date of admission or named consultant and gaps in documentation relating to medicines. This included a signed prescription that was missing signature for the administration of the medicine. In addition staff had not completed a falls risk assessment and the fluid chart was missing. Two of the eight sets of patients' notes did not include a completed pressure ulcer prevention

bundle or a record of their capacity to consent. Staff had also not completed risk assessments for each patient for moving and handling or for mouth care. On ward 3A two patients did not have the name of their consultant documented, two patients did not have their date of admission documented and three patients had missing fluid balance information.

- We found inconsistencies in the completion of medicine charts in the sample of eight records we looked at on wards 3A and 5C. We spoke with a pharmacist about this. They told us inconsistencies between wards in the standards of documentation were common but that initial critical information was always completed. They also said that height and weight information was a consistent area of concern and they often had to complete this themselves after a patient was admitted.
- On ward 3A staff had not consistently documented observations for a patient following the insertion of a peripheral venous cannula. Although a care plan was in place, this was incomplete and there was no evidence staff had completed ongoing observations.
- In other wards, documentation was completed more consistently and to a high standard. In addition ward managers used audits to identify opportunities for improvement in the completion of patient documentation. For example, the ward manager on ward 4D identified a need for higher quality record keeping following the introduction of a number of new nurses. The latest audit results for records indicated a 70% compliance rate with trust standards, which they told us demonstrated a steady improvement from previous audits.
- On ward 5B we saw that tissue viability documentation relating to a patient with a grade three pressure ulcer had been inaccurately and inconsistently completed. This was because staff had completed a body map and marked the pressure area in an incorrect location. In addition, staff documentation varied between noting that the patient had 'no pressure ulcer' to a 'moisture lesion' and then a grade two pressure ulcer within 24 hours. There was a significant lack of documentation relating to care and condition management for this patient. For example, on two days of their admission no care was documented for 17 hours on one day and 15 hours on another day. Inconsistent documentation continued on three more occasions before staff found the pressure ulcer had deteriorated further to a grade

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three incident. Staff had reported this and the safeguarding team was involved in the investigation. We also found this to be an isolated incident in all of the records we checked.

- We looked at five patient records on ward 5C. All patients had up to date risk assessments but staff had not completed hospital ID numbers on each chart and two records did not have medicine charts in them. Staff were not immediately able to locate these.
- An auditing team monitored the completion and quality of patient records relating to care and risk assessments every quarter. The latest available results from January 2017 demonstrated inconsistent performance across medical inpatient areas. For example, none of the inpatient wards met the trust's 90% target for all 12 documentation criteria in this period. Ward 3A west achieved the target in 10 of the criteria and ward 3A east achieved this in nine of the criteria. Wards 5B and 5D achieved the target in one of the 12 criteria during this period. Senior ward teams planned to conduct a reaudit in April 2017 to identify progress.
- As part of a safety and quality improvement strategy, staff audited the completion of risk assessments for venous thromboembolism (VTE) in patient records on a monthly basis. Between November 2016 and February 2017 medical inpatient wards performed variably. Overall staff had completed a VTE assessment for 77% of patients. This was an average figure and reflected completion rates ranging from 56% on ward 5A to 100% on ward 4D. Staff had completed and maintained up to VTE risk assessments in 11 of the 15 records we looked at.

Safeguarding

- Between March 2016 and February 2017 staff in medical care services reported seven incidents relating to safeguarding. Incident reports and investigations reflected a proactive and multidisciplinary approach to escalating safeguarding concerns. For example, a student nurse had reported concerns of domestic abuse following a confidential discussion with a patient. In another situation nurses had worked with the safeguarding team and a dietician to support a patient they were concerned was malnourished.
- The trust had a target of 90% for the completion of safeguarding training. As of March 2017, medical staff met the target for three of the five safeguarding modules. Medical staff did not meet the target for

safeguarding adults level two (76%) or safeguarding children level two (83%). Nursing staff also met the target in three of five safeguarding modules. Nurses did not meet the target for safeguarding adults level two (78%) or safeguarding children level three (48%). In the sexual health clinic, 88% of staff had up to date adult safeguarding training to level two and 92% of staff had up to date safeguarding training to child safeguarding level two.

- There was conflicting information about whether staff always had safeguarding training to an appropriate level based on the patients they cared for. For example, nurses on ward 4D cared for children with cystic fibrosis but one nurse told us they had not completed child safeguarding training. We asked the ward manager about this who said ward sisters had child safeguarding training to level three and all staff nurses had this training to level two. We also checked safeguarding training records for this ward and found 95% of nursing staff had child safeguarding level one training, 71% had child safeguarding level two and 86% of required staff had up to date child safeguarding level three training.
- A nurse safeguarding lead was in post and provided training and teaching to ward staff on mental capacity and mental health.
- A safeguarding link nurse was in post in the cancer wards and heart centre and provided additional support for patients with complex needs, particularly in relation to social care.
- A safeguarding lead was available for sexual health services and met monthly with their counterpart in the hospital to discuss patients seen by multiple specialties. For example, where a patient was seen in the sexual health clinic for care relating to problematic drug use, the safeguarding lead liaised with their hospital counterpart to ensure the patient's children and family were not at risk.

Mandatory training

- All staff were required to maintain a minimum standard of 90% completion of mandatory training, which was delivered through a mix of online and classroom-based sessions. This included 23 modules for medical staff and 27 modules for nurses. As of March 2017, medical staff did not meet their target for four modules. This included 72% completion for blood transfusion, 82% for fire

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safety and 78% for medical gas safety. Nursing staff did not meet the target for eight modules. This included 79% completion for medical gas safety, 81% for blood transfusion and 80% for moving and handling.

- Staff in specialist clinical areas undertook additional mandatory training such as in blood transfusions and stem cell transplant care.
- Senior ward staff were not always able to demonstrate how they could be sure staff were up to date with mandatory training. For example on ward 5A, the electronic monitoring system showed that some staff training had expired in March 2016 and on ward 5D the same system showed an expiry date of September 2013 for some staff who were still actively employed. Senior ward nurses were not able to confirm that the data available at this level was the same information used at trust board level to assess the compliance rate of staff with mandatory training requirements. However, individual staff we spoke with told us they received e-mail updates when training was about to expire to help them remain up to date.
- Staff were given protected time to complete mandatory training and each individual we spoke with was able to give examples of recent training.

Assessing and responding to patient risk

- A consultant of the week and registrar of the week provided cover in the heart centre for acutely unwell patients as well as those at risk of deteriorating. The medical team conducted additional ward rounds in the coronary wards for these patients, which enabled continuity of care for those with complex needs.
- Medical cover was provided in the heart centre that enabled deteriorating or acutely unwell patients to be quickly and safely transferred to St Bartholomew's Hospital from other NHS or independent hospitals. For example, during our inspection a patient was transferred from another NHS acute provider within two hours of a call from their consultant to the heart centre. This patient received immediate specialist care that could not be provided by other cardiac centres and as a result their condition improved.
- Clinical staff in the heart centre had reduced risks to patient safety that occurred from the merging of several different cardiac teams. For example, an incident occurred in which a member of staff inserted a valve

implantation incorrectly due to staff from different units working to different protocols. As a result the clinical teams worked together to establish common protocols and practice that resulted in reduced patient risk.

- Staff used the national early warning scores (NEWS) system to monitor patients who were deteriorating. Where a patient scored over five on the NEWS scale, staff referred them to the critical care outreach team. This team provided an on-call service 24-hours, seven days a week. We looked at the records of 20 patients being cared for in the respiratory and cancer wards. In each case staff had documented the NEWS score regularly and there was evidence of appropriate escalation when the score increased.
- The hospital audited the use of NEWS in each clinical area in February 2017, following an audit in September 2016 that highlighted several areas of concern that required improvement. The latest audit identified that staff had correctly and fully completed NEWS observations in 91% of cases in medical wards. This included 100% completion of blood oxygen saturation levels in all medical wards except 5D, where 98% of oxygen blood saturation were correctly completed. In all cases staff had correctly completed and documented blood pressure although rates of completion of level of consciousness observations varied between 91% on ward 5A and 100% on ward 3A east. The audit results indicated a need for more accuracy in the completion of NEWS calculations on some wards. For example, only 86% of NEWS scores on ward 5D were correct and only 88% on ward 6D were correct. In the audit sample 100% of NEWS scores on ward 5A were accurate. The audit also identified that 25% of patients whose NEWS score was elevated did not receive observations at appropriate intervals overnight. This was an average figure across all areas of the hospital and the audit found the frequency of observations to be generally unacceptable and contributing to an inappropriate clinical response in 10% of cases. However, overnight observations did reflect an 11% improvement from the September 2016 audit.
- Anaphylaxis kits and equipment to treat cervical shock were kept in the sexual health clinic in addition to resuscitation equipment. We saw staff had documented safety checks on all equipment at appropriate intervals according to hospital guidance.

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- Each clinical area had emergency equipment including oxygen and defibrillators. We looked at the daily safety records for each item of equipment and found staff signed checks of these at least daily on every date in the three months prior to our inspection.
 - Chemotherapy nurses used a modified early warning score system to identify patients at risk who called the triage emergency hotline. Nurses in this unit were also trained in blood work analysis, which means they could identify patients who required more urgent intervention.
 - As part of a strategy to reduce falls, staff displayed 'call don't fall' notices in patient bathrooms to encourage patients to call for help rather than risk a fall by trying to mobilise themselves.
 - The trust had a target of 90% for the completion of basic life support and resuscitation training by medical and nursing staff. As of March 2017, medical staff had a 70% completion rate and 83% of nurses had up to date training. In the sexual health clinic, 88% of staff had up to date training.
 - A clinical nurse specialist (CNS) led risk factor modification and primary prevention discussions for patients with non-obstructive coronary disease as part of a follow-up clinic. Staff also referred these patients to their GP to continue risk management following discharge.
 - Where patients could be more appropriately treated by another specialist service within the trust, clinical staff facilitated inter-hospital transfers to ensure patient risk was minimised. Staff used specific care pathways to achieve this, which meant they could complete transfers safely and with the supervision of appropriate clinical management.
 - As part of local safety standards for invasive procedures (LocSSIPs), staff in the cardiac catheterisation laboratories (cath labs) used safety checklists to ensure care and treatment was provided whilst protecting patients from clinical risks. Checklists included a swab and instrument count sheet, a code red or emergency procedure checklist and a debriefing checklist.
- ## Nursing staffing
- Site managers and senior ward staff used the Shelford Group Safer Nursing Care Tool and a patient acuity tool to review staffing levels daily. Staff also discussed this during the daily safety briefing.
 - A team of 34 cancer CNSs worked in the hospital. This included two head and neck specialists, eight CNSs in haematology-oncology, specialists in skin and brain cancer, a CNS for the Macmillan Information Centre and three endocrine CNSs. In cardiology, 27 CNSs provided care within seven specialties, including heart failure and inherited arrhythmia.
 - A team of 47 staffed the cath labs, which reflected a 38% decrease in vacancies within the previous two years.
 - A team of nurse practitioners led services in the sexual health clinic supported by band six trainee nurse practitioners and seven sexual health technicians.
 - Nurse handovers took place at the beginning of each shift on every ward or clinical area.
 - As part of our inspection we observed handovers in three medical inpatient wards. We saw in each case a senior nurse led the handover and ensured it was interactive and included each staff nurse who attended. The teams discussed the wider needs of each patient, including their social care needs and circumstances. Nurses also individually reviewed vital signs including NEWS and ventilation.
 - Ward managers were empowered to resolve recruitment shortages by working together to offer existing staff development opportunities. For example, following a nurse shortage on a cancer ward, ward managers offered nurses on other wards a development programme that enabled them to develop skills and clinical competencies and relocated them to the ward to provide a more stable permanent team.
 - Use of agency nurses was generally low and during our inspection we saw two agency nurses working in inpatient areas. Ward managers told us they used a core group of experienced agency nurses when needed to cover short-term staffing shortages but this was no longer a regular occurrence due to improved overall staffing levels.
 - The nurse in charge on the chemotherapy day unit attended four daily safety huddles, including one with the pharmacy lead and one with the site manager.
 - The nurse to patient ratio in each inpatient area was maintained at between 1:3 and 1:7 in line with national guidance and the bi-annual hospital review of the Shelford Group Safer Nursing Care Tool. In the chemotherapy day unit the ratio was typically 1:7, with two band seven supernumerary nurses and 22 nurses. We saw that senior staff provided extra cover and support when patients attended with complex needs.
 - Medical care services had an overall established whole time equivalent (WTE) need for 309 nurses. As at March

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2017 257 WTE nurses were in posts, which represented an overall vacancy rate of 17%. Vacancies on individual wards varied from two WTE nurses on ward 5B to 17 WTE nurses on ward 5A.

- Bank nurses filled daily shortfalls and the senior team had launched a new recruitment programme. Vacancies in individual areas varied from 39% of establishment in wards 5C and 5D to 6% of establishment in the cath labs and 0% vacancy rate in ward 6D. We spoke with three patients on ward 5C who said staff were responsive to call bells and they felt the ward was well staffed. The senior team had projected the reduction in nurse vacancy rates if recruitment plans succeeded and international appointees accept job offers. This would reduce the overall vacancy rate to 5%.
- A CNS for colorectal cancer joined consultant ward-rounds twice weekly and referred patients to surgical colleagues where a surgical intervention was needed.
- A team of healthcare assistants (HCAs) supported patients and the nursing team on each inpatient ward. HCAs conducted blood pressure and blood sugar tests as well as provided personal care. However HCAs and nurses we spoke with in some areas, including ward 5C, said there was a lack of clarity in the HCA role. Staff told us this meant the support provided was inconsistent and because the senior nurse did not always include HCAs in handovers, nurses were always aware of specific responsibilities for the shift.
- All nurses working across the four specialties in the heart centre had a joint daily handover so that they were aware of the needs of patients in each ward and the demands on each nurse team. This meant patient knowledge was shared between teams and staff could be redeployed to ensure the skill mix and distribution met patient needs.
- A team of band six nurses led the chemotherapy assessment unit and each area had a senior sister. HCAs trained in phlebotomy supported the nursing team.
- Between February 2016 and January 2017 the trust reported a nursing staff sickness rate of 4%. This was slightly higher than the trust target of 3%. This was an average figure and sickness rates ranged from 6% in endocrinology to 2% in the cancer clinical academic group (CAG) management and cardiovascular services CAG management.
- Between March 2016 and January 2017 medical areas reported variable use of bank and agency staff. Cancer

CAG management and cardiovascular CAG management reported the lowest levels of agency or bank use, at a maximum monthly rate of 1% and eight months with no usage. Solid tumour oncology and haematology-oncology reported the highest usage of bank and agency staff, with monthly averages of 44% and 36%. During the same period electrophysiology and respiratory medicine reported consistent reductions in the use of bank and agency staff, including a 19% reduction in electrophysiology.

Medical staffing

- Medical teams were made up of 35% consultants, 16% junior doctors, 4% middle career doctors and 45% registrar group doctors, which was similar to national averages.
- Three respiratory consultants of the week were on site 24-hours a day, seven days a week with a further three consultants on call at all times. In cardiology, two consultants of the week were on site between 8am and 6pm seven days a week with two consultants on call between 6pm and 8am.
- In cardiology and the respiratory wards, four specialist registrars (SpRs) and nine senior house officers (SHOs) were available daily between 8am and 6pm. Overnight in cardiology three SpRs and three SHOs were on site with an additional doctor at each grade at weekends.
- In oncology, consultants provided daily on-site and on-call cover and a core medical trainee (CMT) was available on the wards with a resident CMT until 8.30pm Monday to Friday. At weekends two CMTs and two SpRs were on site between 8.30am and 8.30pm.
- Two disease-based medical teams worked in haematology-oncology with daily consultant on-site and on-call cover. Two SpRs worked in this area from 9am to 5pm alongside a CMT from 9am to 8.30pm Monday to Friday. At weekends two SpRs and two CMTs were available between 9am and 5pm.
- A consultant ward round took place at least daily seven days a week on each inpatient ward.
- Two senior house officers (SHOs) and a specialist registrar (SpR) reviewed patients in the cancer inpatient wards between 8.30am and 8.30pm and one SHO was available overnight. An SpR was available on-call overnight.
- The consultant of the week led weekend ward rounds in the heart centre and on the cancer wards.

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- A consultant oncologist was available on the cancer wards daily between 5pm and 8pm.
- A consultant and lead clinician for the networked sexual health service led sexual health and HIV services and a genitourinary medicine consultant was nominated for this hospital. In total four consultants were available in the sexual health clinic with support from junior doctors and clinical fellows.
- Consultants and junior doctors conducted a grand round on a weekly basis as a best practice education tool.
- Between February 2016 and January 2017, the medical staff turnover rate was 3%. This was better than the trust target of 5% and reflected a range from 0% turnover in electrophysiology, haematology-oncology, respiratory medicine and solid tumour oncology to 23% in endocrinology.
- Between February 2016 and January 2017 the trust reported a medical staff sickness rate of 0.2%. This was significantly better than the trust target of 3%. Seven of the nine medical services areas reported no sickness during this period.
- Between March 2016 and January 2017 medical services reported overall low rates of bank and locum doctor use. During this period the highest single monthly use of bank or locum staff was in specialised cardiovascular services, at 11% in August 2016. Six of the nine medical specialty areas reported monthly locum use at no more than 2% in each month during this period.

Major incident awareness and training

- The trust had a target of 90% for the completion of emergency planning training. As of March 2017, 94% of medical staff and 96% of nursing staff had completed this training.
- Staff we spoke with demonstrated inconsistent knowledge of the major incident or evacuation procedures for their usual area of work. For example, one member of staff on ward 5C said, "I know there's an evacuation policy but I don't know what it is. I think there are different alarms for different situations but I wouldn't know what to do if I heard one. We could do with better training on that." However, two nurses we spoke with on ward six demonstrated in-depth knowledge of emergency procedures, including how to carry out a complex vertical evacuation.
- It was not standard practice for staff to undertake practical evacuation training but some staff we spoke

with said the trust fire officer provided detailed information when an emergency procedure changed. For example, the evacuation routes and staff rendezvous point from the sexual health clinic had recently changed following a reconfiguration of the building. In response, the fire officer had visited and briefed staff on the new emergency procedures.

Are medical care services effective?

Good



We rated effective as good because:

- Staff in all of the clinical services we inspected delivered care and treatment in line with national best practice guidance and standards issued by appropriate bodies. This included the World Health Organisation, National Institute for Health and Care Excellence, the British Association for Sexual Health HIV, the Faculty of Sexual and Reproductive Health and the British Cardiovascular Society.
- Clinical departments benchmarked their use of national policies through local audits, peer reviews and service evaluations. This demonstrably led to service improvements such as in better quality discharge and transfer documentation and the establishment of a 24-hour nurse-led hotline.
- Multidisciplinary audits were used to identify risks to patients and to reduce these as part of on-going evidence-based practice. This included work by the pharmacy team to improve awareness of allergies.
- Diabetic nurse specialists and dieticians supported nurses and the medical team in maintaining appropriate nutrition and hydration for patients.
- The heart centre demonstrated an average 'door to balloon time' of 60 minutes, which was better than the national average of 90 minutes.
- Results from the national lung cancer audit indicated the hospital performed better than the national average in every indicator.
- Consultants were participating in a multi-partner heart improvement programme to reduce late admissions and improve patient outcomes through a heart failure community of practice and a virtual experience reference group.

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- A nurse education team and specialist educators were in post in each clinical area to lead on staff development and training. This included through protected training time and support during induction.
- A rehabilitation support team and multidisciplinary therapy team supported patients with rehabilitation goals and strategies to improve their recovery. This was part of a broad multidisciplinary approach to care and treatment that ensured patients received a holistic and individualised recovery plan.

However:

- Although nurses and sexual health technicians in the sexual health clinic received appropriate clinical training, there was no formal framework or structure for this.
- There was not daily on-site cover from a tissue viability nurse and ward nurses told us they did not feel confident in identifying or treating pressure sores. This was reflected in the number of hospital-acquired pressure sores in the previous 12 months.
- There were gaps and inconsistencies in staff knowledge with regards to the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards. We found insufficient and inappropriate documentation and records of monitoring with regards to this in two wards.

Evidence-based care and treatment

- Staff in the catheter labs used the World Health Organisation (WHO) safety checklist for procedures including angiograms. We saw this in practice during our inspection and from looking at patient records.
- Staff provided care according to national best practice guidance in their clinical area. This included guidance issued by the National Institute for Health and Care Excellence (NICE) such as clinical guidance 172 in relation to cardiac rehabilitation as part of a heart attack care and treatment pathway.
- Clinical staff in the sexual health service provided care in line with British Association for Sexual Health and HIV (BASHH) guidance and the Faculty of Sexual and Reproductive Health UK Medical Eligibility Criteria (MEC). This meant clinicians assessed how safe an intervention may be for each individual before agreeing to a course of treatment. Sexual health services were

also one of twenty Public Health England GUMNET services, which meant they were active participants in national and international research initiatives as a strategy to develop evidence-based care.

- Staff in the sexual health clinic audited the identification of new cases of gonorrhoea amongst patients in line with the WHO international guidance on increasing prevalence. The clinic had a target of 94% identification at the initial point of care and achieved 98% detection in the 12 months prior to our inspection.
- The pharmacy team had completed an audit on allergies, looking at patients who were allergic to penicillin to ensure staff captured this across all of the systems used to document patient care and treatment. The results showed that staff at ward level were 90% consistent in recording allergy information across all platforms and systems. Results in other areas were variable and in the chemotherapy day unit only 60% consistency was found between different recording and prescribing systems. This meant that 40% of patients may have been at risk of being prescribed medicine they were allergic to. This was recognised by service leads on the risk register and the pharmacy team had initiated targeted work with clinical prescribers to ensure medicines were issued safely. This included training for doctors and nurses, posters to highlight awareness and a relaunch of allergy cards for staff.
- Staff had improved the care and records of patients who were transferred or discharged following regular audits in the heart centre. For example, staff had used different systems to complete transfer summaries, which meant they were not always completed consistently. As a result the medical team introduced a new system and provided training for all consultants, registrars and trainee doctors to ensure transfer summaries followed a standardised format.
- Staff had electronic access to hospital, trust and national policies and procedures through the intranet. All of the staff we spoke with at different levels of seniority were able to show us how they accessed this. Three of six nurses we asked about mental capacity and assessment policies were unable to locate these online but knew who to contact for immediate support.
- Staff in the cancer wards held a monthly audit meeting to highlight and discuss the results of up to three local audits. For example, an audit meeting before our inspection included the results of a discharge process audit that indicated a need for better documentation.

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- Staff demonstrated a proactive approach to developing services based on audit and peer review. For example, following an external review of chemotherapy services, a chemotherapy assessment unit and 24-hour nurse-led hotline was opened. In addition, a new immune-oncology group was established to embed this specialty into existing services.
 - The hospital had implemented an action plan in response to the results of the national 2016 oesophago-gastric cancer audit. This included implementing multidisciplinary reviews of patients diagnosed with dysplasia, introducing a named lead to ensure data completeness for audit purposes and reviewing protocols for emergency admissions. The hospital had achieved all points relating to medical services in the action plan, including liaising with the London Cancer Pathway Board to implement GP and community health education campaigns.
 - Each clinical specialty had an audit programme in place that aimed to evidence practice against local and national guidance, such as that issued by the British Committee for Standards in Haematology in relation to the use of bisphosphonate therapies. Overall for 2016/17 there was 95 audits planned for cancer services, 38 audits in cardiology, 13 audits in haematology-oncology, nine audits for chemotherapy day services, four audits for respiratory medicine and three audits for inherited cardiovascular disease services.
 - The hospital was participating in the Royal College of Physicians national chronic obstructive pulmonary disease (COPD) exacerbation audit and included patients living with COPD who were treated under specialties other than respiratory. A respiratory consultant met fortnightly with the audit team to discuss individual cases and track data trends. The latest audit began in January 2017 and at the time of our inspection there were no outcomes yet available.
 - In March 2017 the director of quality and safety implemented an action plan in response to the National Institute for Cardiovascular Outcomes Research (NICOR) audit. This included 19 individual actions for six clinical functions such as the implementation of new databases to improve data collection in adult percutaneous interventions. In addition, they implemented a process for developing patient consent for validation in congenital heart disease.
 - The trust participated in the national mandatory clinical audit programme for cancer. This included the national bowel cancer audit, the national lung cancer audit, national prostate cancer audit and the oesophago-gastric cancer audit. At the time of our audit the trust's data submissions were up to date but there were no available results.
 - Clinicians implemented audits relevant to learning from practice, incidents and complaints. For example, in haemato-oncology, an audit was underway to assess communication standards between staff and patients in clinical trials.
 - A doctor and specialists in colposcopy and cytopathology were delivering a cervical cytology update programme to staff in the sexual health service to ensure practice reflected the latest evidence and guidance. This included ensuring smear tests were conducted in line with the NHS cancer screening programme and the national cervical screening programme.
- ## Pain relief
- A specialist pain team was available in the hospital on weekdays from 9am to 5pm and the trust had a multidisciplinary persistent pain team that patients could access on referral.
 - All 15 patients we spoke with said they felt staff managed their pain well and staff responded quickly to requests for pain relief at all times.
 - Staff had documented regular pain scores in three of the four patient records we looked at on ward 5C and in all other records we looked at.
 - The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015), including in relation to pain assessment, time between pain relief and multidisciplinary input.
- ## Nutrition and hydration
- Nurses used the malnutrition universal scoring tool (MUST) to assess nutritional needs when patients were admitted to an inpatient ward. From looking at patient records we saw staff used this tool consistently.
 - A dietician was available to assess patients whose MUST score indicated they were at risk of malnutrition.

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- Nurses and healthcare assistants provided assisted feeding to patients who were at risk of malnutrition because they found it difficult to feed themselves including due to swallowing difficulties or psychological issues.
- Although we found staff completed MUST scores consistently, they had not documented height and weight in any of the four sets of patient records we looked at on ward 5C.
- A diabetes specialist nurse and two diabetes link nurses were available on referral and provided dietary advice and guidance for patients and staff caring for them.
- Nurses and dieticians provided nutrition support in line with NICE clinical guidance 32 in relation to nutrition support including oral nutrition, enteral tube feeding and parenteral nutrition.
- A senior team audited the standard of documentation relating to nutrition in patient records every quarter in each inpatient ward. The audit included five standards including whether nutritional care plans supported individual needs and preferences and whether food charts were completed accurately. We looked at the latest audit results from January 2017 and found no inpatient ward met the hospital standard of 90% in all five criteria. Ward 5B did not meet 50% in any of the criteria and ward 3A west was the only ward to achieve 51% or above in every criteria.
- Clinical specialists had developed a radial lounge, which was one of the first to establish radial procedures that were less invasive. This meant patients could be more relaxed, which contributed to better outcomes.
- Staff teams demonstrated a proactive approach to testing and embedding improved practices to improve patient outcomes. For example, staff in the cancer wards had established pilot schemes and working groups to reduce falls, reduce pressure ulcers and to introduce an enhanced care package. Each working group monitored specific outcomes to measure effectiveness for patients. Since the introduction of the falls working group, falls on the cancer wards had been reduced by 50%. This involved cohorting patients into the same bed bay where staff were aware of a falls risk and coaching relatives in falls prevention strategies. In addition, staff had access to a falls prevention toolkit on the intranet, which was based on the falls prevention competency framework. There had been a corresponding decrease in the number of falls in the previous six months. For example, average falls on ward 5A had decreased from 4.8 per month to 2.6 per month.
- The heart centre demonstrated an average 'door to balloon time' of 60 minutes, which was significantly better than the national average of 90 minutes. This is an indicator that reflects the proportion of patients who undergo an emergency procedure (percutaneous coronary intervention - PCI) to improve blood flow to the heart muscle in the event of a heart attack (myocardial infarction - MI) within and up to 90 minutes of arriving at hospital. It is the interval between the arrival at hospital and the time that the PCI procedure is performed.
- The clinical team in the heart centre maintained the established audit programme during a merger of teams and services to ensure the continuity of care and quality.
- Between December 2015 and November 2016, the average length of stay for medical patients admitted for an elective procedure was 3.8 days, which was less than the national average of 4.1 days. During the same period the average length of stay for non-elective patients was 5.3 days, which was less than the national average of 6.7 days. Patients admitted for elective clinical haematology had an average length of stay of 10.6 days, which was longer than the national average of 5.7 days.

Patient outcomes

- Senior clinical staff used an interventional data set to monitor NICOR outcomes as part of a national reporting system to assess the hospital for medical outliers. The hospital performed in line with national averages but demonstrated a 20% mortality rate for patients with predicted worse outcomes. The senior team recognised a contributing factor was that the hospital accepted acutely unwell patients that other hospitals could not accept and they had established better working with the local NHS ambulance service to improve assessment of the circulatory system to ensure the patient was admitted to the most appropriate hospital.
- Clinicians had introduced an emergency arrhythmia service as part of an emergency pathway with the local NHS ambulance service. This meant patients could now be admitted to this hospital and receive highly specialised care.

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- Between November 2015 and October 2016, medical patients had a higher than expected risk of readmission for all elective specialties and all non-elective admissions except for cardiology, compared with national averages.
- The one year survival rate for patients diagnosed with lung cancer in 2016 was 39%, which was similar to the national average of 38%.
- In the 2016 national lung cancer audit the proportion of patients seen by a cancer nurse specialist was 72%, which was worse than the audit minimum standard of 90%. This was also a decrease from the 2015 audit result of 83%. However, the hospital performed significantly better in this marker than the national average of 57%. In the audit, 23% of patients with a histologically confirmed non-small cell lung cancer (NSCLC) underwent surgery. This was better than the national average of 17%. In addition, 77% of patients with small cell lung cancer underwent chemotherapy, which was better than the national average of 69%. Amongst patients with advanced NSCLC, 72% received chemotherapy. Although this was better than the national average of 64%, it represented a decrease of 11% from the previous audit in 2015.
- Heart failure nurses and consultants joined colleagues from other specialist cardiology centres as part of the UCL Partners Heart Improvement programme. This programme aimed to reduce late diagnosis and unnecessary admissions. To date the programme had established a heart failure community of practice and a virtual experience reference group to assist in information and best practice sharing across a multidisciplinary team. In addition, a heart failure project had been initiated across this trust to reduce unplanned admissions and increase evidence-based prescribing of heart failure medication. This was a new project at the time of our inspection and so immediate outcomes and results were not yet available.
- The hospital was in the process of implementing local safety standards for invasive procedures (LocSSIPs), based on their national equivalents issued by NHS England, to ensure that all wards in which staff carried out invasive procedures were compliant with best practice guidance. This included using safety checklists, auditing procedures and using standard operating procedures. As at April 2017, wards 3A, 4D, 6D and 7A

were compliant with LocSSIPs in peripherally inserted central catheter lines. Wards 5C and 5D did not meet the required standards and had been prioritised by the project team for implementation in May 2017.

- In the cath labs, staff had developed two pathway-based LocSSIPs; one for individual patients and a list pathway for a group of patients. The pathways ensured staff provided care against specific safety criteria such as a safety briefing, a pause and a handover. March 2017 audit results indicated consistently good performance in LocSSIPs. For example, staff had documented a team brief in 99% of the 183 procedures included in the audit as well as achieved 100% compliance for documentation and a team debrief.

Competent staff

- A senior nurse, nurse education practitioner and nurse education facilitator provided a nurse education team.
- Senior clinical staff in the cath labs had developed simulation learning that was also offered to the multidisciplinary team. This team had also improved training and support for junior doctors to ensure they had better supervision and education and learning support dedicated to specific educational areas.
- Nurses were offered regular study days as part of their rota and were encouraged to advance their clinical skills and knowledge.
- The pharmacy team carried out training for all new prescribers on e-prescribing. For example, specialist registrars were given e-prescribing training and completed additional sample prescriptions before being signed off to prescribe. Pharmacy technicians trained nurses in regulations relating to controlled drugs and medicines management.
- Pharmacy staff attended junior doctor's inductions to introduce general doses and administration.
- Staff in each clinical area had access to protected teaching, learning and development time. For example in the sexual health clinic a senior clinician led learning sessions every Wednesday morning.
- Sexual health technicians were trained in microscopy to detect specific conditions and received individual competency coaching and checks from nurse practitioners to be able to do this. Technicians were required to achieve a 100% pass rate in a competency-based practical exam before they could practice microscopy themselves.

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- A chemotherapy nurse specialist educator and cancer care educator were in post and worked with staff to maintain and develop their skills and competencies.
- Nurses and healthcare assistants working in cancer wards and in the heart centre had the opportunity to rotate between different clinical specialties to develop their specialist skills. Ward managers coordinated rotations on a six monthly basis and provided support along with clinical educators to make sure nurses were provided with a safe and structured experience. Nursing teams also had the opportunity to undertake specialist communication training to help them communicate complex information in challenging circumstances to patients and relatives. We spoke with a nurse on ward 5C about this. They said they felt development opportunities were readily available and that access to clinical educators meant the nursing team was, "...really well looked after."
- The chemotherapy nurse educator team had introduced a 'train the trainer' programme to improve training strategies and programmes. We spoke with nurse educators who said they felt this had a positive impact on the quality of training but that training governance could be improved if they had protected time to update their students on hospital training opportunities.
- Agency nurses who worked in specialist clinical areas had completed specific competency assessments for their work, including for chemotherapy.
- All staff undertook a period of induction on joining a clinical team for a minimum of two weeks. During this period they completed an initial competency booklet and mandatory training and spent time shadowing the various clinical teams in their area. We spoke with a healthcare assistant in a cancer ward who had recently completed their induction. They said, "I had a very positive start to working in this team. I got to shadow different people, including the doctors. I feel much more confident because of this."
- The Barts Education Academy held weekly multiprofessional education sessions for undergraduate student nurses to provide instruction in areas such as the use of the national early warning scores. Student nurses also had access to a student forum that enabled them to meet members of the senior team and plan their future with the trust.
- All of the staff we spoke with were positive about the training and development opportunities available to them. One nurse said, "[The training] makes you feel invested in and makes you want to stay. I think that's why we have such good loyalty here."
- Staff we spoke with were positive about the appraisal process and said this had led to opportunities for them. For example one nurse said their last appraisal had enabled them to access more training and another said they had been supported to enrol on a university course as a result.
- Staff on ward 6D had undertaken dementia training following a sustained increase in the number of patients admitted who were living with this condition. One nurse we spoke with said all staff had been encouraged to complete the training and this helped them to communicate more effectively with patients and their relatives.
- We spoke with a medical oncology specialist registrar who described their experience of training and supervision as positive with regular opportunities for teaching and learning. Medical trainees were supported to complete additional training and academic development, including to PhD level.
- A senior nurse practitioner worked on the haematology-oncology unit and was working with the clinical director to develop their clinical competencies to better support doctors.
- Following a merger between community contraception services and the sexual health clinic, staff from community services had undertaken training to help them provide services for the needs of patients seen at the clinic. This included skills to provide care for patients with sexual health needs relating to drug use and gay men's health.
- Staff in the sexual health clinic had undertaken training delivered by psychologists on identifying patients with a suicide risk and those who presented with depression. All clinical staff were trained in motivational interviewing techniques, which helped them to obtain more accurate sexual history information from each patient.
- A nurse consultant in sexual health services led clinical staff education and nurses were organised into teams of mentors. This meant all staff had regular clinical supervision in addition to an annual appraisal based on patient case reviews. Although this meant qualified nurses received ongoing support, senior staff told us there was room for improvement in the education and

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learning framework for new and trainee nurses. For example, there was no formal educational structure for trainee band six nurses and senior staff told us the clinic was too busy to provide the level of supervision required.

- Senior teams had worked to improve training and development opportunities for junior doctors. For example, a new multidisciplinary approach to training had been implemented. This meant junior doctors spent time with general managers, pharmacy staff and other roles to continue their development. We spoke with three junior doctors who spoke positively about this and said they felt it represented an improvement in their development. The trust's senior leadership team had identified this as a priority for future development as part of the 2017-2019 business planning priorities, which included the development of a junior doctor education hub.
- Appraisal rates between April 2016 and April 2017 varied between 80% in clinical oncology and 100% in endocrinology and medical oncology.
- Nurses working in chemotherapy undertook a range of annual competency assessments and re-accreditations following an initial cytotoxic chemotherapy workbook, which resulted in an initial accreditation for the administration of systemic anti-cancer therapy. This included annual reaccreditation for the administration of systemic anti-cancer treatment and drug preparation. In all cases they were observed and signed off by chemotherapy clinical nurse educators in practical scenarios.

Multidisciplinary working

- Multidisciplinary teams at each of the trust's hospitals met weekly to coordinate care and discuss complex patient cases. This meant consultants and clinical nurse specialists could review patients who were treated by specialists at more than one site and ensure those who were transferred between sites received continual care.
- Clinical staff, physiotherapists (PTs) and occupational therapists (OTs) attended a weekly multidisciplinary meeting to review treatment and discharge plans for individual patients. Staff also used this meeting to identify barriers to discharge that caused delays, such as social needs.

- Rehabilitation support workers, PTs and OTs conducted patient management meetings daily to ensure that individual needs were met, such as maintenance on mobility support plans and rehabilitation goals.
- The Barts Heart Centre was part of the UCL Partners Academic Health Science Network; which facilitated research, development and collaboration across a wide group of healthcare providers and academic institutions.
- A palliative care team, including a consultant, was available on site 24-hours, seven days a week and worked with ward-based staff to facilitate fast-track discharges and palliative care pathways.
- Staff in the cancer wards had access to palliative care social workers to help coordinate packages of care for patients due to be discharged. However social workers for other needs were not readily available or contactable, which staff told us often resulted in delayed discharges.
- Specialist dieticians worked in each clinical area and provided targeted support and assessments for patients with specific risks, such as those being treated for cystic fibrosis.
- Nurses and healthcare assistants in each clinical area undertook additional specialist training and attended regular quality meetings to enable them to act as link practitioners in specific areas. This included in infection control, safeguarding and mental health.
- The clinical lead for OT and PT arranged their team so that each inpatient ward had linked OT and PT therapists and rehabilitation support workers. This meant the team had built working relationships with ward staff and had developed their skills to work with patients being treated for specific conditions.
- Dieticians, PTs, OTs and clinical nurse specialists provided a multidisciplinary stem cell transplant review clinic. This enabled patients to access pre-treatment advice and also meant patients had early access to an outpatient therapies leads, which helped prepare them for their care after discharge.
- The allied health professional team had worked with the spinal clinic to significantly reduce waiting times for braces, from two weeks in the previous year to a same-day service.
- Pathway coordinators were based on site and a core group of specialists led weekly videoconferencing reviews of patients treated on specific pathways, such as for ovarian cancer. This included a consultant

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oncologist, a clinical oncologist, a radiologist, a pathologist and a clinical nurse specialist. This meant the multidisciplinary team could make decisions jointly and efficiently, such as whether to admit an individual as an inpatient or to book them into the chemotherapy day unit. We saw this meant patients benefited from timely and coordinated care and reduced the need for multiple assessments by different teams or specialists.

- Clinical staff had access to a range of specialties at the trust's other hospitals, including renal, neurology, gastro-intestinal and urology. We saw communication links between such teams were well established and an acute oncology team based at the Royal London Hospital worked with St Bartholomew's teams to ensure a seamless transfer.
- A tissue viability nurse (TVN) was available on referral but was not permanently based at this site. Ward staff were not always aware of the support available to patients. For example, one nurse on ward 3A said, "I know we have a TVN but I don't know who they are or how to reach them. It feels like reducing pressure ulcers is a big focus for us at the moment but a lot of nurses don't know the difference between a moisture lesion and a pressure sore. We could do with more help in that area."
- End of life care and palliative care services were networked in the trust and a hospital lead was in post for staff to refer to. There was a partnership in place with a nearby hospice, where staff could refer patients directly. In addition each ward had an end of life care link nurse and the senior hospital team had partnered with a specialist NHS hospital to provide training to them.
- Staff had implemented a multidisciplinary approach to treating endocarditis and had reduced mortality from 12% to 7% in the 12 months prior to our inspection.
- An advanced practitioner pharmacist had trained as a specialist prescriber in oral chemotherapy to support patients in the chemotherapy day unit. This pharmacist maintained an up to date knowledge of new cancer drugs, funding and governance processes, which supported the service as a whole.

Seven-day services

- The clinical pharmacy service was available seven days a week in the cancer and cardiology wards and a pharmacy technician reviewed each patient at weekends. This enabled new prescriptions to be issued and doses changed any day of the week.
- OT and PT services were provided Monday to Friday from 8am to 6pm and a weekend emergency service was provided for patients being cared for in the respiratory ward.
- There was a consultant presence in each inpatient area at weekends and 24-hour service was provided through an on-call system.
- Implementing seven day services fully across all of the Barts medicine services that were shared with their main NHS specialist partner formed part of the trust's planning priorities for 2017-2019 as well as to open a 24-hour seven day heart rhythm centre. A consultant was leading this development plan, which aimed to reduce the risks of suboptimal care at weekends that could result from reduced consultant presence and insufficient staffing.

Access to information

- Medical staff completed a discharge summary for each patient's GP. This system had recently been improved following inconsistencies highlighted in consultant-led audits. For example, consultants provided training to other medical staff and checked each patient individually to ensure they had a summary produced prior to discharge. We looked at a sample of ten discharge summaries in the heart centre and cancer wards and found them to be comprehensive and to include details of treatment given and medicine prescribed.
- A pilot scheme was taking place on a cancer ward and a respiratory ward that required a pharmacist to review discharge medicines before patients left the ward. This was part of a strategy to improve the discharge experience for patients.
- Staff in the sexual health clinic provided services according to a confidentiality policy and worked with patients to encourage them to disclose new diagnoses of an infection or HIV diagnosis to their GP to ensure they received more coordinated care.
- The senior cardiology team audited patient records on a monthly basis for discharge summaries. In February 2017, 14% of patients were discharged without a clinical

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summary for their GP. As a result the auditing team implemented an education and engagement programme to ensure medical staff completed clinical summaries more consistently.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Where patients lacked the mental capacity to consent to care or treatment, medical staff conducted a mental health assessment to establish their ability to understand the situation and need for intervention.
- Not all staff had training in the Mental Capacity Act (2005) or in caring for patients with reduced mental capacity. In addition, staff in some areas had not always documented mental capacity for all patients. This included for two out of four patients whose records we looked at on ward 5C. However in other areas we observed staff consistently obtained and recorded consent before carrying out procedures or examinations.
- Senior nursing staff and doctors in each clinical area had been trained in the use of the Deprivation of Liberty Safeguards (DoLS). Senior nurses we spoke with demonstrated knowledge of DoLS and how this affected the care they could provide. We looked at the documentation of five patients with a DoLS authorisation in place. In most cases we saw a senior clinician had conducted a best interest assessment and mental capacity assessment with input from the wider clinical team. However, we found one patient on ward 3A with significant gaps in documentation in relation to a DoLS authorisation. For example, staff had used inappropriate language in their description of the patient's mental cognition. This included, "Patient was inappropriate so re-sedated." We spoke with the nurse in charge about this but they were not aware of which patients had a DoLS authorisation in place and could not find any medical assessment of their condition on the electronic records system.

Are medical care services caring?

Good



We rated caring as good because:

- Patients and relatives we spoke with were unwaveringly positive in their discussions of care and treatment. Each person we spoke with said staff were kind and compassionate.
- Patient survey results were consistently good and there was evidence staff used narrative feedback to improve and develop services.
- Staff demonstrated how they ensured patient's dignity and privacy during all of our observations.
- Between September 2016 and February 2017 over 90% of patients awarded each inpatient medical area the maximum five-star rating in a national independent patient feedback programme.
- Staff demonstrated how they recognised the needs of patients and relatives who travelled long distances to the hospital, such as by providing local guidance and advice.
- Staff in each clinical area provided emotional support based on the needs of their patients. This included bereavement support in the cancer and heart centres and counselling for patients who had been diagnosed with HIV in the sexual health clinic.

However:

- Between February 2016 and January 2017 the average response rate to the NHS Friends and Family Test was 9%, which was 16% lower than the national average. However, ward managers demonstrated how they were working to improve response rates.
- Results from the 2016 cancer patient experience survey indicated there was room for improvement in how patients accessed private discussions with staff and in the sensitivity of staff when communicating.
- Although the hospital had a track record of involving patients and relatives in their care, patients felt there was room for improvement in how staff supported them to make decisions about their care.

Compassionate care

- All 15 of the patients we spoke with described the care they received positively, including in relation to privacy and dignity. For example, one patient said their condition meant they could not always predict when they needed to use the toilet, which meant they sometimes soiled the bed. They said, "The nursing staff have always been quick to change the bed sheets and make sure I have a wash straightaway. They're very kind and have always protected my dignity in these

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situations.” Another patient said, “I can't fault the care [staff] give. It's been 100% and they are very caring. The one criticism I have is the very long waits for medications; it's particularly stressful if you're part of a trial.”

- We observed consistently friendly and positive interaction between staff and patients as well as between staff and the relatives of patients. For example, staff spoke with patients quietly and used curtains to ensure their privacy was maintained when in shared bed bays.
- We observed a volunteer team on ward 5C and saw they approached patients and relatives with respect and kindness and provided an opportunity to talk.
- One patient in a cancer ward said, “I've never been in such an excellent hospital. They have excelled at everything.” One patient in the heart centre said, “The first night I was here a nurse stayed with me in my room because they were worried I'd have another heart attack. That was amazingly kind of them.”
- As part of our inspection we asked patients and relatives to complete CQC comment cards. We received 33 completed cards from the cancer wards and 18 completed cards from the heart centre. All of the comments relating to staff were positive and patients noted the caring and compassionate nature of their ward team. Two negative comments were made; one in relation to the quality of food and one in relation to the cleanliness of toilets. These were balanced with seven positive comments relating to the quality of food and 12 comments that praised the cleanliness and hygiene of the environment.
- Between February 2016 and January 2017 the response rate for the NHS Friends and Family Test was 9%, which was significantly worse than the national average of 25%. Individual ward response rates varied between 3% for ward 7A and 56% for the WG Grace ward in the heart centre. During this period the percentage of respondents who would recommend their ward varied from 74% in January 2016 in ward 7A to 30 instances of 100% across the 10 participating wards. Ward 5A achieved a 100% recommendation score in five months during this period and ward 4D achieved this in seven months.
- Medical inpatient services participated in a national independent patient feedback programme. Between September 2016 and February 2017, medical wards

received variable rates of positive feedback. For example, in September 2016 68% of respondents said they would recommend the care on the ward. In the same month 86% of respondents said they would recommend ward 5C. In October 2016 83% of respondents said they would recommend ward 5B. These scores represented the lowest during this period for all medical inpatient areas and in every other month each ward scored above 90%. As part of the survey patients were asked to rate the ward based on dignity, involvement, information, cleanliness and staff. In each month every medical ward scored the maximum five-star rating for each descriptor by over 90% of respondents. During the same period the sexual health clinic received consistently positive levels of feedback in same programme, including six months of 100% recommendation ratings.

- Cancer services and the chemotherapy day unit had participated in the cancer patient experience survey in 2016. The survey measured patient experience against the Macmillan values based standard that aims to improve patient and staff experience and facilitate culture change. From 101 survey responses, 64% of patients said they were often or always able to speak with staff privately on request and 6% said they could never or rarely do this. In addition, 76% of patients said staff always communicated sensitively and 89% said staff always acknowledged them when they needed urgent support.

Understanding and involvement of patients and those close to them

- Staff involved patients during routine care. For example we saw that staff on ward 4D explained to each patient what their medication was for and asked them if they had any questions. We also saw staff encouraged patients to be as independent as possible during personal care, such as by ensuring they could participate. One patient said, “I prefer to wash myself and staff always make sure I have time and space to do this.”
- Patients told us they felt staff had kept them informed during delays caused by a prolonged IT failure. For example, one patient said their scheduled chemotherapy had been delayed by two hours and staff had updated them regularly during this time. This included offering updates on the situation, explaining

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how the IT failure had impacted treatment and offering refreshments. Six patients we spoke with on the respiratory ward told us they felt clinical staff were good at explaining care and treatment.

- All of the staff we spoke with demonstrated a detailed understanding of the needs of the relatives of patients. For example, nurses were aware relatives travelled from across the country to the hospital and they often needed help in navigating the local area, particularly with transport and hotels.
- We observed a multidisciplinary ward round and saw each member of the team explained their role and plan, where appropriate, with each patient. Staff used straightforward communication and helped to allay patients' concerns and anxiety.
- Results from the 2016 cancer patient experience survey indicated patients broadly felt staff understood and involved them. For example, 83% of patients said staff often or always asked them how they would like to be addressed and 79% said staff often or always asked them questions they were felt were important. In addition, 86% of patients said staff often or always clearly explained their next steps in treatment. However only 61% of patients said staff often or always supported them to make decisions about their treatment while 29% indicated staff did this only sometimes and 7% said staff never or rarely did this. This was reflective of broader patient feedback and complaints feedback that indicated there was room for improvement in the standard of communication with patients.

Emotional support

- Staff in the cath labs were working to establish a bespoke bereavement system that would include a lead consultant and psychologist. Staff said this would supplement the trust's existing bereavement service to provide a more individualised option.
- Nurse practitioners and health advisors in the sexual health service provided emotional and counselling support to patients including motivational interviewing.
- Staff in all clinical areas provided bereavement support to relatives. Consultants in the heart centre sent a letter to bereaved relatives one month after a patient's death to invite them to a meeting to discuss their family member's care, treatment and lunch.

- Health advisors in the sexual health clinic provided counselling for patients newly diagnosed with HIV and emotional support for patients who were anxious about sexual health screening.
- A multi-faith chaplaincy team was available on-call 24-hours, seven days a week. This was clearly advertised in wards and relative's rooms and all of the staff we spoke with knew how to contact the team.
- All of the patients we spoke with said they felt staff provided emotional and psychological support whenever they needed it. One patient on a cancer ward said, "Staff are phenomenal. I have been treated here for many years and they've made sure I've never felt alone."
- In the 2016 cancer patient experience survey, 95% of patients said staff often or always took their worries seriously and patients commented that staff were always sympathetic.

Are medical care services responsive?

Good



We rated responsive as good because:

- Clinical areas offered a range of additional services and support to improve patient experience and to facilitate positive recovery, including complementary therapies.
- Staff on individual wards worked with volunteers to provide services and events that helped patients to socialise and feel less isolated, such as a weekly cake morning.
- The sexual health service had adapted to the needs of the local population including through the provision of a team of consultants, nurse practitioners and sexual health technicians who provided targeted support for patients with specific sexual risks.
- A new neuro-oncology rehabilitation service had been implemented to support patients with complex rehabilitation needs relating to cancer. A specialist team of nurses had developed an apheresis clinic in the chemotherapy day unit, which had expanded the range of specialist services available.
- Clinical services had adapted access times and pathways to provide a safer and more responsive service. This included a two-week wait for angiograms

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and angioplasty after a cardiac inpatient stay in the heart centre and an electronic booking system in the sexual health clinic to reduce waiting times during walk-in sessions.

- Specialist nurses led a 24-hour chemotherapy advice line, which patients could use during their treatment to ask questions or to access emergency admission pathways.
- Patient flow coordinators were available on site daily and led daily meetings to ensure services had capacity and could meet demand.
- Each ward had private space for patients and relatives to relax, socialise or talk privately. This included libraries, TV rooms and kitchens to make drinks and snacks. Hospital volunteers also provided daily snack and toiletry services on inpatient wards.
- Senior staff in cancer and heart services used patient experience reports to understand patient experiences through complaints, feedback, incidents and near misses. This led to recognition that there was a need for improved communication in some areas, which was delivered through better staff training.

However:

- Signage in some medical areas was difficult to identify and did not support easy navigation. This included closed reception desks on third, fifth and sixth floors of the main building missing signage externally for the sexual health clinic. This was reflected in the results of the 2016 patient-led assessment of the care environment and the senior facilities service lead had implemented an action plan to introduce environmental improvements.

Service planning and delivery to meet the needs of local people

- Clinical areas offered a range of additional services and support to improve patient experience and to facilitate positive recovery, including complementary therapies. This included art therapy and massage therapy. A weekly cake club took place each Thursday on the cancer wards and staff and relatives brought in food to encourage patients to participate in this as a social event.
- In January 2017 an independent inspection found gaps in the appropriate provision of meals for medical inpatients. This included patients who could not eat hot meals if they were not ready at a specific time,

insufficient numbers of staff to serve meals and a lack of appropriate choice to meet nutritional needs. At this inspection we found a new catering contractor was in place and there were improvements in service. For example, each ward kitchen had a new display board that staff used to highlight nutritional and dietary needs of each patient, such as if they had a soft diet or needed higher calorie food. Volunteers were available at mealtimes to assist patients to eat and staff used a red tray system to indicate patients who needed extra support, such as those living with dementia or with swallowing difficulties.

- All of the patients we spoke with said the food service was good and we saw there were enough staff on each ward to give patients a positive mealtime experience. Staff told us some patients had complained about small portion sizes and they were working with catering staff to resolve this.
- All nurse practitioners in the sexual health clinic were prescribers and sexual health technicians were trained to take sexual histories from patients aged 17 and over. This helped to reduce waiting times as a range of staff could meet their diverse needs.
- The allied health professional team had successfully implemented a neuro-oncology inpatient rehabilitation post as a strategy to reduce the length of stay for patients with complex cancer rehabilitation needs.
- A dedicated apheresis bay had been developed in the chemotherapy day unit for the treatment of conditions that required the removal of blood components. A specialist senior sister led the care in this unit, which had enabled the service to expand services available to patients.
- Staff in the sexual health clinic had adapted specialist services and weekly clinics to meet the needs of the local population. For example, in response to an increase in diagnoses, a nurse consultant had initiated a weekly herpes clinic and a consultant led a weekly erectile dysfunction clinic. In addition, trained staff provided a weekly clinic for sex workers along with an advocate who could provide Portuguese language support. This clinic also provided patients with the opportunity to discuss drug use and sexual risk with a specialist consultant who could refer them into a targeted service for regular support if needed. This team also developed care pathways in line with national standards and programmes to meet the needs of local patients. This included increasing engagement with

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young people through the National Chlamydia Screening Programme and implementing an accelerated partner therapy model through a National Institute for Health Research initiative.

- A team of psychologists provided support to patients and staff in the sexual health clinic. For example, the team had recently provided staff with training on supporting patients with persistent anxiety. This enabled nurses and sexual health technicians to better support patients with emotional needs.
- Cancer inpatient wards provided chemotherapy, symptom control and palliative care within a range of specialties including urology cancer and head and neck cancers. A haematology-oncology ward also provided stem cell implantation.
- Clinical service leads demonstrated an on-going focus on improving the health of the local population through primary and secondary care prevention of cardiovascular disease. This included through the implementation of a new high-risk clinic for young people, pharmacy engagement with the local population and personalised risk reports through the NHS health check system.

Access and flow

- Cancer services did not always meet targets for the 62-day screening target or 62-day rare cancer target. For example, 84% of patients were seen within 62 days for rare cancer referrals against a target of 85%. Although the hospital met this target on four occasions between April 2016 and December 2016, in the remaining months compliance varied between 77% and 85%. The hospital collected data on a local basis only and did not use this to benchmark services against other providers nationally.
- The cancer centre treated an average of 5000 new cancer diagnoses per year with additional tertiary referrals.
- The cath labs utilisation rate was 80% and the senior team had established plans to increase this to 100% in the coming year.
- A patient flow manager met with senior ward teams three times per day to reduce discharge delays and minimise the need for patient transfers.
- Staff in the sexual health clinic had adapted the service to meet the needs of locally-based patients, who often attended with limited time to wait. For example, the clinic had introduced a target waiting time of 60 minutes

during walk-in clinics and had developed an on-line booking system so patients could reserve a slot to be seen in. This helped patients to plan the amount of time they needed at the clinic. In addition, sexual health technicians triaged patients with an initial assessment. This reduced the need to wait for more senior staff if the assessment showed no need for additional tests.

- The sexual health service offered a combination of walk-in slots and pre-booked appointments Monday to Friday between 9am and 5pm with two days of extended hours to 8pm. This was a networked service and the trust offered out of hours sexual health services at other sites, details of which were available to patients online.
- Capacity in some areas had been reduced due to an IT systems failure. For example, chemotherapy services usually treated up to 80 patients with a solid tumour per week but this had decreased to 60 per week. The service maintained its usual capacity for haematology patients.
- Consultants in the heart centre and colleagues in the cath labs introduced a two-week wait for angiograms and angioplasty following discharge from the heart centre to ensure patients had the appropriate recovery time after their procedure.
- A discharge coordinator liaised with social services out of the local area where a patient was admitted and needed a package of care.
- Staff in the chemotherapy assessment unit could change the configuration of the unit depending on demands on the service. For example, the four-bedded assessment unit could be used for daily chemotherapy or equipped with beds for overnight stays if safe staffing levels could be assured.
- Staff in the chemotherapy assessment unit provided a 24-hour telephone triage and advice service for patients who were feeling unwell during their treatment and patients who had completed a course of treatment within the previous six months. This enabled patients to ask a nurse questions about treatment, symptoms and side effects and enabled rapid access to the hospital if medical intervention was needed. This also enabled patients to be admitted as an inpatient on an emergency basis if their condition deteriorated. A nurse triaged emergency patients, who were then seen on admission by a specialist registrar or senior house officer. An appropriate clinician always made the decision to admit.

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- Staff provided patients with a pre-treatment orientation to help them become familiar with the clinical environment. This involved sitting in a chemotherapy chair, trying on scalp protectors and discussing items of equipment with nurses.
- The chemotherapy day unit included an ambulatory stream for peripheral intravenous catheter line insertion, which patients accessed on a walk-in basis.
- A nurse coordinator was available on each shift in the chemotherapy day unit and ensured the ambulatory pathway was staffed appropriately and that flexible bed space and treatment areas were used appropriately.
- Between April 2016 and February 2017 88% of patients experienced no bed moves during their stay, 7% experienced one bed move, 3% experienced two bed moves and 1% experienced three bed moves. During this period no patients experienced more than three bed moves during a single admission period.
- It was not always evident from reviewing incident reports that patient flow management and coordination took into account actual bed capacity or the ability of wards and staff to meet individual needs. For example, in March 2017 staff in ward 3C reported that 28 patients had been booked into the cath lab for procedures the following day who would require a trolley in the ward. As the ward had space for only 14 patients, this situation was escalated and the cath labs agreed to cancel 10 patient procedures. However, the cancellations did not occur and ward 3C consequently operated over capacity and nurses worked longer than their safe hours. This incident was under review at the time of our inspection but there was no evidence from the details submitted by staff that a patient flow coordinator had been appropriately involved in the situation.
- Between September 2016 and March 2017 inpatient wards reported two mixed sex breaches. They occurred on ward 5B in September 2016 and were reported as incidents related to a lack of bed capacity. There were no further breaches following this.
- Ward moves between 10pm and 7am were rare. Between September 2016 and February 2017, only two patients experienced an overnight bed moved between medical inpatient wards.
- A dedicated psychologist was available for patients being treated for cystic fibrosis and for cancer. Other patients had access to this service on request or when recommended by their main clinician, including for psychosexual support in the sexual health service.
- All of the patients we spoke with spoke positively about food and drink in the hospital. One patient said, "I always have enough to eat and there's always been a good choice for each meal." Another patient said, "The food is much better than I'd expect for a hospital, I've been here for a few weeks and every meal has been good with plenty of choice."
- A member of the pharmacy team counselled each new patient starting oral chemotherapy. Pharmacists were based in the clinic and saw patients immediately after doctors. Pharmacy staff also arranged medicine supply, counselling and homecare where needed.
- Patients treated as inpatients on the cancer wards had individual fridges next to their bed and relatives were encouraged to bring in their favourite foods and snacks. Along with dietician input this supported patients to feel more at home on the wards.
- Each inpatient ward had recreational and relaxation space available for patients and their relatives. This enabled patients to spend time away from their bed.
- Staff in the sexual health clinic proactively offered additional tests and screening based on each patient's recent travels and sexual behaviour. This meant staff could screen patients for specific infections where they had travelled through areas of high prevalence.
- Each inpatient received a welcome pack on arrival that included information on the services provided by the ward, who to contact if they needed assistance or support and what to expect from the types of treatment provided.
- A clinical nurse specialist led a weekly new patient clinic for patients being treated on a colorectal pathway and provided individual support to patients by providing them with a direct line number to call them on.
- Signage in some medical areas was difficult to identify and did not support easy navigation. This included closed reception desks on third, fifth and sixth floors of the main building missing signage externally for the sexual health clinic.
- A specialist team led a 'managing cancer' psychology workshop for patients undergoing treatment. This

Meeting people's individual needs

- Staff had access to translation services and interpreters, including for British Sign Language.

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included input from clinical fellows, psychologists and a clinical nurse specialist and covered topics such as talking about cancer, body image and sexual relationships.

- Staff told us they did not routinely offer patients a choice between male and female staff for personal care but this could usually be accommodated due to a broad mix in gender of staff at nurse and healthcare assistant level.
- Each inpatient ward had an information board prominently displayed with the names and roles of key staff. This included information on how to contact them.
- A wide range of printed information was available on each ward relevant to the clinical specialty. For example, cancer wards included leaflets on support groups for people living with specific types of cancer as well as contact details for hospices and holistic therapy groups. In addition, staff had worked with local police to provide printed information for people in crisis and who needed urgent support in relation to forced marriage and honour-based violence.
- Cancer wards had private bedrooms available for relatives to stay overnight. Relatives could book these with the nurse in charge, who prioritised the relatives of patients who were being cared for on an end of life care pathway.
- Hospital volunteers provided a daily mobile refreshment trolley service in inpatient wards with newspapers, toiletries and snacks. Each inpatient ward also had a self-service kitchen with hot drinks and fresh fruit available for patients and relatives.
- Staff used a range of different support services to help them communicate with patients whose first language was not English or where other barriers existed. This included interpreters and translators. Nurses also described cases where they had found patient advocates to help them understand consent and medical decisions. We spoke with a patient who needed support due to a visual impairment. They said, “If staff haven’t had something in large print for me then they’ve sat and patiently read it out to me. Like the late-night menu one night, I really appreciated that.”
- A bereavement suite was available in the cardiology wards.
- A ten-bedded hostel was available on site for patients to stay between chemotherapy treatments. Patients needed to be able to care for themselves but the hostel meant they had access to an en-suite bedroom, fully

equipped kitchen and communal space for friends and relatives. This reduced the need for patients to spend time and energy travelling and meant they could remain on the hospital site between treatments with medical assistance readily available.

- Staff who worked in chemotherapy services provided additional help and support to patients to improve their wellbeing and mental health during treatment. For example, a hairdresser was based on site and provided wigs and scarves. Staff helped patients to find the correct size and explore different styles as part of their coping strategies to treatment.
- Staff in the sexual health clinic had separated patient waiting areas as a result of feedback from patients and the implantation of two access systems. For example, one waiting room was allocated for walk-in patients and another for patients who had pre-booked an appointment. This ensured patients who walked in did not feel anxious because others who arrived were seen first. Digital information screens provided patients with information including estimated waiting times and reasons they might experience a longer wait such as patients undergoing medicine reviews or those requiring additional support.
- A female-only examination room with en-suite bathroom was available in the sexual health clinic.
- Each inpatient ward area had quiet areas for relatives, including day rooms with small libraries and televisions.
- Equipment and facilities in the chemotherapy day unit had been adapted to meet the needs of patients who visited for several hours at a time. This included haematology-oncology chairs that were automated, which patients could control themselves. A ‘help yourself’ trolley was also available so patients and relatives could help themselves to drinks and volunteers led a snack and treat menu that included sandwiches and ice-lollies.
- Macmillan nurses provided workshops for patients undergoing cancer for treatment. This included mindfulness, yoga and a ‘look good, feel better’ course. The hospital also linked patients with an educational programme specialist for cancer survivors.
- A clinical nurse specialist (CNS) led a follow-up clinic for patients treated for obstructive coronary disease. A consultant prepared a treatment plan prior to the follow-up meeting for each patient and a CNS ensured patients understood this as part of the clinic.

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- In the patient-led assessment of the care environment (PLACE) for the dementia-friendly environment ward 3A scored 50% and wards 5A and 5C both scored 73%. For accessibility for patients with a disability, ward 3A scored 60% and wards 5A and 5C both scored 75%. For the quality of food, ward 3A scored 87% and ward 5A scored 92%. However, it should be noted the PLACE assessment took place before the implementation of a new catering provider. The senior facilities service lead had prepared an action plan that addressed all areas identified as deficient in the PLACE report. This included a review of the environment with facilities and estates staff to implement improvements for patients living with dementia, including visual signage and colour-coded doors. There was evidence of multidisciplinary involvement in the action plan and during our inspection we saw improvements were on-going. This included more prominent signage, information provided in large print and clearer communication from staff on noticeboards.

Learning from complaints and concerns

- Between April 2016 and March 2017 medical care services received 59 complaints, of which 21 related to communication. This included 13 complaints related to poor verbal communication.
- During the same period the sexual health service received two complaints. The senior team investigated both complaints and instigated an incident report as a result of one. We saw in both instances the senior team reviewed areas for improvement in clinical practice, such as improving the completion of clinical notes that involve multiple services in the trust.
- Ward 5B had the highest number of complaints at 14% of the total received, all but one of which related to communication.
- The trust took an average of 28 days to investigate and resolve complaints, which was in line with the complaints policy.
- Senior nurses in cardiology and cancer services reviewed complaints and patient feedback along with incidents on a quarterly basis across each division as part of an on-going patient experience review. This enabled the senior team to identify themes in feedback and more readily identify areas for improvement based on patient experience.
- We looked at the latest available patient experience reports, which related to September 2016 to December

2016 for both divisions. We saw staff used the information to identify trends. For example, cardiology services received 18 complaints regarding communication. Although this was a relatively small number when considered in the context of the 20,000 patients seen, staff recognised there may be patients unwilling or unable to complain. They therefore identified this as a priority area and implemented an action plan to provide extra training and guidance for colleagues. Staff also used the reviews to identify potential serious incidents and plan strategies to avoid them in the future. Although we saw a proactive approach to identifying such issues, there was limited evidence of meaningful change. For example, a nurse in cancer services noted that a patient death could “possibly have been avoided” but did not state further details or provide an action plan.

Are medical care services well-led?

Good



We rated well-led as good because:

- Each clinical area had a distinct vision and future strategy and all of the staff we spoke with were aware of this and enthusiastic about it.
- Clinical divisions used a triumvirate model that we saw provided accessibility to and visibility of the leadership team.
- Staff in each division placed a high priority on research and senior clinical teams provided dedicated time for this. This included a 10-year track record of stem cell research and the development of a transatlantic interventional research programme in the cath labs.
- The trust's 2017-19 business planning priorities included service developments and transformations in each medical area with an overall focus on health promotion, governance and engagement.
- Senior divisional teams used clinical dashboards and risk registers as part of their overall risk management and clinical governance strategy. Clinical teams used this information to review incident investigations and track the level of risk presented to patients, staff and services.

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- Each inpatient ward and clinical department participated in the trust's 'You said, we did' scheme. This meant the team in each area used feedback from patients, relatives and visitors to make improvements to the service.
- We saw a track record of innovation in clinical areas aimed at future service sustainability and the development of research. This included through an experimental medicine cancer centre, through membership of the East London Cancer Board initiative and through annual participation in the British Association of Sexual Health and HIV conference.

However:

- There was limited evidence divisional teams mitigated the impact of risks on risk registers or that they conducted regular reviews. This included in the lack of action relating to a change of disposable equipment following a never event.
- Although staff in most areas told us they felt engaged by managers and the trust, some staff in cancer services said they did not always have ready access to emotional support.
- Staff in sexual health services said human resources or occupational health had not supported them during a period of unpredictable change.

Leadership of service

- A matron, clinical director and ward manager led each of the heart centre wards and cancer wards as part of a triumvirate. A ward manager, assistant director of nursing, chemotherapy lead nurse and general manager led the chemotherapy day unit.
- A ward manager led each of four cancer inpatient wards with overall nursing leadership provided by a senior nurse. The ward managers and senior nurse met every two weeks formally to discuss the operation of the wards and other clinical governance and leadership issues. The team met informally every day and worked closely to be able to provide staffing support where one ward experienced unexpected short staffing or additional pressure on the service.
- Three service managers led breast, endocrine and haematology chemotherapy services.
- The senior team on each ward led ward meetings, which differed in frequency between clinical areas. We looked at a sample of ward meeting minutes between September 2016 and February 2017 for each medical

inpatient area and found senior staff encouraged everyone on the ward to contribute to discussions, present their ideas and discuss future plans for the ward. In each case we saw senior staff followed up on staff suggestions and celebrated success and achievements.

- We asked staff in each clinical area about the visibility of their leadership team and about their relationship with them. Staff in all areas except the sexual health service said their leadership team was visible, accessible and readily available to escalate issues to. In sexual health staff told us they felt working relationships were excellent but some staff did not always feel that this clinic was as readily involved with the rest of the network as others.

Vision and strategy for this service

- Staff in each clinical area were aware of the vision and strategy for their service as well as for the trust. This included bank and student nurses and locum doctors we spoke with.
- Staff in cardiology told us they felt part of the trust as a whole. For example one nurse said they had good communication with their counterpart at the Royal London Hospital and felt patient care was consistent because of this.
- The heart attack centre leadership team were working towards their vision of establishing two permanent fellow posts and a community-based model of care for east London. The senior team planned to implement highly specialised atrial fibrillation community clinics to reduce the need for hospital admission.
- As part of the trust's 2017-19 business planning priorities, senior teams were planning a series of service transformations that planned to develop leadership in arrhythmia and cardiovascular prevention and develop specialised services including cardio-oncology, acute heart failure and grown up congenital heart (GUCH) service expansion. The senior team had also identified infrastructure and equipment as priorities for improvement including the development of improvements in site communication and the audio-visual tools available for multidisciplinary meetings.
- As part of the trust's planning priorities, the cardiovascular strategy aimed to create an integrated system of cardiovascular care across North and East London that would include partners to provide

Medical care

continuous provision for complex and emergency procedures. The cancer strategy aimed to strengthen governance and integrate the latest research and technology through the development of five networked services.

- A senior cancer team had completed a planned site cancer strategy and as a result launched service reviews for the treatment of specific tumour groups including brain and head and neck cancers. Clinical staff aimed for the service reviews to result in improved service and patient experience and ensure service resilience.
- The heart centre and cancer centre had developed five-year strategic development 'roadmaps' to direct change and drive innovation and clinical excellence. This included specific aims for each clinical specialty in the centres such as growing a clinical trial portfolio for skin cancer and increase academic work in coronary intervention.

Governance, risk management and quality measurement

- Medical care services were divided into divisions, or clinical academic groups (CAGs). These included a cancer CAG, a cardiovascular CAG and a clinical support services CAG. The sexual health service was part of the emergency and acute medicine division based at the Royal London Hospital. Within each CAG, individual wards were part of service areas. For example ward 5A was a medical oncology ward and was part of the cancer CAG and the solid tumour, lung, head and neck and urology service area.
- Senior divisional teams used risk registers to monitor and track risks to the service. Each risk had an assigned owner who was responsible for reviewing and updating the concerns. At the time of our inspection medical care services had 105 risks assigned to them. Of these, 15 risks were assigned to haematology-oncology four risks were attributed to cardiology, two were attributed to the cath labs, three were attributed to medical oncology and three were attributed to respiratory medicine.
- We looked at risks related to medical services and found that although review dates had been met, there was limited evidence of progress or resolution in the majority of cases. For example, following a previous never event, the trust had instructed clinical areas to remove 1ml syringes. One risk attributed to respiratory medicine indicated the immunology team could not remove this equipment as they needed it to administer

small doses of medicine. Although this risk had been reviewed once in the previous 12 months, there was no evidence staff had fully mitigated the risk or sought an appropriate alternative. In cardiology, one risk related to the lack of integration between IT systems that meant test results might not be readily available to clinicians. The risk owner had reviewed this in April 2016 and was due to do so again in March 2017 but there was no documented update.

- The senior team in each division used a monthly clinical dashboard to maintain oversight of the operation of services. This included tracking incidents, serious incidents, reportable complaints and patient access against national and local admission targets. The dashboard system also enabled staff to monitor overdue reviews on the risk register, the time taken to close incidents and complaint investigations and to track patient-specific data such as capacity and treatment. We looked at the latest dashboards for cardiology and cancer services for February 2017 and found them to be up to date with evidence on ongoing monitoring and action supported by the minutes of clinical governance meetings. Although these indicated the senior team knew how to escalate risks where needed, there was not consistent evidence that the items on the risk register were reflected in meetings or discussions.
- During the inspection period medical care services were impacted by an IT systems failure and a cyber-attack that affected the rest of the trust. We saw that services were maintained with some impact on elective work. For example, staff implemented a paper-based patient records system as a back-up to ensure patients could be cared for safely with documented observations and referrals. Medical care support services demonstrated flexibility in the use of their business continuity plans. For example, the pharmacy team had accepted support from another NHS trust in staffing and paper-based systems to ensure gaps in the service were minimised.
- The pharmacy chemotherapy manufacturing unit kept a separate paper record of all patients it produced chemotherapy for. This meant that during the IT failure blood result losses were minimised, with one day's worth of results lost at the time of our inspection. In addition, a consultant oncologist had been based in the unit to ensure patients received the correct doses and types of treatment while minimising delays.

Medical care

- Cancer ward managers led a daily site safety meeting for their respective team to review staffing levels, any risks to the service and to introduce new or agency staff.
- Senior staff from the respiratory team attended a monthly clinical governance meeting that incorporated morbidity and mortality and incidents.
- Two pharmacy site leads convened a monthly medicines safety committee and used this to review the outcomes of quarterly medicines management audits in each clinical area.
- Some staff in clinical support services, including allied health professionals, described challenges in engaging with senior CAG staff as managers were based cross-site and had to be reached through an escalation process that they said could result in delays.
- A cancer board maintained oversight and clinical governance of cancer services through three groups. This included a systemic therapy group, tumour specific group and governance group. Each group included named leads for specific clinical conditions or specialties and the governance group included seven quality and safety leads and seven tumour-specific governance leads.
- The triumvirate leadership teams in each area met with the divisional boards, such as the heart centre board, monthly to escalate issues and ensure oversight was continual. In addition each triumvirate met weekly to review safety and risk.
- The senior nurse in charge of the sexual health clinic was a member of the trust's networked sexual health services board and was also responsible for chairing team meetings.
- Cancer services' governance was jointly led by governance leads and directors based at St Bartholomew's Hospital and staff in the same role based at a partner NHS hospital. This group met together on a quarterly basis to review practice, safety and risk.
- The cancer triumvirate met monthly with the consultant body to improve communication between clinical and leadership groups. Managers we spoke with said attendance could be variable but they felt this approach had improved engagement between teams.

Culture within the service

- We asked a variety of staff at all levels of clinical responsibility in each area about the duty of candour (DoC). Most staff demonstrated knowledge about this and could demonstrate when they had used it. For

example, a specialist registrar (SpR) in the heart centre explained how they had spoken with a patient and their relatives following a medical intervention that went wrong resulting in a longer hospital stay. In addition to the immediate explanation, the patient's consultant had written to them after their discharge and offered the chance to return to the hospital and discuss their care. However, not all healthcare assistants demonstrated knowledge of the DoC, including in a cancer ward and the sexual health clinic.

- The senior team responsible for the cath labs had introduced a 'no one correct way' of working as part of a staff engagement approach to ensure a positive working culture when three teams merged.
- All of the staff we spoke with described their pride in working in their specialist areas. One SpR said, "I think we're all proud of the number of specialists around and the dedication of every single person here. It means patients get the same care overnight and at weekends. It also means everyone [staff] here really wants to work here and their pride and passion shows."
- Staff in the heart centre, cancer wards and respiratory wards spoke confidently of the values of working in the hospital, including the levels of empathy and caring attitudes they felt their teams showed.
- Temporary staff we spoke with described an open and welcoming working environment. For example, a student nurse we spoke with said they had found staff in their ward to be supportive and approachable. They said, "Even doctors and nurses visiting from other wards have been so kind. I asked a surgeon if I could visit theatres sometime and they arranged for me to have a visit with some of their own nurses."
- We spoke with a nurse who worked in an area that had recently experienced significant change. They said, "We have team meetings and make sure those who can't attend are included in the minutes. But more importantly we have good social cohesion in the team. We get to know new people and make sure new international nurses feel part of the team. We take time to help them settle in."
- The cardiology leadership team facilitated broader attendance to operations meetings to ensure more staff could be involved in the running and development of the service. For example, junior doctors and nurses were invited to each meeting to encourage their development in governance, operations and leadership.

Medical care

Equalities and Diversity

- Staff in the sexual health clinic demonstrated an acute awareness of delivering care and treatment to a diverse patient group and had adapted services accordingly. This included specialist sexual health, drug counselling and sex advice services to patients based on sexual identity, gender identity and individual risk behaviour. Printed information in the clinic and online information reflected this and provided patients with signposting to support groups such as for transgender patients who were transitioning, sex workers and those with an addiction. This ensured services were provided without bias or discrimination based on any personal factor.

Public engagement

- Each inpatient ward and clinical department participated in the trust's 'You said, we did' scheme. This meant the team in each area used feedback from patients, relatives and visitors to make improvements to the service. Staff used a visual display board in each ward to demonstrate the latest changes to the service as a result of feedback. For example, patients had commented that wi-fi was unreliable on ward 6D. As a result the IT team had improved this facility, which we saw provided a fast connection during our inspection.
- Staff on ward 6D had developed a brightly coloured, visually engaging display for patients, relatives and visitors to provide information on the team's values and give an opportunity for open feedback. Part of the display included a whiteboard and marker pens for people to write ad-hoc comments to staff for everyone to see. Comments on display during one day of our inspection included, "A big thank you, you guys rock!" "A big thank you to all that believed in me", and "You all do an amazing job. Invisible hugs to you all."
- Staff gave each patient a feedback card prior to their discharge as a strategy to improve response rates. This was a new approach to feedback implemented shortly before our inspection and senior staff planned to compare new response rates to identify if this approach resulted in a higher response rate.

Staff engagement

- The senior team in the cath labs held a weekly catch-up session for all staff to ensure the team was up to date with any changes in the department and to give each individual the opportunity to bring up feedback or concerns.
- All of the staff we spoke with said they felt well supported by their immediate manager and by their senior leadership team. For example, one nurse said young patients who were admitted with complex conditions could often be rude and aggressive due to the nature of their condition. They told us they always received emotional support from their manager whenever this happened.
- Staff received dedicated bereavement support following the death of patients they had cared for and become acquainted with.
- At the time of our inspection local commissioners were re-tendering sexual health services. This meant staff were working in uncertainty as currently funded positions could be removed or changed in the near future. Staff told us although they received support from the local leadership team during this period they felt undervalued by the trust and senior managers of the networked service. For example one member of staff said, "I think we are often overlooked as a small clinic on the outskirts of the hospital." Some staff said they felt human resources or occupational health did not support them during this period and that there was a lack of awareness from the trust senior team in relation to their Freedom to Speak Up Guardian responsibilities or those staff at risk. For example, one nurse said they had only just found out that guardianship could be used by staff as well as patients and said they had not received information on this. A Freedom to Speak Up Guardian is an individual appointed by an organisation who staff can approach in confidence as an anonymous whistle-blower when they want to speak up about something that concerns them.
- Staff who had experienced periods of change elsewhere in the hospital said they felt supported and kept up to date. One ward nurse said, "We had a period of uncertainty when our manager left. That was worrying but the senior nurse came down every day, gave us updates on what was happening and encouraged us to keep going."

Medical care

- Ward managers on each cancer ward led a weekly team meeting that was used to discuss incidents, any unusual events and to give staff the opportunity to suggest areas for improvement or areas of concern.
 - Some staff in the chemotherapy day unit told us they felt there had been an increase in staff sickness that coincided with on-going IT systems failures. This included absence amongst senior nurses and bank nurses, which meant some shifts were unfilled and there was an impact on the wellbeing of staff nurses. Nurses told us this meant they often had to stay late and although the senior team was supportive, they said they had not been kept up to date with progress to resolve the problem.
 - Staff we spoke with did not always feel emotional support was available to them despite challenging working circumstances. One nurse on ward 5C said, "Counselling might be available for staff but it's not advertised, I'd have to go and look for it. There's a lot of sadness here and a good team helps but I don't know that [the trust] knows what we go through."
 - Consultants and senior teams responded to feedback from junior doctors when they wanted more consistent education and training. In response in cancer services, a new education lead was implemented and a weekly journal club was initiated.
 - Leadership teams in each clinical area could demonstrate how they worked with their teams to support new and junior staff. For example, new junior nurses were paired with senior colleagues and junior doctors were paired with a consultant. Junior staff were empowered to make their own decisions with senior support as soon as they demonstrated clinical competency. Each individual also had direct access to a senior member of staff at all times to escalate concerns or issues.
- Innovation, improvement and sustainability**
- Staff in the cath labs had established plans to ensure sustainability and to expand the service in line with growing demand. This included the implementation of an electronic patient records system and the planned implementation of improved quality audits led by an external specialist provider. In addition the senior team had successfully combined three different labs into one to improve staff efficiency and patient satisfaction.
 - Staff in the cath labs were given dedicated time for research and a head of interventional research and transatlantic partnerships had been appointed. This team was focused on developing innovative treatment pathways to share with other specialist centres internationally. Such developments complemented 10 years of continuous stem cell research and staff based research strategies on patient feedback and demand.
 - The pharmacy team had identified a need for funding to be able to provide a dedicated counselling service for inpatients who started a course of chemotherapy. As a result they had submitted a business case, which was pending at the time of our inspection.
 - With the exception of sexual health services, nurses told us they felt there were clear leadership and development pathways available to them as part of their future in the trust.
 - Senior teams encouraged staff to participate in research and develop innovative projects to improve care in their clinical area. For example, staff in ward 6 had been recognised as finalists for a Health Service Journal award in November 2016 for their work in redesigning a specialist service. In addition, staff teams from wards 4C, 5D and 6D had conducted falls prevention research that led to the introduction of falls champion badges for staff who had demonstrated skills development in falls prevention and who could train or coach colleagues. A research ambassador group supported staff to engage in research in line with national ethics guidance.
 - Staff in the sexual health clinic were encouraged to apply to present their work at the annual British Association of Sexual Health and HIV conference as a strategy to share best practice and new learning. For example staff had attended a 2016 conference to present a reflection on their clinical practice in the management of syphilis and to present the work of a satellite screening partnership clinic with a nearby private pharmacy.
 - The clinical lead for oncology therapies was leading a cancer rehabilitation project that aimed to develop rehabilitation services for patients receiving cancer treatment who also had complex neurological impairments. This project was based on future service sustainability and aimed to implement a virtual ward to provide rehabilitation interventions in a widening-access environment. This project was at the pilot stage at the time of our inspection.

Medical care

- The trust was participating in the East London Cancer Board initiative. This was collaboration between 20 organisations and 50 professionals who sought to agree priorities for improvements and drive positive change in local cancer services. In January 2017 the board announced its key areas of focus and planned work together including incorporating patient experience narratives and identifying opportunities for new care pathways such as for prostate cancer follow-up care.
- An experimental medicine cancer centre had recruited 934 patients to trials developing practice-changing medicine for four cancer types.
- An international cancer specialist organisation had selected the hospital as one of 20 global sites of excellence in immune-oncology to advance the development of cancer immune therapy.
- The project lead of the 2016 Macmillan cancer patient experience survey had established an improvement plan based on the results of patient feedback, including the development of patient and staff work streams to capture mutual experiences and implement a team transformation programme for long-term sustainability.
- Staff at all levels demonstrated a proactive approach to improving services and experiences for patients. For

example, an art psychotherapist had led a pilot study of the impact of art therapy on patient recovery amongst 16 patients who received chemotherapy. The therapy sessions were designed to support patients who were experiencing anxiety, loneliness or stress and each patient who took part reported a positive outcome. For example, eight patients said they had found meaning through making art and seven patients said it was useful to have time to discuss non-medical topics of conversation. Following the pilot the art therapist was able to accept on-going referrals through the hospital's psychology service and provided lunchtime training sessions for staff on the benefits of such therapy.

- Staff in sexual health services demonstrated a track record of research activity and national recognition for improving patient outcomes. This included participation in the national PROUD study, which evaluated the effectiveness of new HIV prevention medicine. The research team had been awarded the British Association for Sexual Health and HIV Cathy Harman Award for Innovation and the Rosalind Franklin Appathon Award for work in developing, piloting and evaluating the first NHS online automated clinical care pathway for management of people with genital chlamydia.

Surgery

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

Information about the service

St Bartholomew's Hospital (St Bart's) provides a range of elective, emergency, and day case surgical services to approximately three million people in North and East London, and West Essex. Cardiac and Thoracic surgery accounts for the majority of the work, with smaller provisions for breast surgery, endocrinology, and reproductive surgery. Surgery services conducted 2,578 surgical procedures between April 2016 and Jan 2017. Elective admissions accounted for 1,595 (62%), 937 were non-elective admissions (36%), with 46 day cases (2%).

There are currently eight main operating theatres at St Bart's Hospital, with a further two theatres due to open in July 2017, and 62 beds in total. There are 36 beds for cardiac surgery patients across two wards including 14 single side rooms (with a further eight beds due to open in August 2017), and there is a further 26 beds for thoracic surgery including two also available for breast surgery patients.

The majority of surgical activity (cardiac, thoracic, and breast surgery) at the hospital was led under the division of Cardiac & Cancer Services, with the fertility service under the Women's and Children Division, and surgical endocrine services under the Department of Endocrinology.

We inspected the surgical care pathway from pre-admission, through operating theatres and recovery, and onto surgery wards. During our inspection we visited a sample of operating theatres, three surgery wards, anaesthetic rooms, recovery areas, and pre-admission clinics.

We spoke with 25 patients and their family members, and reviewed feedback cards left by service users for inspectors. We looked at 20 care records and observed care and treatment throughout the service. We also spoke with more than 40 staff members, including allied healthcare professionals, nurses, doctors in training, consultants, ward managers, and senior management staff. In addition, we reviewed national data and performance information about the service.

Surgery

Summary of findings

We rated this service as good because:

- Staff we spoke with felt there was a good attitude from managers towards reporting and learning from incidents within surgery, and they felt encouraged to report concerns or issues. Root-cause analysis of the never events resulted in review of standard operating procedures, and the introduction of Local Safety Standard for Invasive Procedures (LocSIPP) to minimise the risk of a repeat incident.
- The service had significantly reduced the number of surgical site infections (SSI) in the last 12 months.
- Most of the surgery wards and theatres we visited were clean and well-maintained.
- There were a number of audits in place to monitor performance of medicines administration and management.
- Surgical pathways were delivered in line with national clinical guidance and best practice
- There were effective processes in place to ensure patients' pain relief needs were met and pain was well managed in the surgery service.
- Staff we spoke with stated they found the appraisal process useful, and felt there were good opportunities for professional development with the trust. Surgery staff were meeting most of the mandatory training targets for the trust.
- There was effective multidisciplinary team (MDT) working in place. We attended a number of ward meetings attended by medical, nursing, and MDT staff, and found communication to be effective and well managed.
- Patients we spoke with gave us positive feedback on the quality of care they received. Positive interactions between staff, patients and their families was observed. Patients and family we spoke with felt they had been well involved in their care.
- Feedback from the Family and Friends Test (FFT) was consistently good across surgical wards, with an average of 98% for the period between April 2016 and February 2017.
- Flow through surgery services was well managed and efficient.
- The specialised cardiovascular surgery service provided inter-hospital support for a number of

district general hospitals (DGHs) in the north and east London area. Emergency on-call surgeons were available 24/7 to treat complex aortovascular patients.

- Surgery services had access to a number of Clinical Nurse Specialists who could provide additional support for patients with any additional clinical needs.
- There were a number of post-discharge wound clinics available to support patients with their recovery.
- There was a positive culture within surgery services at the hospital. The leadership team was well established and there were good connections throughout the service. The team were managing a very complex critical care environment in a very integrated and seamless way.
- The senior leadership team within surgery had effectively overseen the joining of three separate specialist surgery services into one organisation since 2015. This included standardising process, developing a unified culture and identity for surgery services, and maintaining quality of care for patients.
- Surgery services had divisional level business plans and strategies for developing the service within each area of clinical speciality for the next one to five years, which aligned with the hospital-wide priorities for the future.
- There were effective governance arrangements in place and senior staff had a good understanding of risks facing the service.
- There were a number of leadership development courses available to staff who wished to have more responsibility.
- Cardiothoracic surgery services were leading a number of innovations both within the UK and internationally.

However:

- We found examples of National Early Warning Scores (NEWS) being incorrectly scored for patients on surgical wards.

Surgery

- There were significant vacancies in the nursing and medical teams, however this was mitigated by the use of regular bank staff. Surgery services also had a robust recruitment programme with a number of new staff due to start.
- Refrigerators for medication on surgery wards did not have their temperatures checked consistently.
- The trust had recently had a major IT shortage prior to the inspection, which had resulted in severe disruption to accessing electronic images and blood results.
- Some of the policies we reviewed on the trust intranet for surgery services had passed the date from review.
- Surgery services were not meeting the trust target for appraisals for non-medical staff.
- There was variable performance in surgery services relating to care for dementia patients.
- Patients stated that communication from staff regarding discharge planning could be inconsistent.
- There was limited signage in the outpatients building for pre-admission appointments.

Are surgery services safe?

Good



We rated safe as good because:

- The service has significantly reduced the number of surgical site infections (SSI) on the ward in the last 12 months.
- Staff we spoke with felt there was a good attitude from managers towards reporting incidents within surgery, and they felt encouraged to report concerns or issues; albeit learning outcomes were not always communicated effectively.'
- Most of the surgery wards and theatres we visited were clean and well-maintained.
- There were a number on audits in place to monitor performance of medicines administration and management.
- Surgery staff were meeting most of the mandatory training targets for the trust.

However:

- We found examples of National Early Warning Scores (NEWS) being incorrectly scored for patients on surgical wards.
- There were significant vacancies in the nursing and medical teams, however this was mitigated by the use of regular back staff. Surgery services also had a robust recruitment programme with a number of new staff due to start.
- Refrigerators for medication on surgery wards did not have their temperatures checked consistently.
- The trust had recently had a major IT shortage prior to the inspection, which had resulted in severe disruption to accessing electronic images and blood results.

Incidents

- Between March 2016 and February 2017, the service reported no incidents which were classified as never events for Surgery at St Bart's Hospital. 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.

Surgery

- Detailed root cause analysis (RCA) investigations were carried out in response to serious incidents. RCAs determined the main actions leading up to the incident, and recommended changes to practice to minimise the risk of repeat occurrence.
- The surgery service at St Bart's Hospital reported five serious incidents (SIs) to the NHS Strategic Executive Information System (STEIS) between March 2016 and February 2017.
- The trust used an online system for reporting incidents. Surgery staff received training in the use of this system, and were provided with individual logins for access. Staff we spoke with showed a good understanding of when they would need to report incidents and stated they were confident in using the reporting system.
- Staff we spoke with felt there was a good attitude from managers towards reporting and learning from incidents within surgery, and they felt encouraged to report concerns or issues. From March 2016 to February 2017 staff within surgery report 827 incidents, which suggested a good incident reporting culture. In the trust's incidents log we found general themes relating to infection prevention and control, issues with medical devices, and medication errors.
- There were a number of local team and divisional meetings in place to discuss reporting and learning from incidents. Surgery staff had weekly team meetings which covered any incidents or learning from incidents within the service. Staff attended monthly quality and safety meetings where incidents and learning from incidents could be discussed in more detail. Information on incidents was also disseminated in safety huddles and by email.
- Surgery staff on the wards and in theatres attended daily safety huddles to discuss any patient safety issues, safeguarding risks or patients with diminished capacity, staffing issues, and theatre lists. Managers for each ward also attended a hospital-wide safety briefing every day and reported back on any site-wide issues to their teams. We observed safety huddles taking place in wards and theatres and found good engagement from staff and thorough discussions on any safety concerns or issues.
- There was evidence of staff learning and changes in practice from trust-wide never events in the past twelve months. The context of never events and the changes to practice following the root-cause analysis were clearly displayed on the walls of surgery wards we visited.

Root-cause analysis of trust-wide never events resulted in review of standard operating procedures, and the introduction of Local Safety Standard for Invasive Procedures (LocSIPP) to minimise the risk of a repeat incident.

- We found ward and theatre staff had variable knowledge of the occurrence of never events at the other hospital services in the past twelve months. Some staff we spoke with stated they were aware there had been never events at the trust, but were not sure of the details. Most staff we spoke with were also not aware of never events that occurred within surgery services at other Barts Health sites.
- Mortality and Morbidity was discussed in a monthly half-day clinical governance meeting attended by all medical staff, anaesthetists, theatre nurses and allied professionals. All patient mortalities were reviewed using a standardised review form which was added to the patient record and used as information in meetings. Staff stated that having a longer period for monthly meetings allow them to discuss cases in more detail and offer more in terms of learning and changes to practice.
- Duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had a good knowledge of DoC, and we viewed that incident reporting system only allowed staff to complete the report once DoC information had been included. Investigations into incidents we viewed also contained sections and recommendations relating to DoC.
- Action plans from the most recent staff survey state that many staff do not feel that the outcomes of investigations into incidents are always communicated effectively to staff. Senior staff we spoke with stated this was an area they would like to improve, and are looking at ways of improving dissemination of learning from incidents.

Safety thermometer

- The NHS safety thermometer is an improvement tool used for measuring, monitoring and analysing patient harm and harm free care. It provided a monthly audit of the prevalence of harm to patients, such as new pressure ulcers, urinary tract infections (UTIs), patient

Surgery

falls, and Venous Thromboembolism (VTE) incidences. Surgery services collected and audited safety thermometer data and the results were made available to all surgery staff.

- Between February 2016 and February 2017 surgery services reported to the NHS safety thermometer: 60 pressure ulcers (grades 2,3, and 4), 17 patient falls with low or moderate harm, and 25 catheter-acquired UTIs. No cases of Meticillin-resistant staphylococcus aureus (MRSA) and ten cases of Clostridium difficile (C Diff) infections were reported in surgery; however the hospital reported three cases of MRSA and ten cases of C Diff in other areas of the hospital. MRSA and C Diff infections had been analysed and areas for learning identified for staff to reduce future risk of infections.
- The most recent results of safety thermometer data were clearly displayed in the surgical wards and theatre areas we visited. This meant that information was clearly available to staff and patients. Staff we spoke with stated that the ward safety performance was discussed in team meetings.
- Senior staff we spoke with stated that safety performance would be discussed in monthly Quality and Safety meetings, with any areas of concern or change reviewed to establish if actions were required. Minutes of Quality and Safety meetings we reviewed reflected discussions around patient safety and data on patient harm.
- Staff placed 'I am clean' stickers on equipment which were dated to identify them as clean. We also checked cleaning rotas on wards and found them to be routinely completed.
- Staff had easy access to personal protective equipment (PPE) such as gloves and aprons in all areas we inspected and staff used PPE during activities as required. Staff also adhered to infection control precautions such as being bare below the elbow, and were comfortable challenging visitors to the wards to ensure they complied with these protocols.
- We observed good compliance with hand hygiene protocols on the wards and in theatres. Staff cleaned their hands using gel dispensers when entering and exiting the ward and after each patient contact. Monthly hand hygiene audits provided for surgery show performance was between 85% and 98% between April 2016 and February 2017, with good individual performance for each of the surgery wards. Reminders to maintain good hand hygiene practices were visible on the wards.
- Surgery services conducted regular audits of cleaning and infection control performance. The Infection Prevention and Control (IPC) lead nurse conducted an annual audit on each of the ward and theatre areas, identifying areas for improvement. An external provider also reviewed performance reports in theatres. Audit results were visibly displayed on wards and other clinical areas, and any infection control issues were discussed in quality and safety meetings, as well as in the recently introduced weekly IPC meeting.
- Patients were screened for infections such as MRSA or C Diff on admission, and the hospital had a monthly audit in place to monitor performance on MRSA screening. Patients with a confirmed infection were clinically managed in a side room to minimise the risk of cross-contamination, with rooms deep-cleaned following the patient's discharge. The trust also produced a leaflet to provide additional information on how to manage MRSA or C Diff.
- The service had significantly reduced the number of surgical site infections (SSI) on the ward in the last 12 months. Data provided by the trust stated that between January 2016 and September 2016, surgery services has an SSI rate of 12%, which has now been reduced to 3% at the time of our inspection. Surgery services addressed this by introducing a fortnightly multidisciplinary IPC meeting led by a surgeon to

Cleanliness, infection control and hygiene

- Most of the surgery wards and theatres we visited were clean and well-maintained. Corridors, bedrooms and clinical areas were clutter-free, and there was no evidence of dust. Staff and patients we spoke with were satisfied that the wards and surgical areas were clean, and that infection control was generally well managed.
- There was dedicated staff for cleaning the surgical wards and they were supplied with and used nationally recognised colour-coded cleaning equipment. This enabled cleaning staff to follow best practice with respect to minimising cross-contamination. Cleaning staff understood cleaning frequency and the required standards, and nursing staff stated cleaners were responsive when needed.
- We looked at equipment used across wards and theatres and found them to be cleaned regularly by

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discuss any SSIs, and also employed a full-time SSI nurse who has helped to introduce a care bundle looking at practice pre-operatively, during surgery, and post-operatively. Senior staff provided additional training to staff in wound management, and the wound clinic was run by a Surgical Care Practitioner to provide more expertise to patients. Patients were able to access the wound clinic directly without referral if they had any concerns post-discharge.

- Compliance with trust policies relating to cleanliness and infection control are monitored by the IPC lead nurse for the hospital. Each ward and the theatres area had a nurse with an IPC link role who liaised with the IPC lead for the hospital.

Environment and equipment

- All of the wards we visited were well organised and quiet. The ward environments were spacious and free of clutter blocking any corridors or rooms. Patients we spoke with stated the ward was comfortable and a good environment to recover in, and there were day rooms that patients could access if they wanted to watch television or leave their room. Family members we spoke with stated they could use the family room provided if needed and they felt welcome on the ward
- The theatres area was well resourced and clean. Staff we spoke with stated it was a very positive clinical environment to work in, and they felt they generally had the equipment they needed to provide care. Changing rooms were spacious and provided plenty of locker space for staff, and there was a large meeting room for briefings. We visited five anaesthetics rooms, and found them to be clean and tidy, with anaesthetic machines regularly checked.
- Wards were accessible and provided plenty of space for beds or patients with limited mobility. There was access to disabled toilets and accessibility rails on walls.
- There were fire extinguishers and fire safety information at appropriate points throughout wards and theatres.
- Store rooms in theatres and on the wards were generally well maintained and organised. We did however see one linen cupboard outside one of the wards which had two dirty linen bags left untied on the floor and clean linen being stored in a dusty cupboard with broken shelves. We were also able to access two unlocked clinical waste bins in the waste cupboard along the same corridor.

- Staff stated that generally they could access the equipment they needed from the ward stock, or in-house equipment library.
- There was sufficient staff rest areas across the wards and theatre areas we visited, which had facilities for making drinks and lockable storage cupboards for belongings.
- On ward 4A, we noticed that the emergency chest-drain trolley had significant gaps in daily safety checks between January and April 2017. In other areas we saw resuscitation equipment was readily available on the wards, with security tabs present on each one to show it had not been opened since last being checked. Systems were in place to check equipment daily to ensure it was ready for use, and we observed staff had signed and dated when they completed their checks.
- All equipment we inspected had a sticker indicating when they had been serviced in the last year. However, portable appliance testing (PAT) was inconsistent in some ward areas, and we found stickers that were out of date. We highlighted this to the ward manager who was not clear on the reasons for the inconsistency.
- Surgical wards received visits from Patient Led Assessment of the Care Environment (PLACE) reviewers. Reviewers stated in the PLACE report they were 'very confident that the environments on Wards 4A and 4B (Cardiac Surgery wards) supports good care'. The same wards also received a PLACE score of 100% for 'Cleanliness' and 71% for 'Disability'

Medicines

- We found that medicines were stored securely and monitored appropriately, and treatment rooms were clean and tidy. Keys to medicines cupboards, trolleys and patient bedside lockers were retained by the appropriate staff member, and there was restricted access to where medicines were kept.
- Medicines room and fridge temperatures were checked by inspectors, and were found to be within the normal recommended range of 2-8 degrees, with documentation to show it was regularly checked. Medication audit data for October 2016 to December 2016 shows that daily temperature checks had not been performed 28 times on surgical wards in this period, which was significantly worse than other quarterly audits of the same areas in 2016.
- Staff demonstrated a good understanding of how and when to report medicines errors. Staff were able to

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provide examples of when medication errors had occurred, and how the pharmacists were involved to rectify the issue and establish how practice could be improved. We observed that the learning from a recent medication incident was also clearly displayed on the walls of the surgical wards. Medication errors were also discussed in quality and safety meetings

- Controlled Drugs (CDs) were kept in a locked CD-only cupboard and any administration was routinely documented by staff. Any access to the CD cupboards was only available to authorised personnel. We checked CDs administration on the wards and in theatres and found documentation to be completed and matching with medication counts.
- Monthly audits of staff performance in administering CDs showed that performance had improved in September 2016 on the wards compared to performance in August and July of the same year. Data provided by the trust of monthly CD audits between January 2016 and February 2017 show that performance was average when compared to other wards within the hospital.
- There were a number of audits in place to monitor performance of medicines administration and management. Audits were conducted monthly to review management of medication including CDs, missed doses, safe storage, completion of documentation, and environmental checks such as security and tidiness. Audit performance was reviewed by pharmacy staff and discussed in clinical governance meetings.
- We found an example on one ward where a CD had recently expired and not been disposed of. Pharmacy technicians were informed of this, signed the documentation with a nurse present and removed the item appropriately. Audits of CD administration between October 2016 and December 2016 found no incidents of expired medication.
- Keys to the drug cupboards and patients own drugs (POD) lockers were held by registered nurses, and doors to medication rooms were locked. There was a policy in place to support the use of PODs and we saw evidence of PODs appropriately stored in lockers beside patient bays.
- We reviewed prescription charts for five patients on each of the three cardiothoracic wards and found

documentation to be well completed and signed. Charts included information relating to allergies, medicines reconciliation and guidance on administration where necessary.

- Although patient prescription documentation was routinely completed, we saw evidence of patients receiving oxygen nasally on wards, without this being prescribed in the patient record, which was confirmed by the ward pharmacist. Prescription of oxygen is identified as best practice in the British Thoracic Society guidelines on oxygen use in healthcare settings.
- Support in prescription and administration of medication was available to the pre-admission teams by an on-site pharmacy technician, who rotated from the main surgery wards. The pharmacy technician could provide prescription information and support to clinical staff as well as leaflets and guidance for patients.
- Senior hospital staff had recognised the impact on discharge timing due to take away (TTO) medications being unavailable when the patient was otherwise ready to leave. The trust provided more staffing in patient facing areas and fully integrated pharmacy labelling and stock control system at ward level, enabling the labels and reordering of stock to be managed quicker. An audit of the implementation of these systems in January 2017 showed average length of time waiting for TTO medication to be 11 minutes, and 100% of discharge prescriptions were dispensed and ready within one hour.
- Staff competencies for prescribing and administering medication was assessed by a dedicated induction process provided by the trust through their internet portal.
- The hospital had access to a part-time consultant pharmacist, a full time pharmacist clinical lead for cardiothoracic surgery and pharmacy technicians working across cardiothoracic surgery wards and pre-admission. Pharmacists attended ward rounds five days a week excluding weekends, with an on-call service available at the Royal London if needed out of hours.

Records

- Surgery services used the trust electronic records system (ERS) to record and maintain patient notes. This system was available to all healthcare professionals and patient information was loaded on to the system from

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pre-admission. Staff seemed to be comfortable using the ERS and stated they had training in how to use the system. Nursing staff also used paper records for completing documentation of patient contacts.

- We reviewed 20 patient records across surgical wards and found them to be comprehensively completed. Patient records we reviewed contained details of clinical interactions with staff and completed descriptions of care plans. Records also contained completed sets of risk assessments including early warning scores, risk of venous thromboembolism (VTE), pressure ulcer assessments, falls assessments, nutritional needs, and medication charts.
- Paper copies of patient records were confidentially stored by patient beds or stored in locked medical record trollies. Staff required a password to access the ERS system, as well as an electronic identification card. We were told that temporary staff would be provided with an allocated key-card and login.
- Staff used the ERS to create an electronic warning flag for any patient who had a significant clinical risk that needed to be monitored. The ERS used a yellow star to flag high-risk patients to any clinical staff who could then take any potential risk into account. As well as monitoring clinical risk, the ERS could also flag patients who were an infection control risk, safeguarding risk, or patients with limited capacity to consent to treatment.
- Information governance was part of the mandatory training programme for all staff to complete annually. Surgery staff at St Bart's Hospital had an overall compliance rate of 94% at the time of inspection, against a trust target of 90%.
- Pre-operative assessments were undertaken using an integrated care pathway record for either cardiac or thoracic surgery, and completed with a nurse practitioner. The pre-admission team had administrative support available to create electronic records for patients, and ensured paper records were then made available to the ward.
- Some surgery staff we spoke with stated that access to clinical records and other information could be severely limited by slow computers on the wards. Staff stated that it can take a long time to access the information through the system and computers could be extremely slow, and this often impacted on the time taken to complete or access patient records. Staff also stated it can be difficult to access IT services to support when computers stop working.

- The trust had recently had a major IT outage prior to the inspection, which had resulted in severe disruption to accessing electronic images and blood results. Senior staff stated the cause of the outage was being investigated, but that it had impacted on the picture archiving and communication system (which stored imaging and diagnostic results) and not on the ERS. Staff we spoke with stated that the issues caused by this had not been completely resolved, and during this period accessing vital diagnostic information both before and after surgery could be very difficult. Staff also stated that while there had been a good response from clinical staff to the major outage and they worked more directly to continue delivering the service, there was no major incident policy in place for such an incident that could be quickly implemented.

Safeguarding

- Surgery services complied with the trust-wide safeguarding policy for working with vulnerable adults and children. The safeguarding policy and procedures were readily available on the trust intranet, and included guidance on how staff can make a referral if needed.
- Staff we spoke with had a good understanding of when they may need to make a safeguarding referral, and what they would need to do to ensure vulnerable patients were kept safe. Staff stated they could also access support from the safeguarding lead for the hospital if needed, who could support them with advice or provide guidance through the referral procedure.
- Safeguarding information was visible on the walls of the wards, pre-admission areas, and in other clinical areas we visited. There was also a trust leaflet which provided more information on safeguarding and how to make a safeguarding referral visible in ward areas.
- Safeguarding training was covered under the trust's mandatory training programme and was integrated into the trust's induction package. Surgery staff at St Bart's Hospital had an overall compliance rate of 97% for safeguarding adults level 1 at the time of inspection, against a trust target of 90%. However just 79% of required staff had completed safeguarding level 2 training.
- Staff compliance rate for safeguarding children level 2 training was 85%, against the trust target of 90%.

Mandatory training

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- The trust had a target for staff completion of mandatory training of 90%. The overall compliance of staff within surgery services at the time of inspection for all mandatory training modules was 91%
- The mandatory training programme included Information governance, safeguarding, infection control, conflict resolution, fire safety, equality and diversity, moving and handling, incidents training, and basic life support (BLS). Mandatory training involved a mix of online learning and class-based training. Staff we spoke with stated that most of the mandatory training modules were covered in the induction programme provided by the trust if needed.
- Staff used an online training management system to monitor their compliance with mandatory training and were alerted if the training was due to expire. Managers used the same system to monitor their staff upcoming training or training which needed revalidation.
- Staff we spoke with stated they generally were able to find time to complete their mandatory training during work, but also had the option to complete the training remotely if needed. Staff also stated they could access support from practice education nurses if needed.

Assessing and responding to patient risk

- Surgery services used a scoring system known as the national early warning score (NEWS) to monitor patients' vital signs and flag those that are at risk of deteriorating. In 5 records we reviewed, we identified inconsistencies in NEWS scoring, with some scores not being added up, some being added incorrectly and some of the items (such as oxygen requirement) not scored correctly. This meant that some patients risk of deteriorating was not being accurately assessed.
- The trust completed an audit of NEWS completion and accuracy in February 2017. Surgery service results show that monitoring of patient's vital signs (temperature, heart rate, blood pressure, and oxygen) were completed in 92% to 100% of cases. However the audit also found that the NEWS score was correctly calculated in patient records in 62% to 83% of cases. This suggests significant gaps in the assessment of deteriorating patients using the NEWS score.
- Surgery services had a clear process for addressing deteriorating patients. Staff referred any patient with a high NEWS score to the Clinical Nurse Practitioner for the Critical Care Outreach Team (CCOT). The CCOT assessed the patient, liaised with the nursing and

medical team, and helped to develop a management plan for the patient. The CCOT then escalated to medical leads on the ward if the patient continues to deteriorate, who referred the patient to the Acute Critical Care Unit (ACCU). If the patient was not admitted to the ACCU, the CCOT provided support to the ward team in keeping the patient stable.

- The trust policy, contact details for the CCOT, and a pathway for managing deteriorating patients were clearly visible on the walls of each surgical ward.
- Staff we spoke with felt they had the necessary access to senior medical staff when a patient was deteriorating. Staff stated there was a good process in place for managing at risk patients, and as medical staff were required to refer patients to the ACCU, there was good oversight of patients at risk of deteriorating.
- Staff in pre-admission carried out a number of risk assessments (risk of VTE, weight, nutrition and hydration, pressure ulcer assessments, allergies) and flagged any concerns in the pre-admission pathway documents for cardiac surgery or thoracic surgery, which was uploaded to the patient's electronic record. Patients had access to pre-op anaesthetic reviews and input from on-site pharmacy.
- The surgery service completed safety checks before, during, and after surgery as required by the 'five steps to safer surgery' – the NHS Patient Safety First campaign adaptation of the World Health Organisation (WHO) checklist. We observed surgical staff completing these safety steps throughout the surgery.
- The trust audited performance in relation to the WHO checklist. From July 2016 to February 2017, surgery services had close to 100% scores for team completing the pre-brief, sign-in, time-out, and sign out. However, performance for the team debrief was variable (between 84%-98% compliance).
- Surgery services had a standardised procedure for completing the WHO checklist. The trust had implemented a paper audit of the WHO checklist using national safety standards for invasive procedures (NatSSIPs) template. Surgery staff we spoke with felt that the WHO checklist was implemented well, and that it was taken seriously as important safety steps.
- The trust had developed an action plan for the introduction of sepsis six (a procedural guideline designed to reduce the mortality of patients with sepsis) by July 2017. The trust had already appointed a clinical sepsis lead for the site, and ward level sepsis

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champions, and intended to improve staff awareness of the risk of sepsis before including the guidelines in the induction programme for new staff. Cardiothoracic surgery staff had a 46% compliance rate of staff trained for use of the sepsis screening tool. Staff knowledge of best practice relating to sepsis at the time of inspection was varied.

- Surgery staff were not meeting the trust target for resuscitation training. Data provided by the trust shows that as of March 2017 84% of surgery staff had completed their resuscitation training, against a target of 90%.

Nursing staffing

- As of March 2017, surgery services were not meeting the trust target of 5% vacancy rate for theatre staff or for nurses on the wards, and there were significant use of bank staff to cover shifts. Across surgery wards there was a 21% vacancy rate, with 35% vacancy on ward 4B. This was due to reduce to 7% following significant recruitment. Theatre staff was currently at a 33% vacancy rate, however this was also due to reduce to 13% as staff were due to start. Theatre staff stated that although there were vacancies overall, they were at full complement for scrub nurses.
- Senior surgery staff we spoke with stated they tried not to use agency staff, and had a bank of regular staff who were offered shifts when there were gaps in rotas. Bank and agency usage between March 2016 and January 2017 was 21% for surgery wards and 33% for theatres. We spoke with staff that stated that this agency staff usage had not impacted on delivery of care; however, there were a significant number of incidents in data provided by the trust which related to agency staff being unfamiliar with ward procedures.
- The vacancy rate for Operating Department Practitioners (OPDs) was 33%, which was due to fall to 16% with new staff joining. Senior theatre managers stated there had been a high sickness rate for OPDs, but that this had improved and retention was now stable
- Bank and agency staff received a local induction when they first worked with surgery services, and were assessed on a competency checklist before working unsupervised.
- The acuity tool used across all of Bart's Health was the Shelford Group Safer Nursing Care Tool. Acuity & dependency scores were collected daily by each ward area and were fed into the bi-annual review of staffing

establishments and skill mix. The current guideline ratios for surgical wards were 5:5 patients to 1 cardiac nurse and 5.7 patients to 1 thoracic nurse. This could be increased or decreased at handover depending on patient acuity.

- Skill mix is reviewed bi-annually using ward data by matrons, the Associate Director of Nursing (ADoN) and the Director of Nursing (DoN) for St Bart's Hospital. Safety performance indicators (such as the safety thermometer) and staff feedback are also considered. Recommended changes to staffing levels were then made to the Chief Nurse who along with Executive colleagues made the final recommendation to the Trust Board.
- St Bart's hospital had supported a large recruitment drive for surgery staff that was ongoing at the time of inspection. The hospital held recruitment days, open days for prospective staff to visit wards, and recruitment from overseas. Theatre staff we spoke with stated there had been sustained investment in improving staffing, and they had had 31 new starters since June 2016.
- As of January 2017, surgical services were meeting the hospital target for staff sickness of 3%.
- We observed nursing handover in the morning at 8AM and in the evenings at 8PM. Handover was well managed and there appeared to be good communication between staff. Nurses discussed prospective risks to patients, arrangements for bed management such as discharge or new admissions, surgery lists, and staffing issues. Ward handovers were attended by theatre staff for information to be effectively communicated, and vice-versa.
- Nursing staff levels were discussed in daily safety huddles, chaired by the Director of Nursing and attended by all ward managers, site management, and the patient flow team. We observed a safety huddle and found that staff were asked to work on other wards to ensure safe staffing levels across the wards.

Surgical staffing

- There were significant vacancies within cardiothoracic surgery. As of January 2017, the vacancy rate was 20% on surgical wards against a hospital target of 5%. Staff we spoke with stated that this was mostly gaps in the registrars rota, and that although this did not impact on patient care, some staff felt it had limited their access to training.

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- Surgical services covered the current gaps in the rota using bank or locum staff. As of January 2017, the trust reported that locum usage was at 12% within surgery. Senior staff stated that registrar recruitment was one of their biggest challenges, and had been considering developing advanced practitioner roles to address this gap.
- Junior doctors we spoke with felt there was good opportunities to develop skills in their roles and work with some very experienced consultants. Core medical trainees stated there were rotated between surgery, cardiology, and critical care, which allowed them to develop more diverse skills. Medical staff we spoke with stated they felt there was a good relationship between experienced and junior staff.
- The surgery service had a lower percentage of consultant surgeons than the England average, with 38% of medical staff at consultant level compared to the England average of 43%. There was a much higher level of higher tier doctors in training (ST1-6 grades) with 52% compared to 35% nationally. There were fewer middle grade and junior doctors in surgery posts compared to the England average, with 4% and 6% respectively compared to 10% and 11% nationally.
- Cardiac surgical cover was provided 24 hours a day by a dedicated cardiac consultant surgeon, two resident registrars, 1 non-resident registrar, and a ward registrar. In addition to the cardiac on-call service there was a separate dedicated aortovascular consultant surgeon to cover emergency aortic dissection.
- Thoracic surgery cover was provided 24 hours a day by a dedicated thoracic consultant surgeon, supported by a specialist thoracic registrar, and a ward registrar. There was also a thoracic registrar of the week who provided daily ward cover and continuity of care.
- The surgery wards also adopted a 'consultant of the week' rota system to provide daily ward cover and to support registrars, doctors in training, and other clinical staff. The consultant had no operating responsibility for that week, reviewed urgent in-house and inter-hospital referrals, and liaised with the emergency surgeon of the day.
- Daily board rounds are delivered with the consultant body, junior doctors, nursing staff, MDT staff, and the bed management team, followed by ward rounds with the consultant, ward medical staff, surgical nurse practitioner and nurse in charge. Each patient was seen

every day of the week by the cardiac or thoracic surgery consultant. We observed ward rounds taking place and observed good communication between the medical staff and patients.

Major incident awareness and training

- Emergency planning training was covered under the trust's mandatory training programme and was integrated into the trust's induction package. Surgery staff at St Bart's Hospital had an overall compliance rate of 91% for emergency planning at the time of inspection, against a trust target of 90%.
- The hospital had a site level major incident policy which identified procedures to be enacted in the event of a number of large-scale incidents. Surgical staff we spoke with stated that there was protocols in place for deferring elective activity to prioritise unscheduled emergency procedures. There was also a specific action card in the event of emergency for cardiothoracic and cardiac surgery staff, and we saw copies of this present in the MDT rooms of surgery wards.
- The trust had also produced a heatwave contingency plan with support to comply with Public Health England Heatwave Plan 2014. This document brought together the measures the trust would implement to manage environmental, staffing, and capacity issues presented by extreme weather.
- The trust had recently had a major IT shortage prior to the inspection, which had resulted in severe disruption to accessing electronic images and blood results. Senior staff stated the cause of the outage was being investigated, but that it had impacted on the picture archiving and communication system (which stored imaging and diagnostic results) and not on the ERS. Staff we spoke with stated that the issues caused by this had not been completely resolved, and during this period accessing vital diagnostic information both before and after surgery could be very difficult. Staff also stated that while there had been a good response from clinical staff to the major outage and they worked more directly to continue delivering the service, they were not aware of a major incident policy in place for such an incident that could be quickly implemented.

Are surgery services effective?

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Good



We rated effective as good because:

- Surgical pathways were delivered in line with national clinical guidance and best practice
- There were effective processes in place to ensure patients' pain relief needs were met and pain was well managed in the surgery service.
- Staff we spoke with stated they found the appraisal process useful, and felt there was good opportunities for professional development with the trust.
- There was effective multidisciplinary team (MDT) working in place within surgery services at St Bart's Hospital.
- We attended a number of ward meetings attended by medical, nursing, and multidisciplinary staff (including the weekly MDT meeting and nursing handovers), and found communication to be effective and well managed.
- Patients that we spoke with felt they had been well informed regarding their treatment and that consent had been well explained in pre-admission and pre-operatively

However:

- Some of the policies we reviewed on the trust intranet for surgery services had passed the date of review.
- Surgery services were not meeting the trust target for appraisals for non-medical staff.

Evidence-based care and treatment

- Surgical pathways were delivered in line with national clinical guidance and best practice. Senior leaders reviewed service outcome data regularly, both in relation to national measurements and internal performance monitoring.
- We reviewed a sample of trust policies relating to surgery and found appropriate reference to National Institute for Health and Care Excellence (NICE) and relevant Royal College guidelines.
- The trust's policy for recognition of, and response to, acute illness in adults in surgery services was provided in line with NICE CG50 guidance. Trust policy also complied with best practice for rehabilitation after critical illness in adults outline in CG83.

- Staff were able to access policies and corporate information on the trust's intranet. There were protocols, policies, and guidance for clinical and other patient interventions and care on the intranet. Paper copies of policies were also visible in the nursing stations of wards and in the communal area near theatres.
- Some of the policies we reviewed on the trust intranet for surgery services had passed the date from review. A number of clinical policies were identified to be over six months out of date, and had yet to be reviewed by the trust board to ensure they still complied with best practice guidelines.
- Understanding of and adherence to NICE guidelines was embedded in multidisciplinary working and evidenced through the use of audit programmes to benchmark practice. Surgery services had a robust audit plan within both theatres and wards to continually assess performance and compliance with national guidance. Surgery services used audit results to inform future Quality Improvement Projects (QIPs) across the service, which introduced changes in clinical and operation practice. Surgery services had a robust audit and quality improvement plan in place for 2017.
- The trust's clinical effectiveness unit (CEU) monitored the completion of audits across all hospital services. The CEU also identified and disseminated NICE guidelines to staff across the trust. Senior leaders for surgery had developed an action plan for the implementation of National safety standards for invasive procedures (NatSSIPs) and Local Safety Standard for Invasive Procedure (LocSIPP). Surgery services were in the process of implementing these measure across wards and theatres, and had good oversight of the progress they had made so far through audit and policies.

Pain relief

- There were effective processes in place to ensure patients' pain relief needs were met and pain was well managed in the surgery service. Staff informed us surgical services had implemented and worked to the Faculty of Pain Medicine's Core Standards for Pain Management.
- All patients we spoke with told us their pain was well managed and, and we saw evidence in records we looked at that pain scores were consistently completed. We observed staff on rounds discussing pain with patients and recording this in patient records.

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- Staff were able to refer any patient to the specialist pain management team of the hospital, in cases where the pain management plan set by the ward medical team had not optimised the patient's pain relief. Pain specialist nurses we spoke with stated they visited the wards daily and reviewed documentation to ensure pain assessments had been completed correctly.
- Recovery staff and outpatients staff we spoke with stated they had completed courses as advanced anaesthetic practitioners or recovery practitioners, which facilitated recognising the pain management needs of the patient and responding effectively.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed by the nursing staff using the Malnutrition Universal Screening Tool (MUST). Where patients were identified to be at risk, the service put plans in place to assist patients with meals or provide regular risk assessments to monitor malnutrition. Patients could be referred to and assessed by the on-site dietitian if there were specific meal plans or nutritional concerns for the patient.
- Several St Bart's Hospital wards received visits from Patient Led Assessment of the Care Environment (PLACE) reviewers relating to the quality of food provided to patients. The PLACE report dated June 2016 gave the Hospital a score of 86% for the quality of the food. This report did not include any visits to surgical wards.
- Surgery services had pre-operative fasting and fluid-intake guidelines in place for patients to ensure patients were ready for procedures. Patients were provided with a leaflet on fasting prior to surgery on pre-admission. Dietary plans were included in patient care plans where necessary.
- The surgery wards have protected meal times and tried to ensure the wards are calm during these periods. All non-emergency activity from staff is limited during this time, and patients are assisted with eating if needed.
- In patient records we observed that the MUST assessment had been completed and documented. Where patients were at a risk of dehydration, we observed fluid monitoring recorded in the patients notes, Staff informed us that any nutrition concerns or fluid restrictions for patients would be highlighted during handovers.

- The feedback from patients regarding the quality of the food was mixed. Some patients stated that the options provided were not appetising. Patients did state however, that they could access culturally specific or dietary requirement meals if needed.

Patient outcomes

- The trust contributed to relevant national patient outcome audits and performance in national and local audits was presented at regular planned team meetings.
- The trust did not participate in the Anaesthesia Clinical Services Accreditation Scheme (ACSA), however there were Quality Improvement projects underway to establish the standards for the ACSA into practice. The trust also worked to the Royal College of Surgeons (RCS) standards for unscheduled care.
- The hospital contributed to the National Lung Cancer Audit for 2016, and compared favourably to the England average. 95% of patients received CT before bronchoscopy, compared to the national average of 91.2, while the number of patients discussed at MDT was 97% compared to the England average of 95%. St Bart's Hospital was also the same as the national average for number patients receiving surgery a 15%.
- Within Carotid Endarterectomy, the median time from symptom to surgery was eight days, better than the national standard of 14 days. The risk-adjusted mortality and stroke rate within 30 days of this surgery was within the expected rate of 2%, better than the 4% rate in 2015.
- In the 2016 National Emergency Laparotomy Audit (NELA) the trust achieved the national standard of 80% for number of cases with pre-operative documentation of risk of death (83%), access to theatres within clinically appropriate timeframes (80%), and cases admitted to critical care post-operatively 100%. The trust did not meet the 80 % standard for number of high risk cases with a consultant surgeon and anaesthetist present in theatres (50%).
- Of the 2,548 surgery cases at the hospital between June 2016 and May 2017, 19% (473) were day cases. Brachytherapy, gynaecology, and breast surgery accounted for the majority of daycase admissions, with cardiothoracic surgery accounting for 3% of daycase admissions. This reflected the more complex nature of surgery and post-operative recovery for cardiothoracic patients.

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- Surgery services at St Bart's Hospital was not identified as a CQC outlier (significantly worse than the national average in a number of clinical indicators) in the last twelve months.
- Between November 2015 and March 2017, patients at St Bart's Hospital had a lower than expected risk of readmission for non-elective admissions and elective admissions when compared to the national average. The elective speciality for anaesthetics, and the non-elective specialities of neurosurgery and breast surgery had a rate of readmission higher than national average, however for anaesthetics and neurosurgery this was based on a low number of patients (18 and three respectively).

Competent staff

- There was good completion of annual staff appraisals for medical staff, however surgery services did not meet the targets for complete appraisals of non-medical staff. Information provided by the trust for surgery services show that 96% of medical staff had an appraisal within the last year (against a trust target of 90%), however this number fell to 76% for non-medical staff. Staff informed us that their appraisals were used to review their performance, identify learning and personal development needs, and set objectives for the next year.
- Staff we spoke with stated they found the appraisal process useful, and felt there was good opportunities for professional development with the trust. This included in-house developments such as shadowing, mentoring, secondments or rotations, and practical training delivered by specialist consultants and clinical nurse specialists (CNS). Staff on the wards and in theatres had an hour protected time fortnightly for training, which was delivered by consultants discussing their area of expertise.
- Staff also had access to external courses through the trust. Surgery services offered opportunities for staff to undertake nationally recognised cardiac and thoracic care courses through City and South Bank Universities. Many of the nursing staff we spoke with stated they had been encouraged to undertake these courses, and felt they were well supported by their managers in accessing professional development opportunities.
- Surgery services had access to a number of practice education nurses who could advise staff on training or development opportunities available to them, or advise on how to improve clinical competencies. Some staff we

spoke with stated this had been informative in helping to decide their appraisal objectives. Practice education nurses could also support nursing staff going through the revalidation process.

- Newly qualified nursing staff received a comprehensive induction programme including mandatory training, and stated they were well supported when they started. Senior nurses stated that each new member of staff underwent competency based training, which was co-ordinated by the practice education specialist nurses, and included supernumerary shifts for the first six months of employment to enhance learning opportunities. Theatre staff stated the theatre manager had developed a welcome booklet which staff found useful. This included a chart of management structures and leaders within the service, department philosophy and vision, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguarding (DOLS) information, how to manage sepsis, infection control rules, and information on safe staffing.
- Registrars we spoke with stated there were excellent opportunities to learn from and work with some experienced consultants, who provided good opportunities for developing clinical competencies and personal development opportunities.
- We spoke to anaesthetists who felt there had been investment in their professional development and competencies. Anaesthetists stated they were supported in advanced cardiothoracic fellowships, and could work towards accreditation with the British Society of Echocardiography (BSE).

Multidisciplinary working

- There was effective multidisciplinary team (MDT) working in place within surgery services at St Bart's Hospital. Staff we spoke with stated there was a good working relationship between the different disciplines on wards and in theatres, and we observed positive examples of collaborative working throughout the inspection.
- Patient records we checked included input from medical staff, nurses, and allied health professionals (AHPs) such as physiotherapy and occupational therapy. Staff were also able to make referrals to dieticians and speech and language therapy if needed.
- Medical and nursing staff we spoke with reported that physiotherapy and occupational therapy was accessible

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and communicative. Staff we spoke with stated the physiotherapy team was well resourced and that therapy staff attended the weekly MDT meeting, as well as board rounds.

- The physiotherapy and occupational therapy teams offered peer support and advice to nursing and medical staff in patient care. Therapies teams also provided in-house training for staff to deliver a better patient experience. For example, the occupational therapy team had delivered training to ward staff on falls prevention.
- We attended a number of ward meetings attended by medical, nursing, and multidisciplinary staff (including the weekly MDT meeting and nursing handovers), and found communication to be effective and well managed. Theatre staff attended ward handovers to confirm lists for the days and this facilitated effective movement of patients between wards and theatres. During handovers, staff discussed any patient safety issues or additional patient needs, staffing concerns, incidents and any operational issues that may impact running of the ward.
- Surgery at St Bart's provided cardiothoracic support services to a number of other general hospitals within the trust, as well as specialist cardiothoracic care to patients at other hospitals in North East London. Surgery staff we spoke with stated that inter-hospital transfers were managed well and that they had a positive and collaborative working relationship with other hospitals in the area. For example, thoracic surgical consultants attend a number of weekly MDT meetings at other East London hospitals to ensure the service is working to the London Cancer pathway for lung cancer treatment.
- St Bart's Hospital was part of UCL Partners, a large academic health science network comprising of teaching hospitals and universities, and was aligned to a new joint cardiovascular institute run by Queen Mary University London and UCL.

Seven-day services

- Surgery services delivered a full service on five days a week, with a thoracic list every Saturday with alternate cardiac Saturday lists.. The surgery wards also adopted a 'consultant of the week' rota system to provide daily ward cover and to support registrars, doctors in training,

and other clinical staff. Daily board rounds are delivered with the consultant body, junior doctors, nursing staff, MDT staff, and the bed management team, followed by ward rounds with the consultant.

- Surgical emergency services at St Bart's Hospital was covered 24 hours a day, seven days a week. Cardiac surgical cover was provided by a dedicated cardiac consultant surgeon, two resident registrars, one non-resident registrar, and senior house officer. A dedicated thoracic consultant surgeon, a registrar grade doctor (specialising in thoracic surgery) and a senior house officer provided cover for thoracic surgery.
- The National Confidential Enquiry into Perioperative Deaths 1991/2 (NCEPOD) identified the lack of an operating theatre dedicated to emergencies as an important resource shortage. Surgery services at St Bart's Hospital does not currently have a dedicated emergency operating theatre, however the leadership team was considering implementing a dedicated emergency theatre due to the volume of emergency work being carried out.
- Physiotherapy service were available seven days a week during office hours. An out of hour's on-call emergency respiratory physiotherapy service was available seven days a week between 6PM and 8AM to cover post-operative and respiratory compromised patients only.
- Surgery services could access imaging, diagnostic tests, and pathology seven days per week. This was requested and results accessed through the picture archiving and communication system (PACS). However the PACS system had been disrupted by software issues prior to inspection which severely limited access to diagnostic and imaging resources both before and after surgery (at the time of our inspection).
- The Critical Care Outreach Team (CCOT) was available 24 hours a day to provide assessment for patients at risk of deteriorating. The CCOT could provide advice on how to best manage at-risk patients and liaise with the on-site critical care units to arrange a bed on one of their wards if indicated.
- Pharmacists attended ward rounds five days a week excluding weekends, with an on-call service available at the Royal London if needed out of hours.

Access to information

- Computer terminals with access to the patient records systems, imaging and diagnostic system, and intranet

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were available on all wards and in the MDT rooms which supported theatres. There were adequate numbers of computers available to staff, however staff informed us that the recent software issue had made it difficult to access diagnostic work (such as imaging, biochemistry, and pathology) easily. Staff stated they had resorted to more direct communication with the imaging and diagnostic departments and managed to access the work they needed for patients. Staff also stated it was generally difficult to get IT support when computers start to malfunction.

- Agency staff were able to access trust policies, intranet and updates through the temporary staff logins provided by the trust. Agency staff we spoke with felt they were well informed about recent updates or changes in practice at the trust.
- Notice boards in corridors provided information for staff and patients on visiting hours, meal times, current safety performance, names of the staff on shift, and information on recent incidents and how practice had been changed to reduce the risk of repeat occurrence. There were also trust leaflets and leaflets from charities (such as the British Heart Foundation) visible on the surgical wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients that we spoke with felt they had been well informed regarding their treatment and that consent had been well explained in pre-admission and pre-operatively. Patients stated they had discussions with medical staff regarding the risks and benefits. We observed examples of doctors having conversations with patients regarding the procedures - discussing and obtaining consent for surgical procedures.
- All of the staff we spoke with understood the need to obtain consent from patients before performing care tasks, investigations, or giving medicines. We observed good practice from staff in keeping patients informed and obtaining consent before delivering any care. Patient records we reviewed showed consent had been documented, signed and dated clearly by the consultant surgeon performing the operation.
- Staff completed Mental Capacity Act (MCA) assessments for patients who were suspected as not having capacity to consent. Key information about MCA protocols and Deprivation of Liberty Safeguards (DoLS) were available

on the intranet and staff knew where to find this. Staff we spoke with had a good understanding of the principles of MCAs and DOLs and when an assessment would be needed.

- Surgery staff at St Bart's Hospital had an overall compliance rate of 79% for safeguarding adults level 2 (for staff with professional and organisational responsibility for safeguarding adults) at the time of inspection, against a trust target of 90%.

Are surgery services caring?

Good



We rated caring as good because:

- Patients we spoke with gave us positive feedback on the quality of care they received.
- Feedback from the Family and Friends Test (FFT) was consistently good across surgical wards, with an average of 98% for the period between April 2016 and February 2017.
- We observed positive interactions between staff, patients, and their families while on inspection.
- Patients and family we spoke with felt they had been well involved in their care, and staff took time to explain surgical procedures in detail.
- We observed patients were treated with dignity and with a good understanding of their care needs.

Compassionate care

- The patients we spoke with gave us positive feedback on the quality of care they received and were particularly complementary regarding the attentiveness and friendliness of the staff. Patient and family member comments included "The staff were very caring and I was listened to", "excellent staff attitude and excellent care", "The staff have treated my dad with dignity and respect", and "pre-operation explanations were excellent, staff explained things in a way I could understand".
- We observed positive interactions between staff, patients, and their families while on inspection. Staff were compassionate, polite, and professional, and took time to answer any questions patients had.

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- The trust collected patient and family feedback through the Friends and Family Test (FFT), the annual NHS inpatient survey, and through another survey with a national patient feedback organisation.
- FFT results were consistently good across surgery wards, with an average of 98% for the period between February 2017 and April 2016. Across surgery wards the average response rate was 38%, which was higher than the England average of 30%.
- The trust was partnered with a national patient feedback organisation to obtain patient feedback on the service. For surgery wards from March 2016 to March 2017 95% of patients said they would recommend the service to others, compared to a trust average of 92% in March 2017.
- St Bart's Hospital performed well in the National Inpatient Survey compared to the other hospitals in England, and was above average in 52% of scores compared to the national average. 98% of patients stated they were "well looked after" at the hospital (compared to 97% nationally), while 86% stated they were treated with "respect and dignity" (compared to 83% nationally).
- There were feedback forms and comment boxes for the partnered patient feedback organisation at each nursing station within surgery wards. We saw examples where patient were completing and submitting forms on the wards.
- Ward staff displayed thank you cards on notice boards throughout surgery wards. Staff stated it was motivating to see positive comments from patients and their families about the care they had received.
- Patients and their relatives were actively encouraged to be involved in the treatment and discharge plans where appropriate and were given the opportunity to attend a discharge talk which took place daily in the day room of one of the surgical wards.
- There was a range of information leaflets, notice boards, and posters in the day rooms of surgical wards to explain common procedures and provide advice on the post-operative recovery period.
- There were 'you said, we did' posters on wards which provided information on demonstrable changes to practice or the ward environments which came from patient feedback.
- There were two rooms available on site at St Bartholomew's to provide accommodation for relatives and carers of critical care and surgical patients. The James Hora Home at The Royal London Hospital also provided accommodation for relatives and carers of critical care and surgical patients. The home can accommodate up to 26 guests, and ward staff were able to refer family members.
- The surgery wards had a daily audit of intentional rounding (observations every one or two hours), which was carried out before the start of every 12 hour shift. Rounding was done to establish if each patient's alarms, monitoring equipment and call bells are working, and if safety observations have been completed. These daily results were then compiled into monthly results. Results from this audit show call bells were in working order when audited in April 2017.

Understanding and involvement of patients and those close to them

- Patients and family we spoke with felt they had been well involved in their care, and staff took time to explain surgical procedures in detail. We observed instances of staff discussing care plans with patients, and found they were delivered in a professional and empathetic manner.
- We observed patients were treated with dignity and staff had a good understanding of their care needs. For example, breast surgery patients pre and post-operative were treated in side rooms to allow for more privacy.
- There was a psychiatric liaison team available to provide assessment for patients and access to psychological services. The RAID Team (Rapid Assessment Interface and Discharge Team, Department of Psychological Medicine) provided mental health assessment to patients aged 16 and over who have, or develop problems with mental health, cognition, or drugs and alcohol issues.
- Surgery services had a pre-assessment nurse practitioner aimed at supporting patients through pre-admission and their hospital stay. The nurse practitioner provided information outlining the patient journey and an assessment of the patients' physiological and psychological needs.
- The hospital completed a bereavement survey from July 2016 to November 2016. The trust asked family of their

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opinion on staff, care provided, support for beliefs, support at the time of death, and support from the bereavement officer. The survey results put family satisfaction in these areas above 90% in each category.

- The hospital had a non-denominational chaplaincy service which could provide support for patients spiritual needs. The chaplaincy facilitated links with religious leaders in the local community. We observed the chaplains visiting the wards and speaking with patients and staff. We also observed posters and leaflets on the wards informing patients and their relatives of the chaplaincy service.
- Patients are referred to social workers on the hospital site if there are concerns regarding their social support or post-discharge arrangements. Social workers visited patients on the wards where concerns were flagged, and liaised with social services or directed the ward team to the appropriate resource.

Are surgery services responsive?

Good



We rated responsive as good because:

- Flow through surgery services appeared to be well managed and efficient.
- The specialised cardiovascular surgery service provided inter-hospital support for a number of district general hospitals (DGHs) in the north and east London area.
- Emergency on-call surgeons were available 24/7 to treat complex aortovascular patients.
- Surgery services had access to a number of Clinical Nurse Specialists who could provide additional support for patients with any additional clinical needs.
- There were a number of post-discharge wound clinics available to support patients with their recovery.
- Surgery services provided support for patients or families with religious or cultural needs both on the wards and in theatres.
- Patients were aware of how to make a complaint and felt they would be supported by staff to access the PALS service if they needed to.

However:

- There was variable performance in surgery services relating to care for dementia patients.

- Patients stated that communication from staff regarding discharge planning could be inconsistent.
- There was limited signage in the outpatients building for pre-admission appointments.

Service planning and delivery to meet the needs of local people

- Surgery services at Bart's Hospital provided both local, specialist, and emergency services for cardiac and thoracic surgery, as well as smaller surgical provisions for breast surgery, endocrinology, and reproductive surgery. Local services extended through North and East London, with some specialist services accepting nation-wide referrals.
- In May 2015, the cardiothoracic services from the London Chest Hospital and the Heart Hospital (part of another London trust) were brought together with those on site at St. Bart's Hospital. This reorganisation resulted in the closing of an older hospital building and opening a redeveloped new facility at the King George V Building.
- Cardiac and Thoracic surgery conducted 2,578 surgical procedures between April 2016 and Jan 2017. Elective admissions accounted for 1,595 (62%), 937 were non-elective admissions (36%), with 46 day cases (2%).
- Between December 2015 and November 2016, the average length of stay for surgical elective patients was 7.8 days, compared to the national average of 3.3. For non-elective patients, the average was 9.6 days, compared to 5.1 nationally. This is most likely due in part to the highly specialised nature of the surgery and recovery times following cardiothoracic surgery. Trust data between April 2016 and January 2017 showed surgery services was meeting their target of 8 days for elective patients and 16.1 days for non-elective surgery patients.
- Surgery services provided 24/7 emergency services for patients suffering heart attacks or heart rhythm problems, with on-call surgeons and multi-disciplinary colleagues. This service covered a population of approximately three million people across north and east London, west Essex and other surrounding areas.
- Urgent surgical inpatient referrals can be made using the online NHS network referrals system or via the on-call cardiothoracic surgery registrar at Bart's Heart Centre. The service also supported patients transferred

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from other hospitals in the local area for specialist or emergency cardiothoracic care. Hospital transfers accounted for 81 patients of the total 2,578 between April 2016 and Jan 2017.

- There were regular planned lists of surgical procedures on set days each week, up to six days a week. Theatres two and three provided for thoracic lists, theatres four to eight were for cardiac lists, with theatre one provided for breast surgery and endocrinology.
- Surgical staff could also access quiet rooms to discuss sensitive or difficult news with patients or families in private.
- We found signage within the main building for surgery wards and theatres to be clear (although not provided in any other language than English), however there was no signage at the entrance to the outpatients building indicating where surgical pre-admission services were located. This area was undergoing refurbishment, but some patients we spoke with were unclear of how to locate the clinic for pre-admission appointments.

Access and flow

- Patients were referred into the pre-surgery assessment clinics service by their GP or their hospital through the NHS Choose and Book system, or by contacting specialist registrars on the wards. Emergency services, such as heart attack treatment or aortic dissection, were delivered in 24 hours a day, seven days a week by an on call consultant surgeon.
- Patients referred to the pre-surgery assessment clinic booked their appointment through the single point of contact (SPOC) team. There were 14 consultant-led outpatient clinics weekly for new or follow-up cardiac patients, with a further five clinics for thoracic patients.
- Patients attended a pre-admission assessment with an advanced nurse practitioner (ANP), who would follow the patient's journey. This appointment involved an assessment of patient needs, risk assessments, and completion of the pre-admission information for either cardiac or thoracic integrated care pathways. Information from these assessments was put onto the electronic records system, and paper copies were made available to the wards where patients would attend. Following pre-admission assessments, patients are offered a surgery date by the SPOC depending on surgeon's availability.
- Following surgery, patients were discharged to the associated critical care wards for cardiac and thoracic

surgery (or back to the cardiac or thoracic surgery ward depending on clinical need). There were 58 critical beds in total, available for post-operative cardiac or thoracic surgery patients following either of the integrated surgery pathways (which could be level two and level three beds). Staff from surgery wards and critical care wards attended daily beds meetings to liaise regarding availability of beds in each area.

- The operating theatres had a three bedded recovery area for patients following surgery before they were returned to the wards. Some staff we spoke with stated that as there are a low number of recovery beds for eight operating theatres, there can be some blockages post-operatively and patients sometimes recovered in the anaesthetics room. Staff stated they did not feel this compromised patient safety. There had been no instances of patients staying overnight in recovery in the last 12 months.
- Discharge for patients was discussed in daily bed management meetings to help move patients out of hospital earlier in the day. Data provided by the trust show that the number of out-of-hours discharges for the hospital from June 2016 to May 2017 was 7%. Some patients we spoke with stated that communication around discharge planning could be poor, and they would like more communication from staff in relation to discharge plans.
- The ward arranged (TTO) medications with pharmacy, blood results with pathology, and transfers out of hospital with patient transport. Where clinically suitable, staff stated patients could wait for medication or pathology results in the waiting room, as this could improve flow on the wards. Surgery services had a delayed discharge coordinator who supported discharge for patients with complex needs, or could liaise with social workers. Discharge information was also shared with the patient's GP or where necessary district nurses (DN).
- Patients were provided with a discharge information pack. This provided information to support a positive recovery, information on preventing pressure ulcers or venous thromboembolisms (VTEs), information on identifying surgical site infections, and wound care advice. The wound care leaflet provided information on the wound care clinic and how it can be directly accessed by patients. There was also information provided on surgery by charities such as the British Heart Foundation.

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- The wound clinic was available for discharged patients Monday and Friday. Patients were informed they could contact the ward if they had any concerns about their recovery. Staff we spoke with stated any unplanned readmissions would normally come back through the wound clinic. In this case, the Surgical Care Practitioner (SCP) will directly contact the bed managers to arrange prompt access to a bed on one of the surgery wards.
- Surgery services collected data on performance relating to patients being treated within 18 weeks of referral (RTT). Trust data between April 2016 and January 2017 show the hospital was compliant with RTT for 92% of patients. Data provided by surgery also shows that the 52 week RTT target had been breached once in the same time period. The trust was not currently submitting RTT data at a national level.
- Theatre utilisation at St Bart's surgery services compared favourably to other hospitals within Bart's Health. Theatre utilisation across all eight theatres between December 2016 and February 2017 was between 82% and 89%, which was significantly better than the most recent inspection of the Royal London Hospital. Theatre utilisation at St Bart's was also complicated by the complex nature of some emergency cardiovascular procedures. Staff we spoke with stated they felt theatres generally operated efficiently.
- Between March 2016 and March 2017, all patients that had surgery appointments cancelled were offered a new surgery date within 28 days of the original appointment, in line with national standards.
- Staff we spoke with on the wards and in theatres stated that patient flow through surgery was generally efficient, and there were good structures in place to manage flow. Bed managers for surgery wards we spoke with stated they had a good relationship with surgery managers and felt they were well supported by the SPOC team.

Meeting people's individual needs

- Surgery services provided support for patients or families with religious or cultural needs both on the wards and in theatres. Wards could provide access to different religious resources through the chaplaincy service, and there were a number of prayer rooms located throughout the hospital site. Patients were also asked if they would like to request a culturally specific meal, which could be accommodated.
- Staff had access to interpreting services and language line to assist communication with non-English speakers.

Staff also stated that a number of staff spoke languages other than English, and could at times be used to support translation. Staff stated however, that to obtain consent the service always used an interpreter.

- Some of the leaflets on wards contained information in other languages, and there were posters located around the wards and in communal areas stating information could be requested in other languages when needed. Staff in pre-admission stated they would discuss preferred language with the referrer prior to first appointment.
- Surgery staff stated that they did not often have admissions of patients with learning disabilities. However, staff told us their needs would be identified pre-assessment and support would be provided for the patient and their families. The RAID Team (Rapid Assessment Interface and Discharge Team, Department of Psychological Medicine) provided assessment of patients with a suspected learning disability, and staff stated they could access support from the lead Clinical Nurse Specialist (CNS) for learning disabilities at the hospital.
- The RAID team visited any patients with a diagnosis of dementia or suspected complex cognitive needs. The hospital also had a dementia lead who provided screening for older patients, and provided training to staff to improve quality of care for dementia patients. The trust used a 'hospital passport' system for patients with complex needs, which included next of kind details and patient's preferences for care. Carers were also supported to stay overnight if preferred.
- St Bart's Hospital performed worse than the national average on standards for dementia from Patient Led Assessment of the Care Environment (PLACE) reviewers. The hospital had an overall rating of 69% compared to a national average of 75%. Data provided by the hospital for the last twelve months showed that 30% of patients received screening for dementia, while 93% of dementia patients received a risk assessment and referral for additional support.
- Surgery services could access a range of site level or trust-wide CNSs to support the delivery of care to patients. Staff could arrange support from tissue viability nurses (TVS), Pain teams, infection control and well as support for patients with complex needs. There

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were also a number of specialist CNS teams to support specialist services, including a lung cancer CNS, breast cancer CNS, and a Grown Up Congenital Heart disease (GUCH) CNS.

- Staff stated there was good support available from the end of life care team when needed. Staff we spoke with stated palliative staff could quickly arrange end of life medication and organise for patients to be “fast tracked” to their preferred place of death.
- Visiting times on cardiac surgery post-operative ward was 10AM-12PM and 1PM-8PM, and 2:30PM to 8PM on the thoracic surgery ward. Patients were asked to call ahead to visit the cardiology admissions ward.
- There were rooms on wards where visitors or patients could make a beverage. Vending facilities, day rooms, visitor toilets and baby changing/feeding facilities were also available on each ward.

Learning from complaints and concerns

- There were posters and leaflets on each of the surgery wards and in communal areas which provided information on how to contact the trust’s Patient Advice and Liaison Service (PALS) to make a complaint. Staff informed us that they would try to informally address any concerns or issues that patients had on the ward, but if they could not they would direct the patient to the PALS team.
- Between April 2016 and March 2017, there were 19 complaints about surgical care at St Bart’s Hospital. The hospital took on average 28 days to investigate and close a complaint, which did not meet the complaints policy target of 25 working days. Of the 19, complaints eight were upheld, five were partially upheld, and six were not upheld.
- Patients we spoke with stated they were aware of how to make a complaint, and felt that the services would take any concerns they had seriously
- We saw evidence in the minutes of governance meetings that complaints and any learning from them were discussed at ward level, board level, and in specialty and divisional meetings.

- There was a positive culture within surgery services at the hospital. The leadership team was well established and there were good connections throughout the service. The team were managing a very complex critical care environment in a very integrated and seamless way.
- The senior leadership team within surgery had effectively overseen the joining of three separate specialist surgery services into one organisation since 2015. This included standardising process, developing a unified culture and identity for surgery services, and maintaining quality of care for patients.
- Surgery services had divisional level business plans and strategies for developing the service within each area of clinical speciality for the next one to five years, which aligned with the hospital-wide priorities for the future.
- There were effective governance arrangements in place and senior staff had a good understanding of risks facing the service.
- There were a number of leadership development courses available to staff who wished to have more responsibility.
- Staff we spoke with stated there was a positive and collaborative culture within surgery services at the hospital.
- Results from the NHS staff survey showed the trust was the most improved in terms of staff satisfaction of 175 NHS organisations.
- Cardiothoracic surgery services were leading a number of innovations both within the UK and internationally.

Leadership of service

- The trust had developed a site-based leadership model in September 2015 to provide more leadership and oversight at a hospital level. This meant there was a Managing Director, Director of Nursing, and Medical Director responsible for leadership at St Bart’s Hospital. Surgery leads reported into this hospital level executive team.
- The majority of surgical activity (cardiac, thoracic, and breast surgery) at the hospital was led under the division of Cardiac & Cancer Services, with the fertility service under the Women’s and Children Division, and surgical endocrine services under the Department of Endocrinology. The departmental leadership teams

Are surgery services well-led?

Outstanding



We rated well-led as outstanding because:

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comprised of a Chief of Surgery, Senior Nurse, and a General Manager to form a clinical management triumvirate. There were subdivisions within these divisions relating to different surgical specialities.

- Staff we spoke with stated they felt it had been a significant achievement by the leadership of surgery to bring three services together into one organisation, standardise processes efficiently, and continue to maintain the quality of care while doing so. Staff stated that the move into surgery services at St Bart's Hospital had been well managed and the transition was relatively smooth.
- Senior managers and service leads we spoke with stated the current leadership model provided good lines of communication and allowed more oversight to the leadership team than when it was trust-wide. Senior staff stated that the executive team was responsive and that there was a good understanding of the needs of surgery services at the hospital.
- Nursing staff we spoke with stated that their managers were accessible and operated an open door policy, and they felt supported to raise concerns or issues. Staff stated they were supported by their managers and this was reflected on wards and in theatres. We observed positive interactions between managers and frontline staff throughout the inspection.
- Medical staff stated there was good communication and peer support from medical leadership within surgery wards and theatres. Staff stated they felt comfortable raising issues with their managers and senior colleagues.
- There were a number of leadership development courses available to staff who wished to have more responsibility. Internal and external programmes were supported, including the Mary Seacole and Florence Nightingale leadership courses and action learning sets. Senior staff we spoke with stated they were well supported to progress and become leaders within surgical services.
- During our inspection we found that senior medical and nursing staff were visible on the wards and accessible to staff across the service. Staff stated that the hospital executive team would visit the wards, and staff were able to name the hospital executive team and surgical leads when asked.
- Surgery services had divisional level business plans and strategies for developing the service within each area of clinical speciality for the next one to five years, which aligned with the hospital-wide priorities for the future. Divisional priorities for 2017/2018 included opening the remaining surgical theatres (including a robotic assisted theatre for thoracic surgery), recruiting staff to open an additional eight beds on surgery wards, and introducing enhanced recovery in the thoracic surgery program.
- There was evidence of a local strategic document and ward level mission statements, which outlined the vision for surgery services.
- Senior leaders we spoke with stated the vision for cardiac and thoracic surgery was to continue developing and delivering specialist care, be at the forefront of service innovation, and build on the work of bringing three major services together. This included developing a single centre co-locating world-class thoracic surgery and thoracic medicine, and for cardiac surgery to staff and open a complex aortic vascular unit. We saw evidence where service delivery and business cases relating to these goals were discussed in St Bart's Hospital board meetings.
- Staff we spoke with had a good understanding of the strategic goals and vision for surgery services at the hospital. Staff informed us that the trust values were covered in the induction programme, and they felt assured regarding the future direction of the service. Theatre staff stated they also received a welcome pack when starting that contained information on the service's values.

Governance, risk management and quality measurement

- Senior leaders within surgery had a good understanding of the risks facing the service and oversight of the divisional risk register. We saw evidence from the minutes of monthly quality and safety meetings that showed the risk register was regularly discussed. The main risks on the service included environmental and equipment issues (availability of theatre instrumentation, anaesthetic machines coming to the end of service life), staffing skill mix and competency in theatre recovery and critical care, and the increased patient risk in offering perfusion services.
- For each of the risks on the risk register, the owner of each risk also developed an action plan to mitigate the potential for harm to patients or staff. For example, to

Vision and strategy for this service

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manage transesophageal echocardiogram (TOE) machines coming to end of their life surgery services had put forward a business case to replace them and looked into hiring replacement equipment. Surgery services also put plans in place for booking service to schedule theatre cases requiring perioperative TOE based on availability of equipment.

- There were site level clinical governance structures in place across surgery services which were clinically led by a consultant cardiac surgeon, and staff felt they were effective. Staff we spoke with stated they felt there was good oversight of risk from senior staff, systems to measure the quality of performance and meetings to review quality indicators.
- Cardiothoracic surgery had a monthly governance meeting which was attended by surgical consultants, anaesthetists, junior doctors, nursing staff and allied health professionals (AHPs). Each meeting had a minuted presentation, and formal discussion of and morbidity and mortality, as well as covering incidents, complaints, performance and audit. Cardio and Thoracic surgery also had separate monthly board meetings (for speciality leadership), a combined theatre users group (for clinical leads from all surgical specialities) and theatre operational meetings (an open forum for all lead surgeons and theatre staff). Information and action points from these meetings were fed up to the site level Quality, Safety, and Improvement Board.
- Clinical governance meetings across surgical specialities were held monthly with a half day allocated for the meeting. Senior staff and governance leads informed us that this had been expanded since the service had opened to allow more time for presentations, discussion and learning. We reviewed minutes from these meetings and found a robust agenda in place for discussing risk management and quality performance.
- Senior surgery staff we spoke with stated the governance systems were well embedded in the daily and weekly cycles of the wards and theatres. This allowed issues to be discussed consistently, and staff to be aware when meetings would be taking place.
- Senior managers attending site level governance meetings, such as the monthly Quality, Safety, and Improvement Board, provided feedback from these meetings to their respective teams via team meetings and emails. Performance dashboards were also shared to staff within the various specialities and sub-divisions.

- Surgery services displayed Quality and Safety boards throughout wards and theatres, which provided information on recent performance in relation to safety, and identified learning from incidents. Staff we spoke with also frequently mentioned the fortnightly 'Big Four' initiative, where senior staff identified four key risk or performance areas, based on recent outcome or incidents, for all staff to be aware of. The Big Four was sent out by email and discussed in team meetings.
- The hospital had a monthly medicines governance board which reviewed performance of pharmacy services, medication audits, and incidents relating to medicines administration.

Culture within the service

- Staff we spoke with stated there was a positive and collaborative culture within surgery services at the hospital, and felt all disciplines worked well together as a team. Ward and theatre staff stated it was a good place to work and were positive about the future of the hospital.
- Staff stated they felt the service had made a lot of progress the last three years, and were very proud of the service. Staff stated that initially there has been some staff who did not feel the change was for them, but the remaining staff had worked to standardise the practice and develop their own culture.
- Staff stated that they wanted the service to be a world leader and felt it was a realistic ambition with innovative practice, experienced clinical staff, and the development of new services.
- Results from the NHS staff survey, which ran between September and December 2016, showed the trust was the most improved in terms of staff satisfaction of 175 NHS organisations. 83% of Bart's Health staff said they were satisfied with the quality of care provided to patients last year compared to the average of 82%, an improvement of 4% from 2015. St Bart's Hospital was average or above average in 69% of survey questions in 2016, compared to 18% in 2015.
- Staff stated they felt they were encouraged to report issues or concerns to managers, and that there was a good culture of learning from incidents and complaints. Staff also stated that the service was open and honest with patients and families when mistakes were made, and understood their responsibilities relating to Duty of Candour (DoC).

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- Staff said they felt comfortable challenging other members of staff if they did not feel the best care was being delivered. Theatre staff we spoke with stated they were happy to challenge consultants if they felt it was necessary, and felt that medical staff were responsive to this.

Public engagement and Staff engagement

- St Bart's Hospital participated in a trust-wide staff engagement program entitled 'Listening into action' (LiA). LiA was aimed at improving opportunities for staff feedback and included staff surveys, staff consultation events, feedback emails, and changes to organisational practice. Staff we spoke with felt the LiA events were a good opportunity to have their opinions heard and a good opportunity to raise any issues.
- The St Bart's Hospital Inclusion Forum was established in September 2016, and was held fortnightly with a view to becoming monthly once the work was firmly established. The aim of the forum was to improve understanding of equality issues, examine high rates of reported discrimination, and implement the Workforce Race Equality Standard (WRES).
- The hospital had developed a number of action plans following results from staff surveys. Following the NHS staff survey results, the hospital held a number of staff listening events and produced an action plan. The action plan included review of staffing rotas to improve time management for staff, review of staff pay rates, improved availability of occupational health, and better methods for raising concerns relating to bullying.
- St Bart's Hospital had been consecutively one of the top performers since 2012 in Green Flags in the General Medical Council's (GMC) Trainee Survey, and developed action plans each year to improve service delivery and staff satisfaction based on feedback. The most recent available action plan for 2016 included steps to improve access to educational resources, modification of the trust induction programme, and introducing a monthly junior doctors meeting.
- The hospital had a number of volunteering roles available to the public to get involved with the hospital. Volunteers were able to work with and support care for patients living with dementia as 'buddies', support the collection of patient feedback as a 'Patient Evaluation Champion', and support for the MacMillan Cancer charity.

- St Bart's Hospital held a public patient forum in July 2016 with a view to establishing how to deliver more engagement for members of the public. The hospital has yet to introduce a regular patients forum.

Innovation, improvement and sustainability

- Surgery services were in the process of introducing a robotic surgical team with a fully adapted robotic surgery theatre. This would allow the surgery services to offer less invasive cardiothoracic surgery procedures, which led to faster recovery times, minimised trauma, and reduced pain. The robotic surgical program would be the only dedicated cardiothoracic robot in the UK. The Robotic Epicentre for teaching and training in the UK will move to St Bart's Hospital in 2017.
- Surgery services had a clinical research collaboration with a leading electronics company to develop visual applications for thoracic surgery. To support this, surgery services had developed a hybrid theatre, which could allow on-table visualisation of very small cancerous lesions, allowing more precise excision and reducing loss of health lung tissue.
- St Bart's Hospital was the first site in Europe to perform Electromagnetic Navigation Bronchoscopy, and was the only centre offering this in the UK as a routine service. Surgery services are also a training centre for this procedure in Europe.
- Surgery services have employed a consultant with a specialisation in chest wall reconstructive surgery, and with support from plastic surgeons, are developing a service for young adults with severe chest deformities.
- The breast surgery team has recently developed a joint paediatric breast clinic based at the Royal London, which provides care for children under the age of 15 with breast problems in the appropriate paediatric setting, and with support from onsite paediatric physicians.
- The hospital's Grown Up Congenital Heart disease (GUCH) programme had recently received national accreditation and is one of the largest in the world. The service provides supported transition from childhood to adulthood for those born with heart disease via a well-established transition program with a leading London paediatric hospital.
- Surgery services has expanded to five professors of surgery compared to one when the service opened in May 2015. Surgery services have increased academic output to become one of the leading presenting centres

Surgery

at national and international cardiothoracic meetings. Between cardiac and thoracic surgery the services had dedicated space at the William Harvey Institute to pursue academic research.

Critical care

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

Information about the service

The Adult Critical Care Unit (ACCU) provides both specialist and critical care support for the local population, as well as tertiary services including cardiology, cardiothoracic and Extracorporeal Membrane Oxygenation (ECMO). There are 58 beds across the ACCU split across four wards for patients requiring level three care (advanced respiratory support alone or basic respiratory support with support of two other organ systems), and for patients requiring level two care (more detailed observation and higher levels of care such as those receiving basic respiratory support or with single organ failure). Ward 1C provides 16 beds for post-operative cardiac surgery for patients following the integrated cardiac surgery pathway. These beds can be level two and level three beds. Ward 1D is the high dependency unit (HDU) and provides 15 level two beds (three were not in use) for inpatient haemodialysis, cardiothoracic and general surgery. Ward 1E provides 11 level three beds for complex cardiac thoracic surgery patients. Ward 6A provides 16 level three beds (five were not in use) and is a intensive care supporting all specialities including complex cardiothoracic surgery. Patients requiring level three care have one-to-one nursing and those requiring level two have a ratio of one nurse to two patients. A Critical Care Outreach Team (CCOT) assist in the management of critically ill patients across the hospital.

We visited all areas of critical care over the course of our announced inspection. During our inspection, we spoke with 72 members of staff including doctors, nurses, allied

health professionals and ancillary staff. We also spoke with the directorate leadership team, 11 patients and six relatives. We reviewed 13 patient records, 12 prescription charts and many pieces of equipment.

Critical care

Summary of findings

We rated this service as Good because:

- There was a good incident reporting culture and learning from incident investigations was disseminated to staff in a timely fashion. Staff were able to tell us about improvements in practice that had occurred as a result.
- The environment was suitable to provide effective care and treatment and equipment was available and safe for use. Required checks were completed in most cases and we observed good infection prevention and control practice.
- Staff had an understanding of safeguarding systems and there was a safeguarding team within the trust. We found deprivation of liberty and mental capacity was assessed in line with trust policy and legislation.
- Care and treatment was delivered using up to date evidence based practice.
- We saw examples of staff providing compassionate care to patients. Staff took time to discuss care and treatment with patients and relatives and kept them well informed.
- Patient and relative feedback was very positive about the care provided across the critical care services. Staff were described as caring and compassionate.
- There was good access and flow within the critical care service. Delayed discharges on the general critical care unit were below the national average and minimal elective surgeries were cancelled due to a lack of critical care bed.
- There was strong medical and nursing leadership and the service had a strategy in place to develop the service, which was achievable.
- The leadership team had a good oversight of local risks and risks were fully documented, discussed and we saw appropriate mitigation to reduce risks.
- There was a well-respected and proactive leadership team. Leadership of the service was highly effective and managed a complex critical care environment in an integrated and seamless way.

- There was an open and positive culture within the unit. Leaders were visible, supportive and approachable.

However:

- We were not assured sepsis six (a procedural guideline designed to reduce the mortality of patients with sepsis) and the new sepsis pro forma was fully integrated into practice as staff knowledge was varied. However, the trust had a detailed action plan regarding implementation.
- The first floor did not participate in the Intensive Care National Audit and Research Centre (ICNARC) dataset. We were told there were plans to include the first floor in the future.
- The service was not meeting national guidance for dietician and occupational therapy input.
- Visiting times were not always responsive to the needs of relatives and patients. Whilst we saw some examples of flexibility, this was not consistent.

Critical care

Are critical care services safe?

Good



We rated safe as Good because:

- Incidents were reported using the trust incident reporting system. Staff gave us examples of incidents that were reported and told us they received feedback as a result of the investigations. Learning was disseminated to staff through a number of different methods and we saw changes in practice as a result of action plans from incidents.
- We observed good infection control and prevention practices throughout critical care. The wards were clean and staff complied with relevant guidance.
- The environment was suitable to provide effective care and treatment and equipment was available and safe for use. Required checks were completed in most cases including regular checks of resuscitation and difficult airway trolleys.
- Patient records were comprehensive and all appropriate risk assessments were completed.
- Staff had embedded the principles of safeguarding in practice to ensure people were protected from potential harm.
- A team of consultant intensivists led medical care of the unit 24 hours a day seven days a week. The unit was meeting the Faculty of Intensive Care Medicine guidance for consultant cover.
- Escalation strategies relating to deteriorating patients were in place and a critical care outreach team provided rapid reviews and support to ward staff.

However:

- Staff knowledge of the sepsis proforma and sepsis six was varied and we were not assured this was embedded into practice.

Incidents

- The trust reported Serious Incidents (SIs) and Never Events to the Strategic Executive Information System (STEIS).

- The service reported no never events for the 12 months prior to our inspection. 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.
- Incidents were reported via an electronic reporting system that could be accessed by all staff and completed on any trust computer.
- Between March 2016 and March 2017 the Adult Critical Care Unit (ACCU) reported 502 incidents and an average of 42 per month.
- Of the 502 incidents 395 (78.7%) were reported as no harm, 99 (19.7%) low harm, seven (1.4%) moderate harm and one (0.2%) as severe harm or death within the reporting period.
- The most common incidents on the ACCU were pressure ulcers and medicine incidents. To help reduce the number of pressure ulcer incidents the service had created their own tissue viability nurse and created tissue viability link nurses in each ward. The role of the tissue viability nurse was to monitor any pressure ulcers and audit whether assessments have been completed properly.
- Serious incidents (SI) are those that require investigation. Between March 2016 and February 2017, the service reported two SI. This involved sub-optimal care of a deteriorating patient. We saw evidence of investigation reports and root cause analysis (RCA), including action points. There was evidence of duty of candour around the investigation and findings.
- Staff were able to identify how to report incidents and the types of situations that should trigger incident-reporting completion, including near miss situations. There were also information sheets throughout ACCU explaining what incidents, serious incidents, never events and near misses were.
- Staff told us they received feedback and learning points from incidents, including those that occurred in other units within the hospital and other sites within the trust. Learning was shared via a range of methods including directly via email, staff meetings and the ward's communication book.

Critical care

- We saw 'safety matters' newsletters available on the ACCU which discussed incidents and learning from incidents.
- Staff were able to describe action points from incidents. For example, staff told us there had been a number of never events in the past around nasogastric (NG) feeding within the trust. The ACCU had introduced some additional training around the safe insertion of NG tubes in response to incidents within the trust.
- Staff also identified a recent SI on ACCU around management of a difficult airway. The ACCU had revised its protocols and embedded learning from the incident into its regular simulation training.
- There were regular mortality and morbidity (M&M) held on a weekly basis. M&Ms were held to discuss mortality on the ACCU. We reviewed minutes from January 2017 and saw cases were discussed and recommendations were made and actions assigned. Senior leaders monitored when actions completed.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had a good knowledge of duty of candour and, senior staff were very clear about their responsibilities in relation to DoC. We saw DoC information sheets available on the unit.
- ulcer prevention score. We observed there were measures in place to reduce the risk of pressure ulcers occurring, such as use of the SSKIN care bundle and pressure relieving equipment. Tissue viability nurses were also available Monday to Friday from 9am to 5pm to provide specialist advice in this area.
- There were four reported falls between February 2016 and February 2017. We saw evidence of patient mobility assessments undertaken by physiotherapists and patient risk assessments completed where appropriate. Where patients were at a low risk of falls the assessments were conducted by the nursing staff as part of the pathway.
- Catheter care bundles were used by staff throughout critical care. There were two reported catheter associated urinary tract infections (CUTI) between February 2016 and February 2017.
- Venous Thromboembolism (VTE) risk assessments were recorded on the patients' records and completed on a daily basis.
- The safety cross was displayed at each critical care entrance on the first floor. The safety cross is a tool used to display key information about the safety of the ward, which is completed daily. Each number on the cross represents a day and date for the month.
- The safety cross displayed information about the number of pressure ulcers, acquired infection, staffing levels and falls for the current month.

Safety thermometer

- The ACCU participated in the NHS Safety Thermometer scheme. The NHS safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence. This was intended to focus attention on patient harms and their elimination.
- We were told there had been nine acquired pressure ulcers reported by the service between February 2016 and February 2017. There was one serious incident reported which related to a pressure ulcer. During our inspection, we saw patients' risk of developing a pressure ulcer was assessed using Waterlow pressure

Cleanliness, infection control and hygiene

- The service had established systems in place for infection prevention and control, which were accessible to staff. These were based on the Department of Health code of practice on the prevention and control of infections, and included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, and management of spillage of body fluids.
- All the infection prevention and control standard operating procedures we reviewed were up to date and accessible by staff on the hospital intranet.

Critical care

- There were dedicated housekeeping staff for cleaning the ACCU. Housekeepers worked from 6am to 7.30pm. Out of hours a team was available on call. Cleaning staff understood cleaning frequency and standards and said they felt part of the team.
- We reviewed patient areas on the ACCU as well as dirty utility areas and treatment rooms. All areas were visibly clean and free from dust. Patients and relatives were satisfied with the level of cleanliness on the wards.
- Green 'I am clean' stickers were used to identify which equipment had been cleaned by staff and was ready to be reused, such as commodes. We saw stickers were marked with the date the item was cleaned and observed staff replacing stickers once they returned the clean equipment.
- We inspected various pieces of equipment such as commodes and found a good level of cleanliness including under the seats and on the commode legs.
- However, we saw dried blood on the arterial blood gas machine on ward 6A and ward 1C.
- Infection prevention and control (IPC) was part of mandatory training. For nursing staff compliance for level one and two was 99%, and met the trust target of 90%. However, compliance with IPC level one and two clinical (82%) and IPC level 3 (75%) were below the trust target. For medical staffing compliance was 86%, which was below the trust target of 90%.
- There was easy access to personal protective equipment (PPE) such as aprons and gloves in all areas we inspected and saw all staff used PPE as required.
- Staff were 'bare below the elbow' and adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces, and wearing PPE when caring for patients.
- Where patients had a known or suspected infection they were nursed in single rooms. There were signs displaying presence of infection which meant staff and visitors were aware of the precautions to take prior to entering the patient area. We observed staff adhering to these protocols and doors remained closed.
- There were disability accessible patient toilets available on the unit.
- Hand sanitisers were readily available at the entrances to the CCU and at each bedside. We observed staff and visitors decontaminating their hands when entering and leaving the unit.
- We observed bed space curtains were labelled and dated when they were last changed.
- ACCU audited hand hygiene on a monthly basis. We reviewed audit data between April 2016 and February 2017 and compliance varied between 91% and 100% across all four wards. We observed numerous signs across ACCU encouraging good hand hygiene practice.
- Ventilator Associated Pneumonia (VAP) is a common infection found in intensive care units. It increases duration of ventilation and length of stay in hospital. The service conducted an audit between February 2016 and August 2016. VAP infection rates were 2.1% within cardiothoracic critical care (CT ACCU) and 7.3% in general critical care (General ACCU). Both rates were within the expected range of critical care services as described in published rates.
- General ACCU participated in the Intensive Care National Audit and Research Centre (ICNARC). Data showed the rate of unit acquired blood infections for the general ACCU was worse (3.1) than comparator units (2.1) and all units (1.6).
- We reviewed the February 2017 critical care performance review report for both CT ACCU and the General ACCU. Between March 2016 and February 2017, CT ACCU had three unit acquired methicillin-resistant staphylococcus aureus (MRSA) and general ACCU had one case. Both CT ACCU and General ACCU had two cases of Clostridium Difficile (C-Diff). MRSA and C.Diff are both healthcare-associated infections (HCAIs) that can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. We observed various information leaflets around the ward for staff giving advice on steps to take to help prevent new cases of MRSA and C.Diff. This included promoting hand hygiene, staff education and screening.
- Senior leaders identified an issue with surgical site infections. This had led to a better awareness of wound dressing and we saw information available for staff on how to dress post-operative wounds.

Critical care

- ACCU had started an infection prevention and control newsletter which was published each month and displayed around the ACCU. This included tips for things such as post-operative wound management and good infection control practices.

Environment and equipment

- The ACCU was a purpose built bright and spacious unit and there was appropriate levels of storage. Most of the areas had natural light and space between beds was in line with Intensive Care Society standards. The unit demonstrated compliance with most of the Health Building Note (HBN040) recommendations. Health Building Note 04-02 (HBN 04-02) for critical care units gives best practice guidance on the design and planning of healthcare buildings.
- Side rooms had decontamination lobbies in line with best practice guidance. All ventilation on both floors was compliant with HTM 03-01 Specialised Heating and Ventilation for Healthcare Premises. Therefore, ventilation in isolation rooms provided a simultaneous source and protective isolation.
- There was an electronic swipe card entry system for staff and a buzzer entry system at the entrance to all of the ACCU which was used by visitors. This meant staff could control who accessed the wards when the door was secured. All wards and departments that regularly accepted patients' visitors had video intercom. CCTV was considered and rejected on the grounds that visitors were controlled and CCTV can be perceived as an invasion of privacy.
- There were separate lifts for visitors and patients and access by visitors was carefully controlled to avoid cross pathways of patients. Deceased patients were transported via completely separate routes to visitors. This was in line with best practice guidance.
- There were reception desks on all wards which were staffed by ward clerks which meant visitors had a point of contact on admission to the ward.
- There were waiting areas on the first and sixth floor for relatives and also numerous relative rooms. Relative rooms contained drink making facilities and key information for those visiting patients on ACCU. One of the relative rooms had a range of games, toys and books available for children and young people.
- There were no dedicated decontamination rooms on the wards, which did not meet the HBN 04-02 recommendations. We were told all equipment was either cleaned at the bed space or sent to Central Sterile Services Department (CSSD) for sterilisation in accordance with infection control guidelines and protocol. There were dirty utility rooms which contained facilities for disposing of clinical waste and cleaning equipment.
- The ACCU had access to a 'difficult airway' intubation trolley, which contained equipment to help staff intubate patients with challenging anatomy. The content of the trolley met recommendations from the Difficult Airway Society (DAS) 2013.
- Resuscitation trolleys were located at appropriate intervals throughout the CCU. We saw the contents of the trolleys were checked daily by nursing staff and were tagged and sealed.
- Needle sharp bins were available at each bed space and within the medication preparation area. All bins we inspected were correctly labelled and none were filled above the maximum fill line. There were also separate blue-lidded bins for medications which were used correctly.
- Staff told us they were able to access equipment required to care for patients and access to computer terminals to allow access to pathology and imaging results for example as well as policies and guidelines.
- Equipment we checked, including a range of bedside computers and patient hoists, were in good working order and were labelled with stickers indicating when they were last serviced.
- We saw evidence of safety testing for equipment within the ACCU, including ventilators and computers. We reviewed service records and found them to be up to date.
- We observed spare consumables and other equipment were appropriately stored and labelled. We checked various consumables, such as fluids, and found they were all in date.

Critical care

- Staff told us they were able to access equipment required to care for patients and there were computer terminals available to allow staff to readily access pathology results and other policies and guidelines on the staff shared drive.
- ACCU had two critical care technicians whose role involved checking equipment such as blood analysers, cleaning and resetting ventilators and troubleshooting equipment issues.
- Faculty of Intensive Care Medical Core Standards for Intensive Care Units recommends there must be a programme in place for the routine replacement of capital equipment. The ACCU was meeting this standard.
- There were staff photo boards throughout ACCU so staff could see who worked on the wards.
- Oxygen cylinders throughout the ACCU were mostly appropriately stored in designated racks and were in date. However, we found two small oxygen cylinders next to the resuscitation trolley, which were not stored safely.
- The unit was meeting the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommendations around pharmacy technical support. Pharmacy technical support was available for every area and ward for both stock management control and medicines reconciliation.
- Pharmacists attended ward rounds five days a week (Monday to Friday). However, when we spoke to the senior pharmacist we were told they divided their time between attending ward round on 6A three times per week and ward 1C and 1E two times. This was not compliant with the FICM standard
- We saw the unit used a medicines reconciliation process, which meant that when patients were admitted to hospital the medicines they are prescribed on admission correspond to those they were taking before admission.
- Medication management was part of mandatory training. Compliance was below the trust target of 90% for nursing staff.
- We observed staff on each unit preparing and administering intravenous and oral medicines. They followed correct procedures, including checking the dosage, the expiry dates, patient identification and any allergies.
- Medicines were stored in locked units across the ACCU.
- Controlled drugs (CDs), which are medicines requiring additional security, were stored in lockable, wall-mounted cupboards. On each unit, the keys for these cupboards were held by an allocated nurse which was in line with trust policy.
- Registers containing details of the CD cupboards were stored within the cupboard and identified the expected stock of each medicine. Two members of staff checked the CD stock levels collaboratively on a daily basis. During our inspection, the CD stock levels documented in the stock books were checked and were accurate.
- We reviewed 12 prescription charts and saw they were fully completed. Allergies were clearly documented and allergy stickers were applied to patients' records.
- All staff had access to British National Formulary (BNF) as well as policies and information relating to medicines management, including the antimicrobial formulary.

Medicines

- There were systems in place to ensure the safe supply and administration of medicines in accordance with NICE NG5 Medicines optimisation: the safe and effective use of medicines.
- Recommendations from the Faculty of Intensive Care Medicine Core (FICM) Standards for Intensive Care Units identify there should be a critical care pharmacist for every critical care unit. Pharmacy provision included a band 8c consultant pharmacist clinical lead for cardiac services, a full time 8B pharmacist clinical lead for cardiothoracic critical care and cardiothoracic surgery, a full time 8A pharmacist and three band 7 pharmacists working across critical care and CT surgery.
- Faculty of Intensive Care Medicine Core Standards for Intensive Care Units (FICM) recommend there should be at least 0.1 Whole Time Equivalent (WTE) specialist clinical pharmacists for each single level three bed and for every two Level two beds. The service was not meeting this standard. However, staff we spoke to said they had access to the on-call pharmacist when required out of hours and did not experience delays in receiving discharge medicines.

Critical care

- Patients' own medicines were stored in individual drawers at the head of each bed space. We checked numerous bedside spaces and all of them were locked.
- Medicines requiring refrigeration were stored in designated and lockable medicine fridges. Staff checked the temperature of the fridges on a daily basis and we saw no gaps in recording.

Records

- ACCU used a mix of electronic and paper based records to record medical interventions and involvement from the multidisciplinary team. Paper based notes were kept at the end of each patient's bed for easy access. We reviewed 13 sets of patients' records and found they were legible, signed and fully completed.
- Patient observations and assessments were recorded on the daily record sheet which was kept at the end of each patient's bed. Nursing documents were clear and concise and care plans fully completed. This included information such as regular observations, fluid balance and pain scores.
- All the records we looked at included details of allergies, daily plans and a record of daily consultant reviews. We saw staff recorded specialist assessments for patients' needs, for example nutrition assessments.
- Staff demonstrated a good understanding of the need for confidentiality and we observed them using appropriate electronic password protected systems.
- The trust target for completion of information governance training was 90%. ACCU was achieving this target for nursing staff. For medical staff, compliance was 87%, which was below the trust target.

Safeguarding

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the trust safeguarding policy.
- Nursing staff were able to define triggers that would prompt them to obtain a safeguarding assessment for patients. Staff told us they would seek advice from senior staff members and the trust safeguarding team if they had any concerns.

- All staff we spoke with knew the safeguarding team and could identify where to find their contact details if required.
- Safeguarding adults and children training was completed by staff as part of the trust's mandatory training. All staff were required to attend this training. For safeguarding adults and children level one compliance for nursing staff was above the trust target of 90%. Whereas training completion for level two courses for nursing staff were just below the target for both safeguarding adults (88%) and safeguarding children (89%).
- Medical staffing compliance was meeting the trust target of 90% for safeguarding children level one (90%). However, were below the trust target for safeguarding children level two (84%), safeguarding adults level one (87%) and safeguarding adults level two (84%).

Mandatory training

- Key aspects of mandatory training such as information governance and fire safety were undertaken as part of the induction process for new starters. Ongoing mandatory training was undertaken as e-learning modules and further classroom based sessions.
- The trust set a target of 90% for completion of mandatory training.
- For nursing staff the service was meeting the trust target for clinical documentation, dementia awareness, health and safety, conflict resolution, equality and diversity, fire safety and privacy and dignity.
- However, nursing staff were not meeting the target for medical gas safety (78%) and blood transfusion (81%) and medicines management (81%).
- For medical staff the service was meeting the trust target for clinical documentation and safeguarding children level one.
- However, medical staff were below the trust target for all other mandatory training including conflict resolution (86%), consent (89%), dementia awareness (86%), early warning systems (89%), emergency planning (87%), equality and diversity (87%), fire safety (79%), health and safety (87%), medical gas (89%), moving and handling (87%), nutritional care (86%) and privacy and dignity (86%).

Critical care

- For nursing staff, Basic Life Support (BLS) was completed by 96% and Intermediate Life Support (ILS) by 89%, against a trust target of 90%. The trust had also trained some band five nurses (39%) in ILS which was not mandatory. The trust had also trained 28% of band seven nurses in Advanced Life Support (ALS) training and 74% of nurses in Cardiac Advanced Life Support (CALS).
- For medical staff, BLS was completed by 81% of medical staff, which was below the trust target. 100% of specialist registrars were trained in ALS, which was above the trust target of 90%.

Assessing and responding to patient risk

- The ACCU used the 'Richmond Agitation-Sedation Scale' (RASS) to score the level of sedation for each patient receiving sedative medicines. We found evidence this assessment was being completed in patients' records.
- Previously patients were evaluated using the Confusion Assessment Method for ITU (CAM_ICU) flowchart to determine whether delirium was evident. The service had recently started using the 4AT rapid assessment test for delirium. This was in line with best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. We saw evidence this assessment was completed with appropriate patients during the inspection.
- Patients were monitored using recognised observational tools and monitors. The frequency of observations was dependent on the acuity of the patient.
- There was access to liaison psychiatry and/or other specialist mental health support if there were concerns about risks associated with a patient's mental health. Staff knew how to access these services. However, the service was not conducting any risk assessments for mental health.
- There was a well-established Critical Care Outreach Team (CCOT) staffed by six whole time equivalent (WTE) band 7 nurse practitioners, one band 7 allied health professional, 2.6 WTE clinical nurse practitioners and 0.5 WTE consultant intensivists.
- CCOT provided 24-hour hospital wide urgent care for deteriorating patients on wards within the hospital. The service aimed to avert admissions to critical care by early identification and appropriate therapeutic interventions.
- During the inspection we reviewed CCOT staffing rotas and saw there was appropriate cover.
- The team used the national early warning scores system (NEWS) to identify patients who were sick and would benefit from critical care. NEWS was used throughout the hospital wards to enable early identification of deteriorating patients. This was in line with guidance from the Royal College of Physicians and compliant with the NICE 50 guideline. Hospital documentation identified that a referral to CCOT should be made when the NEWS reached a score of five or above or if a person had any single score of three.
- Where critical care was identified as necessary the CCOT facilitated timely admissions to critical care and would follow-up patients on discharge from critical care to other wards within the hospital.
- The CCOT operational policy outlined a timetable allocating key tasks CCOT had to perform on each shift. This included handovers, safety huddles and regular meetings with hospital staff to discuss at risk patients and planned discharges from critical care.
- We reviewed minutes from the Managing the Acutely Ill Patients (MAIP) Group held in February 2017. In February 2017, an audit identified NEWS compliance was 97% but cases were only correctly calculated in 84% of cases. The group discussed NEWS compliance throughout the hospital and actioned ways to improve this such as holding workstations in ward areas where compliance was low.
- The MAIP group discussed sepsis six and identified a need for quality improvement in the recognition and initial care of patients presenting with or deteriorating with sepsis.
- There was a sepsis pathway which aimed to help staff identify sepsis at an early stage. The screening and management proforma allowed staff to follow a clear process when a patient was deteriorating. This incorporated the sepsis six which are six things staff should be monitoring with patients who are at risk.

Critical care

However, staff knowledge and understanding of the sepsis proforma was varied and we were not assured everyone was following this. The trust had an implementation plan in place to drive forward quality improvement in the recognition and initial care of patients presenting with or deteriorating with sepsis. The trust had appointed ward level sepsis champions who were undergoing training around the time of our inspection. There were also plans to have sepsis trolleys and additional training for staff.

Nursing staffing

- A team of 281 whole time equivalent (WTE) members of qualified nursing staff worked across ACCU. This included a 21% vacancy rate, as of May 2017.
- Band five critical care nurses had the highest vacancy rate (25%) followed by band seven nurses (8%).
- Two matrons led the nursing staff. There were 18 nursing teams and each team was led by a band seven critical care nurse.
- The trust used the Shelford safer Nursing Care Tool (SNCT) to assess levels of acuity and dependency of inpatients. ACCU collated the SNCT data but staffing levels were based on the Faculty of Intensive Care Medical Core Standards for Intensive Care Units. This states that all ventilated patients (level three) are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care, and for level two patients a ratio of 1:2. Patient allocation records demonstrated critical care complied with the required staffing levels.
- Patients with additional care needs could be nursed by additional nurses. For example, Extracorporeal Membrane Oxygenation (ECMO) patients were nursed on a ratio of two nurses to one patient. ECMO is a form of life support that provides both cardiac and respiratory support to persons whose heart and lungs are unable to provide an adequate amount of gas exchange to sustain life.
- Each ward also had a supernumerary band six/seven clinical coordinator 24 hours a day seven days a week. This met standards from the Royal College of Nursing. In addition, there were float nurses assigned to each shift to support staff.
- Site safety huddles were held on a daily basis and as part of this staffing numbers were discussed for the following 24 hours. Any changes in acuity resulting in potential shortfalls were escalated to the matron and senior nurse team.
- Nursing handover took place twice daily with the whole team at 8.00am and 8.00pm. We observed one handover and found them to be structured, detailed and focused on personalised care. Nursing staff received an overview of all critical care patients at the start of the shift then a thorough bedside handover once they were allocated a patient.
- New nurses were initially supernumerary while becoming orientated to the department. They were allocated a mentor and received support from the nurse education team.
- Best practice guidance recommends no more than 20% agency staff usage per shift. Trust data between October 2016 and March 2017 showed the ACCU was compliant with this guideline.
- Bank and agency staff received a local induction on their first shift and we saw evidence of completed agency staff induction checklists across ACCU.

Medical staffing

- A total of 48 WTE consultants were in post across the ACCU. In line with recommendations from the Faculty of Intensive Care Medical Core Standards for Intensive Care Units (FICM), 100% of consultants were Faculty of Intensive Care Medicine accredited or had suitable equivalent qualifications
- FICM recommends the consultant to patient ratio should be between 1:8 and 1:15 and consultants participating in the duty rota must not be responsible for delivering other services whilst covering the critical care unit and must be able to attend within 30 minutes. The ACCU rota was in line with these recommendations.
- On wards 1A and 1C there were two consultants on shift Monday to Friday and two consultants to cover nights and weekends.

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- Ward 1D was a level two high dependency unit and operated on an open shared care model with surgical specialities. There was one consultant weekdays Monday to Friday and on weekends, this ward was covered by the 1E and 1C consultants.
- Ward 6A had two consultants on five day blocks plus an extra consultant for ECMO retrieval Monday to Friday. Over the weekend there were two consultants on shift.
- Each ACCU was staffed continuously by one/two middle grade registrar/fellow who works blocks of three/four days.
- Eight junior fellows provided weekday day and Saturday morning support to all CCU. The trust told us there were plans to increase this to 10 junior fellows in order to provide night cover on ward 1D.
- The clinical director told us the junior doctor allocation from Health Education England (HEE) had dropped for intensivists on the ACCU training programme. We were told any gaps in the rota were being filled using clinical fellows.
- There were four consultants on shift during the night and junior doctors said this gave them good access to supervision and support.
- There was a detailed medical handover every morning at 7:30am which included discussions of all patients on the ACCU.
- Medical staff performed ward rounds twice daily, meeting the Intensive Care Society Standards. These included a review of the patient's history, medicine and treatment.

Major incident awareness and training

- There was a hospital wide major incident plan, which detailed what roles staff needed to take during an incident. There were laminated action cards for the ACCU with clear descriptions of duties, process and responsibilities.
- The major incident and fire safety policies were available on the trust intranet and paper copies kept in a red folder at the nurse's station on each ward. Staff we spoke with could identify where this was kept.

- The fire safety policy gave staff information about the protocol to follow in the event of a fire. We reviewed training records and compliance was in line with the trust target of 90% for nursing staff. However, medical staff were below the trust target.
- There had been fire safety preparation exercises completed in the 12 months preceding our inspection.

Are critical care services effective?

Good



We rated effective as Good because:

- The unit used a combination of best practice and national guidance to deliver care and treatment to patients.
- ACCU had a comprehensive audit programme in place to ensure audits were completed at appropriate intervals to monitor quality and safety.
- The education team provided a high level of training and support for staff, and team members were given the opportunity to develop their skills and knowledge.
- We observed excellent examples of multidisciplinary working and all staff reported good joint working between the different disciplines.
- There was a system in place to manage patients who required review of mental capacity and deprivation of liberty safeguards and staff had a good understanding of this.

However:

- The first floor wards did not contribute to ICNARC, which was an expectation for critical care services.
- The number of unplanned readmissions within 48 hours was slightly higher than the national average on General ACCU.
- The service was not meeting national guidance for dieticians and occupational therapy provision.

Evidence-based care and treatment

- Policies and procedures were available on the trust intranet and shared drive. Policies and procedures were up to date and referenced to current best practice from

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a combination of national and international guidance. This included National Institute for Health and Care Excellence (NICE), Royal College guidelines and Intensive Care Society recommendations.

- Staff trained in airway management practised this based on Difficult Airway Society guidelines.
- Ward 6A which was the General Adult Critical Care Units (General ACCU) contributed to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units.
- However, the first floor wards (ward 1C, 1D and 1E) did not participate in ICNARC which accounted for 42 of the 58 beds (72%). We were told ICNARC had recently validated a risk model that extended the case-mix adjustment to include patients who had undergone cardiac surgery and there were plans for the first floor to submit ICNARC in the near future. In the meantime, the first floor captured and entered into their own critical care performance database and produced monthly reports. These reports incorporated nearly all of the ICNARC fields but this could not be compared accurately at a national level. Following the inspection we were shown an action plan regarding ICNARC participation. The first floor was expecting to be fully participating by October 2017.
- There was a local audit programme in place to ensure certain audits were completed at appropriate intervals to monitor quality and safety. For example, Saving Lives and Safety Thermometer. This practice was in line with recommendations from the Faculty of Intensive Care Medicine (FICM) core standards for Intensive Care Units.
- The service also participated in a number of quality improvement projects to ensure compliance with national guidance. For example, one project had looked at surgical site infection and compliance with antibiotic prescribing.
- Evidence based care bundles, such as the SSKIN care bundle, were used to assess and guide patient care regarding specific issues like pressure ulcer prevention. In March 2017, a SSKIN bundle compliance audit was conducted across all four critical care wards (1C, 1D, 1E and 6A). The audit assessed skin assessments, incident completion, wound assessment, Waterlow score completion, SSKIN bundle plan completion, skin checks, repositioning, incontinence and nutrition assessment. Compliance was mostly above 90% in all areas across wards 1C, 1D and 1E. Ward 6A had lower levels of compliance including only 60% of patients having a SSKIN bundle plan completed, 50% having a skin check every 24 hours and 40% of patients repositioning schedule completed.
- In February 2017, ward 1C scored 100% for implementing correct procedures in central venous catheter (CVC insertion), 100% for CVC ongoing care, 100% for peripheral cannula insertion (PVC) and 60% for PVC ongoing care.
- In January 2017, ward 1D scored 100% for implementing correct procedures in CVC insertion (100%) and ongoing care (100%). The ward scored 67% for PVC insertion and 100% for ongoing care.
- In February 2017, ward 1E/6A scored 100% for CVC insertion and ongoing care and 100% for PVC insertion and ongoing care.
- An evidenced-based ventilator-associated pneumonia (VAP) prevention care bundle was in use throughout critical care. The service conducted an audit between February 2016 and August 2016, which found compliance was 62%. The service had put an improvement plan in place to increase compliance that included staff education, and continued auditing.
- Patients were assessed daily for their level of delirium as recommended by the Intensive Care Society Standards and NICE guidelines. The ACCU had recently changed from the Confusion Assessment Method for ITU (CAM-ITU) to the 4AT rapid assessment test for delirium. Whilst we found this to be completed in all records we checked we found staff knowledge of the change of tools was mixed.
- In accordance with NICE quality standard 3, we observed patient risk of Venous Thromboembolism (VTE) were assessed at appropriate intervals (on admission and after 24 hours) and suitable prophylaxis was in place across ACCU. VTE is the formation of clots in the vein.
- The service audited compliance with (NICE) CG 83 rehabilitation after critical illness in adults. The audit identified that ICU was not fully compliant with the

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guidance. The service was not always providing rehabilitation assessments within the recommended 48 hour time frame. Follow-ups two/three months following discharge were also not always happening. The service had put an action plan in place to improve compliance which included regular reminders and checks.

- During the inspection we checked 13 patient records and found all patients received a rehabilitation assessment within the recommended 48 hours.
- Patients' undergoing rehabilitation received regular sessions of physiotherapy which met the Faculty of Intensive Care Medicine Core Standards for Intensive Care Medicine. This recommends a minimum of 45 minutes of each active therapy, for a minimum of five days a week
- The hospital used a sepsis screening tool and sepsis care pathway based on the sepsis six, which is a national a procedural guideline designed to reduce the mortality of patients with sepsis.

Pain relief

- Pain was assessed on an hourly basis as part of observations using a formal patient reported scoring system. Patients were asked to score their pain on a scale of one to three. If a patient was unconscious, staff used the Face, Legs, Activity, Cry and Consolability (FLACC) scale which was a measurement to assess pain in those unable to communicate. Staff told us they would look for signs of things such as grimacing and restlessness.
- Some patients had Patient Controlled Analgesia (PCA) devices, which is a method of pain control that allows patients the power to control their pain.
- Patients told us staff asked them about their pain on a regular basis. All patients we spoke with were happy with their access to pain relief medication and said it was managed well.
- Support for patients with pain issues could be obtained from the hospital acute pain team who were available via a bleep system. The pain team were available from 9am to 5pm Monday to Friday, outside of these hours an on-call service operated. Most staff were able to tell us how to access the pain team.

Nutrition and hydration

- There was 1.6 whole time equivalent (WTE) dietician support available for the critical care unit. This provision was not compliant with the Faculty of Intensive Care Medicine (FICM) recommended numbers of WTE dieticians for the number of critical care beds available. ACCU services would require 5.6 dieticians for the number of beds provided.
- The ACCU had an enteral feeding protocol to assess the nutritional needs of patients, based on height, weight and body mass index. The nurses implemented the feeding protocol when patients were admitted to the unit. Enteral feeding refers to the delivery of a nutritionally complete feed, containing protein, carbohydrate, fat, water, minerals and vitamins, directly into the stomach. Enteral feeding equipment was stored in cupboards on the first and sixth floor and contained a pantry with food blends.
- We were told that currently all patients requiring a enteral feeding, for example, via a nasogastric feed (NG) were reviewed by the dietician on Mondays, Wednesday and Fridays. The dieticians also reviewed patients who were referred to them due to concerns around nutritional needs. However, patients who were not on enteral feeding or referred did not receive input from the dieticians. There was no access to assessments over the weekend and dieticians did not attend daily ward rounds.
- We reviewed 13 patient records and saw evidence of comprehensive fluid balance monitoring on the daily care charts. However, Malnutrition Universal Screening Tool (MUST) scores were not documented for every patient. MUST scores can be used to establish nutritional risk and staff were aware recording of this needed to be improved.
- Parenteral nutrition (PN) was started upon agreement of the ICU medical team. PN could be started out of hours or at weekends by critical care staff. Parenteral nutrition (PN) is the feeding of a person intravenously, bypassing the usual process of eating and digestion. The person receives nutritional formulae that contain nutrients such as glucose, salts, amino acids, lipids and added vitamins and dietary minerals.
- Patients who were able to eat told us they were happy with the food choices available on the unit.

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- We observed patient meal times. Some patients were enabled to eat independently and drinks were placed within their reach. We observed nurses and healthcare assistants assisting patients when required.

Patient outcomes

- General ACCU (Ward 6A) contributed data to the ICNARC database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally for the 16 bedded general ACCU.
- However, floor one (wards 1C, 1D and 1E) did not participate in ICNARC. We spoke with the audit nurse and senior leaders about this and were told this was due to a 'lack of manpower' to input all the ICNARC data. We were told the long-term vision is for all four wards to be participating in ICNARC. Following the inspection the trust provided us with an action plan regarding ICNARC participation. The trust have approved additional audit nurse posts to help with data collection and submission. In addition, the trust are in the process of purchasing their ICNARC subscription and should be participating in data collection by October 2017.
- Senior leaders told us wards 1C and 1E are part of the surgical pathway and therefore collect outcome data as part of this. For example, we were told they submit data to the Society of Cardiothoracic Surgeons (SCTS). We were also told critical care performance data contributes to the National Institute for Cardiovascular Outcome Research (NICOR) dataset reporting cardiac surgery performance and the National Cardiac Benchmarking Collaborative (NCBC).
- ICNARC annual report data showed the General ACCU risk adjusted hospital mortality ratio was 1.1. This was within the expected range. The figure in the 2015 annual report was 1.7, which shows an improvement on the previous year.
- We reviewed quarterly data between April 2016 and September 2016. ICNARC data quoted below relates to this data period for the General ACCU.
- ICNARC data from April to September 2016 showed there were 45 patient deaths. This represented a mortality rate of 21.8%, which was just above expected mortality rate.
- We reviewed more recent mortality data from the monthly critical care performance review reports. These reports were produced each month for both the cardiothoracic (CT) ACCU and General ACCU. Between March 2016 and February 2017, the CT ACCU had unit mortality was between 0% and 5%. For General ACCU the rate ranged from 10% to 50%. For units in the ICNARC case mix programme, the national mortality rate was 11.9%.
- The mean length of stay on General ACCU reported by ICNARC was twelve days which was longer than the average for comparable units (nine days) and all units (seven days). However, the trust stated that comparison was best made on the median length of stay in view of the unusual mix of cardiology, cardiothoracic and haematoid-oncology patients in comparison to other units. The median length of stay was similar (2.8) to other similar units (2.9).
- Patients discharged 'out of hours' between 10pm and 7am were associated with worse outcomes and ICNARC data demonstrated the General ACCU was performing about the same (2.7%) as other similar units (2.1%).
- ICNARC data showed there were two unplanned readmissions to the General ACCU within 48 hours of discharge, which represented 2.7% of patients admitted to the unit in this period. This was slightly higher when compared to other similar units (1.5 %).
- We reviewed CT ACCU performance review report from February 2017. Between April 2015 and February 2017 the mean length of stay on CT ACCU was between two and five days.
- The CT ACCU report showed that between March 2016 and February 2017, the percentage of 48 hour readmissions was between 5% and 10%.
- Patients suspected as having brain stem death or with a plan to withdraw life-sustaining treatment were referred to the specialist nurses in organ donation.
- ACCU was part of the North East and North Central London Critical Care Network which aimed to improve equity of access, experience and health outcomes. There was an ongoing peer review process but the ACCU had not undergone their peer review by the time of the inspection.

Competent staff

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Nursing Staff

- The ACCU employed four clinical nurse educators that supported staff and facilitated a continuing professional development programme.
- New staff attended the trust induction prior to starting work on CCU, where they then received a local induction and were allocated a mentor. Staff were supernumerary for a period of up to six weeks while their competencies were reviewed and signed off as appropriate. Staff told us they had plenty of time to settle into the unit and get to know ways of working before looking after patients independently.
- Overseas nurses received a non-clinical period during which they were supported in preparation for the Objective Structured Clinical Examination (OSCE). This was then followed by a period of supernumerary practice where competencies were reviewed and signed off. The pass rate for these students was 97%.
- Once staff completed the induction programme, they progressed to the National Competency Framework for Critical Care Nurses – Step One. This is a competency-based programme for staff to develop core skills in caring for critically ill patients under supervision from a mentor or practice development nurse. Staff were very positive about the learning and level of support they received during this.
- Competency documents were in use for certain items of specialist equipment, for example the cardiac output monitors and specific types of ventilators and nasogastric feeding pumps. The ACCUs technician held training on different pieces of equipment such as syringe drivers and ventilators.
- There were 18 nursing teams and each team had regular team away days (around 5 a year) which included training.
- We spoke with numerous members of staff who told us there was good access to training for professional development. The clinical nurse educators addressed gaps in competence by providing additional training and support for staff. Any gaps could be addressed at team days.
- The service had developed a professional development pathway for staff to progress from band 5 to band 6 nursing posts. Senior leaders hoped that this would help reduce staff turnover.
- The FICM core standards for Intensive Care Units recommends 50% of critical care nurses should be in possession of a post registration award in critical care nursing. At St Bartholomew Hospital 56% of critical care staff had achieved this award. The trust reported that this should increase to 60% by June 2017.
- Critical Care Outreach Team (CCOT) staff followed a recognised developmental pathway. This was supported by qualified educators and incorporated competency assessment, formal teaching, simulation training and some university based education.
- We reviewed minutes from the education meeting which was held on a monthly basis. These meetings discussed induction processes, new starters, competencies and developmental days.
- Appraisals had been completed within the previous 12 months for 98% of nursing staff.
- The service had set up a rotational system between the three intensive care wards (1C, 1E and 6A). This meant every nine months to one year staff would rotate between the three wards to work in a different clinical area and develop competencies. The high dependency unit (1D) was not included in this rotation. We spoke with the clinical director who told us having a minimum of nine months allowed staff to have adequate exposure and experience on each ward.

Medical Staffing

- Doctors who were new to the trust completed the generic trust induction prior to working on the unit.
- All doctors we spoke with said there was a good induction process, which was relevant and helpful. They said they were well supported and supervised.
- ACCU were introducing the practice of lung and pleural ultrasound within the intensive care service. The aim was to help improve the diagnosis of pneumothorax (an abnormal collection of air between the lungs that causes an uncoupling of the lung from the chest wall), pleural effusion (expulsion of fluid between the lungs) and help reduce overuse of chest x-ray examination. The

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service was delivering training courses so medical staff could become experts with the technology. The service had identified local champions whose role was to encourage use of the ultrasound.

- There were regular simulation training exercises available for both medical and nursing staff. Recent training had included a difficult airway simulation and transport of a critically ill patient simulation.
- Doctors received structured teaching on a weekly basis, which included to a weekly journal club. All doctors we spoke with were happy with their access to training and support for professional development.

Multidisciplinary working

- The service had identified issues in how other departments referred to ACCU. A consultant was allocated the role of 'duty consultant' for every shift. This consultant carried a dedicated phone whose number was circulated amongst other areas within the hospital. The duty consultant acted as the single point of contact for any access to the ACCU.
- The critical care outreach team (CCOT) was responsible for reviewing patients in other areas of the hospital to determine their need for admission to critical care. There were written guidelines which advised when patients should be escalated to the CCOT, for example those with a NEWS score of five or more.
- There was a weekly multidisciplinary team (MDT) meeting to discuss long-term patients. A range of specialities attended this including doctors, nurses, physiotherapists and dieticians.
- There was a weekly MDT tracheostomy ward round where all patients who had a tracheostomy were discussed. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe to help patients breathe. The CCOT physiotherapist oversaw and reviewed the care and directed the weaning programme for patients with tracheostomy.
- All staff we spoke with said there was good MDT working between nursing, doctors and therapists. Therapists worked closely with ward staff to implement rehabilitation plans for each patient and we saw nursing staff and therapists working together to complete patient tasks and rehabilitation during the inspection.

- We observed handovers and ward rounds and saw decision making processes around challenging cases involved feedback from a range of specialists within the hospital. This showed the ACCU was using information from a variety of sources when formulating treatment plans.
- Intensive Care Society (ICS) recommendations state that there should be a minimum ratio of one physiotherapist to four patients. Physiotherapy staff working on ACCU worked as part of the surgical pathways and each of the four wards had a physiotherapy team. These physiotherapists followed patients through the whole pathway and back onto the hospital wards, which offered good continuity of care. Each of the four ACCU wards had a band 7 physiotherapy lead and then a team of band 6 and 5 physiotherapists. There were also two therapy support assistants.
- Staff told us patients received physiotherapy input from early on in their admission, to support airway clearance where needed and for early instigation of rehabilitation.
- There were three WTE occupational therapists (OT) available for ACCU. However, these were shared with the surgical and medical wards within the hospital. This was not meeting the ICS recommendation of 0.22 WTE OTs per level three bed.
- Staff told us they could access speech and language therapy (SALT) within the hospital as and when required. The Faculty of Intensive Care Medicine states that patients should have access to SALT staff with critical care experience. The service was not meeting this recommendation because funding for dedicated ACCU SALT posts was not in place.
- There were examples of joint working between ACCU at St Bartholomew and other ACCUs at different hospital sites within the trust. For example, a patient requiring Extracorporeal Membrane Oxygenation (ECMO) was transferred from the Royal London site. Due to neurological needs there was good joint working between the two hospitals so expertise could be shared. A joint Mortality and Morbidity (M&M) meeting was held for both sites to discuss the case.
- A specialist nurse for organ donation (SNOD) from the Royal London Hospital had visited the St Bartholomew Hospital site and conducted a seminar on organ

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donation. The purpose was to help educate staff on organ donation and increase engagement and patients' referrals. This was a good example of joint working across different sites within the trust.

- The ACCU was part of the North East and North Central critical care network and staff from ACCU regularly attended network meetings to share practice and learning.

Seven-day services

- Consultants completed twice daily ward rounds, including during the weekends, which was in line with recommendations from the Guidelines for the Provision of Intensive Care Services. However, pharmacy staff did not attend ward rounds on each ward everyday which was not compliant with these guidelines. Physiotherapy staff attended ward rounds Monday to Friday but not over weekends, this was not in line with recommendations.
- Physiotherapy services were available five days a week from 8am to 6pm by a dedicated physiotherapist's team; an on-call physiotherapist was available out of hours.
- ACCU could access emergency respiratory physiotherapists support 24 hours a day, seven days per week via a bleep referral. This physiotherapist could assist patients requiring specific airway clearance techniques out of hours.
- There was dedicated dietician input available Monday to Friday from 8:30am to 4:30pm. However, dieticians only visited the ward on Monday, Wednesday and Friday. There was no evening and weekend cover.
- Patients could access investigations such as blood tests, x-rays and CT scans 24 hours per day, seven days per week. Staff reported there were no difficulties for accessing this type of support services usually. However, two weeks before the inspection there had been some trust wide information technology (IT) issues. Staff reported this had led to difficulties in accessing x-ray results.
- The CCOT team was available seven days a week 24 hours a day to assess and provide support for deteriorating patients on wards.
- Staff obtained most of their in-house information via the hospital's intranet and shared drive. This included policies and procedures, mandatory training, and emails from colleagues. Computer terminals were available in patient bed spaces, which allowed access to information.
- There were folders by each patient's bedside which included a range of protocols including feeding, pain assessments, resuscitation and wound management.
- ACCU had communication books for staff which included information around things such as female genital mutilation and end of life care. Staff also received regular updates in handovers and on team away days.
- Patient investigation results, including blood tests and diagnostic imaging, were available electronically.
- Ward 6A had an information leaflet for patients and relatives which contained all key information about the ward, such as visiting times and services available. Staff told us each ward area had their own information leaflets available.
- There were also guides available for relatives which described what to expect whilst staying on ACCU and information about recovery.
- Discharge summaries were completed but it was ward staff who sent them to general practitioners (GPs) when patients were discharged from the hospital. We reviewed some discharge summaries and saw they were detailed and contained all key information.

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

- Staff had access to trust policies relating to the Mental Capacity Act (2005), mental capacity assessments and Deprivation of Liberty Safeguards (DoLS). Information sheets about the mental capacity act (MCA) and DoLS were displayed throughout ACCU. These included all key information and described when capacity assessments might be required.
- Staff knowledge of the MCA (2005) was good across the ACCU. Staff knew that all patients should be assumed as having capacity unless assessed as contrary to this. They

Access to information

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described making best interest decisions for patients who were unable to consent. Staff completed Mental Capacity Assessments for people who they believed may lack the capacity to consent.

- All staff we spoke with understood the need to obtain consent from patients before performing care investigations, and giving medicines. Where staff could not obtain consent, for example unconscious patients, staff explained they provided care in the patients best interests.
- We observed staff seeking consent from patients throughout critical care, including explaining the rationale behind each procedure being performed. We observed staff explaining what they were doing to unconscious patients.
- Staff knowledge of DoLS was good. Staff explained the principles behind DoLS and were clear how this was applicable in a critical care setting. For example, staff knew to use hand mittens and that a DoLS assessment needed to be completed. There was also a MCA best interest form for hand restraints which needed to be completed and submitted online.

Are critical care services caring?

Good



We rated caring as Good because:

- There were examples of staff providing a high level of compassionate care. We received positive feedback from patients and relatives about the level of treatment provided.
- In general, staff maintained patients' privacy and dignity.
- Patients and relatives said they were well-informed and involved in decisions about their care and treatment.
- There were appropriate chaplaincy and bereavement services that were available to support patients and relatives' when required.

Compassionate care

- Being welcoming, respectful and engaging were three of the trusts six values that staff worked with and the CCU

had embedded this in all areas of practice, from clinical care and treatment to time spent talking to friends and relatives of patients. For example, we saw staff talking to sedated patients when carrying out examinations, in case they could hear. We saw one example of a patient's position being moved and a member of staff explained what they were doing. We also saw staff comforting relatives during times of distress.

- We saw examples of conversations regarding a patients care and treatment were managed in a compassionate way. There were quiet rooms available where staff were able to have sensitive conversations with them.
- On occasions some patients became agitated and we saw staff managing them in a calm way to the patient until they became more comfortable. We observed several interactions between staff and patients, saw staff speaking to patients in a kind manner, and they listened to what patients had to say.
- All patients we spoke with were positive about the care received on the unit. Patients said things like: "they have saved my life, I am eternally grateful", "the care here is fantastic and second to none", "the staff are personable and friendly", "the nurses are very empathetic"
- There were many thank you cards from previous patients expressing gratitude on display throughout the units. Cards praised the care received and said comments such as: "Great care", "Above and beyond", "Most excellent care" and "The members of staff are wonderful".
- We observed staff maintaining patients' privacy and dignity most of the time by keeping them covered and drawing curtains for washes. The majority of staff took extra care to ensure curtains were fully closed during ward rounds and when discussing care with patients. However, we observed a ward round on ward 1C and saw the curtains were not always closed and privacy and dignity was not maintained.
- Relatives were mostly positive about the unit and made comments such as: "The nurses are very helpful , nothing seems too much for them", "The staff are amazing here, informative, open and honest" and "The nurses are kind"
- The ACCU follow-up clinic was participating in the 'I want great care' patient survey to obtain patient

Critical care

feedback on the service to make improvements. For the follow up clinic in December 2016 and January 2017 100% of patients said they would recommend the outpatient follow up clinic to others. Positive comments included: 'My care has been 100% perfect', 'Very compassionate', 'Positive vibe and the feeling you were in good hands'.

- ACCU did not start participating in 'I want great care' until March 2017. For April 2017, 100% of respondents said they would recommend ward 1C to others, 92% of respondents said they would recommend ward 1D and 1E and 100% of respondents said they would recommend ward 6A to others.

Understanding and involvement of patients and those close to them

- We observed doctors on ward rounds offering patients and relatives the opportunity to ask questions and to clarify anything they were unsure of. Patients said they were given opportunities to ask questions and these were answered by staff. Patients and relatives told us staff would always explain things in a language they could understand.
- We reviewed patient records and found care and treatment had been discussed with family members. During the inspection, we saw examples of relatives being involved in decision making processes.
- Patients and relatives told us they were kept well informed and up to date regarding their care and treatment. They told us they were given many opportunities to ask questions and staff were always available to answer questions and provide information. For example, one relative told us a doctor had provided them with information about a range of medications.
- The ACCU had developed 'all about me' boards which were displayed at each patient's bed space. This board included information on what the patient preferred to be called, what things they liked such as music and television and what things they did not like. It also included the date and a clock so patients could orientate themselves.
- When patients were unwell or deteriorated staff communicated what had happened to the relatives in a way in which they understood the information they were being given.

- When patients were thought to have brain stem death or if there was a plan to withdraw life-sustaining treatment, there was an organ donation team available to discuss the possibility of organ donation with the patients' next of kin.
- There were information boards available across ACCU which included boards of photographs of each staff member and job title and information for patient son who they could contact if they need support or to raise concerns.

Emotional support

- We saw examples of staff taking time to discuss issues with relatives and responding to them in a supportive manner. Patients and relatives reported feeling supported and reassured by all staff across ACCU.
- There was a chaplaincy and bereavement service which provided support and information for families when required. Staff confirmed that chaplains were available to visit the unit when needed.
- The bereavement information leaflet included a range of external support organisations which offered services locally.
- There was a follow-up clinic available which patients could access for support following discharge.
- Senior leaders across ACCU identified the need for a psychologist to provide additional support for patients and relatives. However, at the time of the inspection no psychologist post was funded.

Are critical care services responsive?

Good



We rated responsive as Good because:

- We found the service had been developed to meet the needs of the patients who used it. For example, services had been developed so that treatment such as dialysis and Extracorporeal Membrane Oxygenation (ECMO) could be done within the unit.
- The General ACCU performed positively compared to the national average for discharge delays and non-clinical transfers.

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- Whilst at times occupancy was greater than the Royal College of Anaesthetists recommendation of 70% critical care occupancy. There was still good access to critical care beds and low numbers of elective surgery cancellations.
- The trust ensured staff had access to translators when needed, giving patients the opportunity to make decisions about their care.
- Facilities for relatives included relative rooms, quiet rooms and overnight accommodation.
- The service did not receive many complaints and there was evidence of learning from the complaints that they did receive. Learning was shared with staff in the daily safety huddle.

However:

- There were no morning visiting hours and feedback regarding flexibility of visiting times was varied.
- Staff had a mixed understanding of the mechanisms in place to support patients living with dementia.

Service planning and delivery to meet the needs of local people

- Critical care served a combination of specialities, including post-operative patients and medical patients. Patients could be admitted after elective or emergency operations or after becoming medically unwell, either in the community or on hospital wards.
- Intensive Care National Audit and Research Centre (ICNARC) data from April 2016 to September 2016 showed the general adult critical care unit (General ACCU) primarily admitted non-surgical admissions (85%). Non-surgical admissions meant patients came from emergency departments, other wards or hospitals and other critical care units. Planned surgical admissions represented 11.3% and unplanned surgical admissions represented 3.6%.
- The cardiothoracic (CT) ACCU performance report showed that between March 2016 and February 2017 the percentage of elective surgeries cancelled due to a lack of critical care bed ranged from 0% to 9%. In March 2016 and October 2016 this was above the national average rate of cancelled elective surgery (5%).

- There were visitors' waiting rooms with beverage making facilities on each unit. There were also beverage vending facilities, visitor toilets and baby changing/feeding facilities available.
- One of the relative rooms had toys, games and books available for children and young people.
- Children over the age of 12 were allowed to visit patients on the ACCU. The ACCU provided guidance and an information leaflet for children to help explain what ACCU was and support them when visiting the wards.
- An 'all about me' board was posted at each bed space. Staff used this to record the likes and dislikes of each patient as well as any other important information.
- There were quiet rooms available throughout ACCU which could be used to have difficult and confidential conversations. This meant privacy could be respected.
- HBN 04-02 recommends services should provide access to overnight accommodation or have arrangements with a nearby hotel. The trust had four relatives' rooms which relatives could use if they wished to stay over.
- Relatives were not usually accommodated in patient rooms overnight but we were told this could be assessed if necessary as single rooms were spacious enough to accommodate this. There were three temporary beds to put into single rooms if required.
- There was a follow up clinic once a week on a Tuesday from 8am to 4pm. Staff told us this gave patients the opportunity to discuss their experience on the ACCU and clinical investigations. For example, discussions around what happened when the patients were unconscious.
- The service identified that patients with chronic kidney failure requiring dialysis were regularly transferred across to a different hospital site within the trust. A quality improvement project identified that this led to poor patient experience and a reduction in the availability of critical care beds. The service introduced a haemodialysis service led by a consultant nephrologist. There were now two single side rooms equipped to deliver dialysis on ward 1D three times a week.

Meeting people's individual needs

Critical care

- Visiting times on ACCU were 2:30pm to 8pm every day. Some relatives told us staff would allow them to visit outside of these times if required. However, this was not offered consistently and some relatives said it would be beneficial to have morning visiting hours.
- The trust recognised the diversity of its local population and provided access to interpreting services 24 hours a day, seven days a week. Staff told us they could book both telephone and face-to-face consultations and told us services were available in a range of different languages.
- There was an easy read comment card with simplified language and pictures for those who might have difficulties completing the feedback form.
- Relatives and patients had access to a multi-faith chaplaincy service and we saw information on how to access this was displayed on the ACCU. There was also an emergency chaplaincy service available.
- Dementia awareness training was a mandatory topic for all trust staff and ACCU was meeting the trust target of 90% for nursing staff. For medical staff this was below the trust target (86%). Some Staff told us if they suspected a patient of having dementia they would contact the dementia nurse within the hospital. However, some staff were unable to identify what mechanisms were in place to support patients with dementia and understanding of dementia varied.
- At the time of the inspection there were no patients on the ward with learning disabilities. Staff told us if there were a patient with a learning disability, they would link with the safeguarding team and learning disability nurse within the trust. The unit could access agency carers for additional support.
- Food menus offered a range of options including mashed choices, vegetarian and gluten free. If a patient had any specialist dietary requirements staff would record this and meet patient needs. For example, halal and kosher.
- Patients who were able to eat told us they were happy with the food choices available on the unit. We observed patient meal times. Patients were enabled to eat independently and drinks were placed within their reach. We observed nurses assisting patients when required.

- There was no counselling or psychological team available on the unit. Staff told us if they thought a patient had mental health needs they would refer the patient to the psychiatric liaison team.
- There was a drug and alcohol liaison service available to review and support patients at St Bartholomew Hospital. They were available seven days a week 8am to 5pm.

Access and flow

- The critical care unit had a clear admission guidelines. All admissions to ACCU had to go through the 'duty consultant' for every shift. This consultant carried a dedicated phone whose number was circulated amongst other areas within the hospital. The duty consultant acted as the single point of contact for any access to the ACCU.
- We reviewed patient records and found unplanned admissions were admitted within four hours of the decision to admit being made.
- Between March 2016 and February 2017, adult bed occupancy has fluctuated around the England average, but was higher in both January and February 2017.
- Recommendations from the Faculty of Intensive Care medicine Core Standards for Intensive Care Units identify that patients should not be transferred to other units for non-clinical reasons. ICNARC data for the General ACCU from April 2016 to September 2016 showed there were zero patients transfers out of the unit for non-clinical reasons which was better than (0) other similar units (0.8%).
- For the General ACCU, there were 730 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 2.3%. This compares to the national aggregate of 5.2%. This meant that the unit was not in the worst 5% of units nationally. The trust did not report this figure in the 2015 audit.
- Patients discharged from critical care 'out of hours' between 10pm and 7am are nationally associated with worse outcomes. ICNARC data for General ACCU from April 2016 and September 2016 showed that seven patients were discharged between 10pm and 7am (2.7%) which was in line with national performance (2.0%).

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- General ACCU and cardiothoracic (CT) ACCU conducted monthly performance audit reports. We reviewed the February 2017 reports for both ACCU and data quoted below relates to these reports.
- For CT ACCU (wards 1C, 1D and 1E) between March 2015 and February 2017 the majority of admissions were elective surgical admissions. For General ACCU, the majority were medical admissions
- Between March 2015 and February 2017 bed occupancy ranged from 60% to 90% on CT ACCU. For General ACCU in April 2015 bed occupancy was below 30% and has steadily increased to between 80% and 100% the past six months. At times these occupancy rates were greater than the Royal College of Anaesthetists recommendation of 70% critical care occupancy. The recommended occupancy rates allow units to be able to take in more patients should there be an emergency. If a unit is at higher occupancy it may be unable to respond to emergency admissions and may be required to step down patients too early.
- There had been no patients ventilated outside critical care (General or CT) owing to bed pressure in the past 12 months.
- Between March 2016 and February 2017, both CT ACCU (between 30% and 60%) and General ACCU (between 10% and 65%) were below the national rate for delayed discharges over four hours of 61.5%.

Learning from complaints and concerns

- Between April 2016 and March 2017 there were two complaints about ACCU at St Bartholomew's Hospital. One complaint was regarding poor post-operative care and the other was in relation to an inappropriate transfer from ACCU.
- Information about how to make a complaint was available in the CCU reception. Staff told us they tried to manage complaints at a local level to try offer an immediate solution.
- Information on the hospitals Patient Advice and Liaison Service (PALS) was readily available on the unit.

Are critical care services well-led?

Outstanding



We rated well-led as Outstanding because:

- There was a well-respected and proactive leadership team. Leadership of the service was highly effective and managed a complex critical care environment in an integrated and seamless way.
- There was a clear trust wide and service vision and strategy that staff were able to identify with. This was embedded in the unit and staff demonstrated how this contributed to improved patient experience.
- There was a robust governance structure both within critical care and within the perioperative medicine directorate with clear lines of accountability.
- We saw strong medical and nursing leadership which had brought together three different services and developed an integrated well run critical care service.
- There was evidence of teamwork between all levels and grades of staff. The staff were committed and highly motivated to provide a high quality of care in line with the services vision and values.
- The management team had identified key areas for improvement such as staffing skill mix and put plans in place to make changes, which were evident during the inspection.
- There was an up to date risk register and this highlighted all risks the department currently faced. Management had oversight of the risks within the service and mitigating plans were in place.
- There were a number of meetings in which risks and issues were discussed and evidence that information was disseminated to staff on an ongoing and regular basis.
- There was a positive culture across the service, staff spoke positively about the leadership team and felt confident to raise issues. Staff told us leaders were visible and approachable.
- The service was innovative and constantly striving to develop and make improvements to the service. For example, the development of the ECMO service and SHOCK protocol.

Critical care

However:

- The first floor were not participating in the Intensive Care National Audit and Research Centre (ICNARC) dataset. This meant the first floor could not benchmark themselves nationally against other critical care units. This was not on the services risk register.

Leadership of service

- We found staff had clearly defined roles and responsibilities. Staff we spoke with knew what their role was within the team. Lines of accountability were clear and staff understood how to escalate problems.
- Clinical leadership was the responsibility of the divisional director who worked closely with the clinical lead consultant and senior nurse and matrons for critical care.
- Two matrons shared responsibility for the leadership of ACCU and were supported by a senior nurse. One matron was responsible for the first floor (ward 1C, 1D and 1E) and the second matron was responsible for ward 6A, the critical care outreach service and surgical wards. Both matrons worked well together to ensure ACCU operated as one whole service and were responsible for all aspects of nursing provision.
- The matrons and senior leaders told us there was a good, well-functioning relationship between ACCU and the hospital management team. They said any concerns escalated were listened and responded too.
- The senior leaders operated an 'open door' policy which meant any member of staff could speak to them at any time they needed support or guidance. All staff we spoke with said this worked well and helped them to feel supported.
- All staff spoke positively about the matrons, praising the matron's supportive attitude and open approach to management. We were told the matrons were readily available and approachable. Staff comments included: "Best matron I have ever had", "There is no hierarchy here I feel very supported" and "Senior leaders are present especially during challenging times".
- During our inspection we found that senior staff were visible on the wards and knew staff across the service.
- Staff told us the leadership team acknowledged their work and they felt valued and appreciated.

- The unit had four clinical educators who were responsible for providing continuous training for all nursing staff and ensuring mandatory training was completed.
- The trust had appointed an established professor in ACCU which had led to a stronger academic group within the service.

Vision and strategy for this service

- There was evidence of a local strategic document, which outlined key areas for improvement and the leadership team's vision for the service.
- Senior leaders told us the vision for the adult critical care unit (ACCU) following the formation of the Barts Heart Centre was to ensure all three hospitals became one entity and to standardise practice. The aim to be seen as a whole centre and ensure a strong focus on recruitment and retention of staff was evident throughout our inspection. ACCU was functioning as one whole service and the team were well integrated and practice had been standardised.
- The service vision 'to be a high performing ACCU renowned for excellence and innovation and providing safe and compassionate care' was well documented and displayed throughout ACCU. Staff had a thorough understanding of the vision and told us they were constantly striving to achieve it.
- Staff knew how their work contributed to the wider vision of the trust and were aware of the trust values. Staff told us values were discussed during the trust induction and were embedded in their practice.
- There was a documented five year strategy for ACCU which included improved discharge planning and development of the Extracorporeal Membrane Oxygenation (ECMO) service. ACCU were about half way through this plan and was achieving the outlined goals. For example, one of the ACCU aims was to become one of England's recognised respiratory ECMO centres. To achieve this aim the trust had heavily invested in training of staff and purchased equipment and systems to build a viable unit. Training was well organised and ACCU nursing staff and consultants were appropriately trained. The ACCU had set up a well governed service

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which worked on a series of standard operating procedures. ACCU had submitted a bid to become a national centre and the service was still awaiting the outcome of this.

- The service had developed a detailed research strategy which aimed to improving nursing and allied health professionals involvement in research. This included supporting staff to complete masters and doctorates and the development of research support infrastructure and research board to drive this forward.

Governance, risk management and quality measurement

- ACCU was part of the Perioperative Medicine directorate (POM). There was an established and robust clinical governance structure which ensured ACCU teams were managed appropriately using guidance that supported them to develop professionally.
- The clinical governance handbook identified the organisational structure within the trust. It provided information about lines of accountability and evidenced how information was fed back to the trust.
- The POM board met on a monthly basis to discuss the whole directorate and ACCU was appropriately represented at this meeting. There were also POM forum meetings held on a monthly basis where key issues were identified and priorities for ACCU were set.
- We reviewed three sets of minutes from the Clinical Practice Group (CPG) meetings and saw they discussed a range of ACCU items such as the floor expansion, ECMO service and patient experience.
- Weekly mortality and morbidity (M&M) meetings were held for three weeks of the month. We reviewed minutes and saw action points were allocated to a responsible person and reviewed regularly. Learning points and actions were shared with band 7 nurses so they could be cascaded down through the nursing teams.
- On the fourth week of each month the ACCU had a quality and safety meeting. The objectives of the quality and safety meeting were to monitor and review risks, incidents, serious incidents and action plans and complaints. All staff were invited to attend the meeting and the ACCU medical and nursing lead generally led this meeting. We reviewed minutes from this meeting and saw input from a range of clinicians.
- Information was cascaded down to staff in a variety of ways including through the band 7, band 6 and band 5 forum meetings which were held on a regular basis. Information was also shared via team away days, communication books and via information boards displayed throughout ACCU.
- The trust had set up a quarterly cross-trust critical care group. This meeting was used to discuss the trust priorities as a group and share any learning and key information.
- Senior staff maintained a risk register to manage risks that could not be resolved immediately. It was evidence that risks on the register were appropriate and well understood by clinical leads. Risks were colour coded to identify the severity and each risk was allocated a leads who owned the risk and reviewed it every month. Risks were reviewed and discussed at the quality and safety meeting and it was a team decision to remove risks from the risk register.
- We reviewed the services risk register for POM and there were a total of 12 risks on the risk register. The senior management team including the matrons were aware of the risks on the register and who was responsible for maintaining the document. The risks on the risk register appropriately reflected the risks within the service. For example, one risk was around the ECMO cooler system and the risk of infection.
- However, the first floor was not participating in ICNARC and this was not on the services risk register.
- Senior leaders were aware of how to raise issues and escalate concerns to governance leads. Staff were encouraged to conduct regular risk assessment and we saw examples of risk assessments and plans in place to mitigate risks. For example, to mitigate the risk around the ECMO cooler system the ACCU were conducting regular microbiology inspections on the machines as per national guidance.
- There was a site safety huddle each day and it was mandatory for ACCU matrons to attend this. A range of topics were discussed at this including risks, incidents, deaths and also safe staffing levels. Any key information was cascaded down to all staff via a range of methods including handover, emails and the communication books. Any recurring concerns were spoke about on team days and information was displayed on the ward.

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- The two ACCU matrons and ACCU senior nurse met on a weekly basis to discuss any complaints, staffing issues and human resources. Any key information was shared with staff on the ward.
- The trust had introduced checklists for Local Safety Standards for Invasive Procedures (LocSSIPs) in advance to the September 2017 requirement. We saw information displayed on ACCU providing information about when this would apply and what checklists would need to be used.
- We reviewed the governance documentation for the ECMO service and found it was well governed. All referrals made were discussed in detail and the decision making process was recorded and well documented. Outcome and activity data was submitted to the registry for Extra-Corporeal Life Support (ELSO). There was also a regular ECMO meeting to discuss referrals, safety incidents and mortality and morbidity.
- The service monitored the effectiveness of care and treatment that had been provided. There was an audit lead who was responsible for co-ordinating the clinical audit programme. We saw evidence of completed care bundle audits and results were displayed across the units.
- There was a governance newsletter which included information about the ACCU risks and was shared throughout the ACCU.
- There was a trust-wide group for sepsis and nominated sepsis leads in different clinical areas. ACCU had introduced sepsis boxes and a sepsis proforma onto the wards, however this was not yet fully integrated and staff knowledge varied. The trust had a detailed action plan on full implementation of the sepsis proforma.
- The first floor were not participating in the ICNARC national dataset. Senior leaders provided data to show how the first floor measured patient outcomes on the surgical pathway. However, until the first floor were fully capturing the ICNARC physiological dataset they could not compare themselves to other critical care units at a national level. The trust had an action plan regarding ICNARC participation. This included increasing the number of audit nurse posts to help with data collection and submission. The trust were expecting to be fully submitting into the dataset by October 2017.

Culture within the service

- There was a positive and open culture across ACCU. Staff were keen to tell us how integrated the service was following the merger of three hospitals.
- Staff told us they were happy, enjoyed working on the ACCU and said they functioned well as a team. We saw good examples of team working during our inspection and staff were willing to help each other when needed.
- Staff said they felt comfortable to challenge each other when necessary, including more senior members of the team, such as in ward rounds and when discussing patient care and treatment.
- Staff told us they were encouraged to report incidents and that there was learning from incidents and complaints. Staff commented there was a culture of 'no blame' should things go wrong. Everyone was encouraged to learn from incidents that occurred both within the ward and across the trust.
- Compliments and feedback from the 'I want great care' feedback forms were communicated to staff via information boards on the ward.
- Staff understood the importance of being open and honest when things went wrong and understood what duty of candour was.

Public and staff engagement

- There were regular team away days held on the unit to develop staff skills, knowledge and improve teamwork.
- Clinical governance information was communicated to staff via a monthly newsletter and also during in the wards communication book.
- The trust held 'hero of the month' and 'star' awards on a regular basis to recognise good work and practice.
- The ACCU encouraged patients and relatives to complete the 'I want great care' feedback forms. Feedback was emailed to staff and used to improve the service.
- The ACCU encouraged patients and relatives to give feedback and there were feedback forms available on the unit for them to complete. There was a 'you said, we did' board on the unit which gave details of any changes made because of feedback. For example, one concern raised was with regards to the fact visiting started at

Critical care





2pm and therefore relatives were not present at the morning ward round to ask questions. The ACCU had introduced patient notebooks where visitors can add any questions they have and the service would then address this and get back to them.

- A patient event was held in April 2017, which gave patient and relatives the opportunity to give feedback about the service.
- The ACCU had been co-designed with patients including the environment. There were patient participation groups within the hospital and ACCU had involved these groups in the design of the new unit. Before the wards were finalised they were invited to do a walk around and give feedback on the layout of the ward, which resulted in change. For example, the chairs in the waiting area had been rearranged into circles rather than rows as a result of patient and relative feedback.
- Staff were involved in the development of the patient flow model for the first floor. The service had also run a number of listening in action events which were well represented by critical care staff.

Innovation, improvement and sustainability

- The ACCU had successfully implemented a well governed multidisciplinary Extracorporeal Life Support (ECLS) service. There was a clear strategy in place which was well executed, including recruiting an experienced team and a comprehensive training plan.
- The service was using technology to support an innovative communication platform for rapid multidisciplinary decision making. They had developed an incident management system for their 'shock' call protocol. This was a tool for rapidly calling a multidisciplinary conference call about very sick patients or patients who need rapid and difficult decision making. Dialling a single number delivered messages to a range of specialty consultants to join a conference call. The innovative technology was being further developed for MDT decision making in other clinical scenarios, as appropriate.
- The ACCU had developed a well-functioning fellows programme. The service had invited doctors from abroad to either do fixed term fellowships or locum consultant posts. As a result, these doctors were now sending over junior doctors to do the same thing, which had increased the ACCUs supply of experienced doctors and helped fill any gaps in the rota.
- The service were in the early stages of discussions around developing a cross-site rotational programme for nurses. The purpose of this was to allow nurses to develop their skills and competency in other specialities. For example, the Royal London Hospital ACCU specialised in trauma and neurology.

Outpatients and diagnostic imaging

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

Information about the service

St Bartholomew's Hospital (St Barts) had 305,617 new and follow up outpatient appointments between December 2015 and November 2016. The five most frequently used services at St Barts are: cardiology, clinical oncology, respiratory medicine, medical oncology, and haem-oncology.

The outpatient department offers a full range of local and specialist services including centres for the treatment of cancer, heart conditions, fertility problems, endocrinology and sexual health conditions.

St Barts supports Barts Health by providing weekly or monthly clinics for a host of specialities, including: diabetic medicine; pain management; fertility; neurosciences; urology; and vascular surgery.

Clinic 1 predominantly provides services for the treatment of cardiovascular and respiratory issues. It has 36 clinical rooms, supported by treatment, recovery, interview, clinical measurement, and phlebotomy rooms. Clinic 2 provides services for the treatment of cancer/oncology, respiratory medicine and pain clinics. Clinic 3 provides associated cardiac testing with six echocardiography rooms and one cardio-pulmonary exercise testing (CPEX) room. The cardiac devices department and the Grown up Congenital Heart (GUCH) centre are located in clinic 5.

The hospital site's East Wing and West Wing provide cancer/oncology outpatient clinics.

The Barts Cancer Centre offers a one-stop breast service, co-locating breast imaging and breast outpatients in the West Wing.

The diagnostic imaging department undertakes x-rays, computed tomography (CT) scan (this uses x-rays to take detailed pictures of parts of the body and the structures inside the body), interventional imaging (this uses minimally-invasive image-guided procedures to diagnose and treat diseases), fluoroscopy (this is an image of moving body structures), ultrasound, sometimes called a sonogram (this is a procedure that uses high-frequency sound waves to create an image of part of the inside of the body), nuclear medicine (this involves a radioactive chemical put into the body that can be picked up by a scanner), and magnetic resonance imaging (MRI), (this is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of inside the body).

Specialist cardiac imaging is provided with cardiac CT, cardiac magnetic MRI, and cardio-pulmonary exercise testing (CPEX), (this involves the testing of heart and lung functions simultaneously).

The pharmacy team is located within outpatients and provides medicines for patients.

We visited a range of clinics including: outpatients, radiology, diagnostic and imaging services, and phlebotomy. We spoke with over 20 patients and their relatives and 30 staff, including consultants, managers, nurses, health care assistants (HCA), allied healthcare professionals (AHP) and medical and reception staff. We observed care and treatment. We also reviewed a range of records and performance information.

Outpatients and diagnostic imaging

Summary of findings

Overall we rated outpatients and diagnostic imaging services as good because:

- Outpatients and diagnostic imaging staff had completed mandatory training and rates were 100% in most teams.
- Staff were clearly able to explain their role in raising safeguarding concerns and how they would escalate concerns.
- There was evidence of the world health organisation (WHO) checklist being completed and audited.
- There was effective use of the national early warning score (NEWS) to identify a patient who might be deteriorating.
- Overall, patients received care and treatment that was evidence-based and in accordance with national guidance. However, we found 15 quality documents in radiotherapy that were not up to date.
- There was compliance with the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER).
- Staff worked together in a multidisciplinary environment to meet patients' needs.
- There was a range of audits in place across outpatients and diagnostic imaging to monitor patient outcomes.
- Consent was sought from patients prior to their receiving care or treatment. Staff received training in the Mental Capacity Act (2010) (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Patients had access to a range of diagnostic imaging specialist investigations.
- The outpatients department had developed some nurse-led clinics; there were also rapid access clinics for patients experiencing conditions such as asthma and chest pain.
- The access issues resolution service (AIRS) was a dedicated helpline offering patients and GPs fast resolution of all booking and scheduling issues.
- Interpreters were available to enable staff to communicate with patients where English was not their first language.

- Between February 2016 and January 2017 the percentage of patients waiting more than six weeks to see a clinician was mostly lower than the England average.
- St Barts had introduced a call reminder service to remind patients of their appointments.
- Outpatients' managers told us they had not had to cancel any clinics as a result of an IT failure on 20 April 2017.
- Diagnostics and imaging services were meeting waiting time performance criteria.
- The trust had consistently performed better or similar to the operational standard and England average for cancer waiting times.
- Staff offered care that was kind and promoted people's dignity. We saw relationships between people who use the service, those close to them, and staff were caring and supportive.
- Most patients and relatives we spoke with told us they were involved in decision making about their care. Patients also understood their treatment and the choices available to them.
- There was a range of emotional support options for people to talk about their condition, including access to chaplains, social workers and community support staff.
- Staff told us there had been improvements in leadership at both an executive and local level in outpatients and diagnostic imaging. Local leaders were visible and staff felt that concerns they raised would be addressed.
- Quality reports and dashboards were sent to the managers of outpatients and diagnostic imaging on a monthly basis; this included key performance indicators (KPI).
- Governance systems demonstrated information was shared and lessons were learnt from events.
- Most staff knew about the trust's values and could explain what these meant to their role.
- There was an open culture within outpatient and diagnostic imaging services. Staff told us relationships between outpatients and diagnostic imaging had improved.

However:

Outpatients and diagnostic imaging

- Incidents in regards to clinics running late were not always reported in accordance with the trust's policy.
- Clinic 5 did not have a sluice and staff were emptying urine into a toilet. This created an infection risk of bodily fluids splashing in the toilet area.
- There was limited signage in the x-ray department informing patients of the dangers of radiation, and the signage did not carry the radiation protection supervisor's details.
- Staff could not be assured that medicines were stored within the required temperature for the safe storage of medicines in clinic 1, as ambient room temperatures were not recorded.
- There was an identified risk due to the age of the ultrasound machines, potentially producing suboptimal images. Although there had been no incidents, there was the potential for this to effect patients' diagnosis.
- IT failures on 20 April 2017 had led to clinicians having to leave their clinical areas to view images in the imaging department. This had taken time out of clinicians' daily schedules and had resulted in some patients having appointments rearranged. The IT system was fully restored by 4 May 2017. However, some patients' historic images were still inaccessible on 11 May 2017. Work was in progress on an investigation and a clinical harm review.
- There were capacity issues in some clinics that meant there was the potential for services to have an insufficient number of clinics to deal with demand.
- There was a risk to on-going service development as clinic space was at a premium and as demand increased, the outpatients' model may make meeting the demand unsustainable.
- The risk register did not contain action plans to explain what actions had been taken to mitigate identified risks or identify timescales for completion of actions to mitigate risks.
- Between December 2015 and November 2016 the 'did not attend' (DNA) rate was mostly higher than the England average.
- There was a risk to on-going service development in regards to the rolling out of a paperless records system due to the reliability of the trust's IT systems.

Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated outpatients, diagnostic and imaging requires improvement for safe because:

- There were systems in place for incident reporting. However, incidents in regards to clinics running late were not always reported in accordance with the trust's policy.
- Clinic 5 did not have a sluice and staff were emptying urine into a toilet. This created an infection risk of bodily fluids splashing in the toilet area.
- There was limited signage in the x-ray department informing patients of the dangers of radiation, and the signage did not carry the radiation protection supervisors' details.
- Staff could not be assured that medicines were stored within the required temperature for the safe storage of medicines in clinic 1, as ambient room temperatures were not recorded.
- There was an identified risk due to the age of the ultrasound machines, potentially producing suboptimal images. Although there had been no incidents, there was the potential for this to effect patients' diagnosis.

However:

- Outpatients and diagnostic imaging staff had completed mandatory training and rates were 100% in most teams.
- Staff were clearly able to explain their role in raising safeguarding concerns and how they would escalate concerns.
- There was evidence of the world health organisation (WHO) checklist being completed and audited. Patient protocols were in place in radiology.
- There was effective use of the national early warning score (NEWS) to identify a patient who might be deteriorating.

Incidents

- 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

Outpatients and diagnostic imaging

harm or death but neither need have happened for an incident to be a never event. Between February 2016 and March 2017, the site reported no incidents which were classified as never events for outpatients and diagnostic imaging.

- The outpatients department used the trust's electronic reporting system to record incidents; we found that incidents were not always reported in line with trust policy. For example, staff told us clinics often ran late and they should report these. However, some staff told us they did not always report these. This meant the service could not accurately monitor the number of late running clinics.
- There had been an incident where a member of the public had gained entry to the x-ray department and had stayed there overnight. In response the department were working with the estates department on fitting alarms to the rooms where imaging equipment was kept. In the interim the service had introduced a procedure whereby ultrasound staff would take responsibility for locking the imaging department in the evening. The out of hours staff would telephone security if they had any concerns about the department's security.
- Incidents were reviewed at regular trustwide outpatient services group performance reviews. We viewed minutes of a review meeting in January 2017. We saw that the outpatients' trustwide incident dashboard was reviewed at the meeting. The dashboard was a traffic light system of red, amber, green (RAG) ratings. The dashboard covered incidents in a 12 month period from January 2016 to December 2016.
- The dashboard recorded when actions in regards to incidents had not been completed. Where actions were incomplete, we found the dashboard indicated they had been completed by the following month. For example, the dashboard indicated that there had been two 'moderate' rated incidents in April 2016 where actions in response to the incidents were overdue. However, these actions were RAG rated and recorded as completed in May 2016.
- Outpatients had reported no serious incidents (SI) to the strategic executive information system (STEIS) in the period January 2016 to December 2016.
- In the period November 2016 to December 2016 monthly reports for outpatients' health records incidents were in

the range of 10 to 2 incidents per month. There was a peak of 24 reported health records incidents in January 2016. Incidents were monitored for themes and trends at monthly outpatients board meetings.

- Staff told us learning from incidents was disseminated at daily safety huddles and team meetings. Staff told us learning from other areas of the hospital and outpatients and diagnostic imaging services was also shared at these meetings. For example, haem-oncology staff told us they had been informed of an incident in clinic 3, where an unauthorised person had gained access to the x-ray department. Staff also gave us an example of being informed about an incident involving a naso-gastric tube from another of the trust's services.

Duty of Candour

- The chief medical officer (CMO) and chief nurse (CN) reviewed all serious incidents (SI), and completed SI root cause analysis investigation reports to ensure compliance with the trust's 'Duty of Candour policy'. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents' and provide reasonable support to that person.
- Staff had to consider the duty of candour when recording incidents, as the trust's electronic incident reporting system prompted staff on whether an incident involved the duty of candour.
- Outpatients duty of candour incidents were recorded on an electronic log sheet. The outpatients log sheet recorded nine duty of candour incidents in the period June 2016 to May 2017. The log sheet also recorded actions the trust had taken in response. For example, an incident in February 2017 had resulted in a SI investigation; whilst another incident in December 2016 had been the subject of a departmental discussion.
- We viewed a radiotherapy investigation report into an incident in 2016 involving a patient who had been exposed unnecessarily to radiation. The report detailed the severity of the incident as 'moderate' due to the possibility of the patient developing a secondary cancer as a result of unnecessary radiation exposure, although the risk was small. The consultant clinical oncologist had apologised to the patient and explained the events and potential risks. The report also identified individual

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support needs for the patient; as well as potential factors that may have contributed to the incident, which was the inability of the hospital to recruit a locum to cover a period of staff leave.

- Most nursing staff we spoke with were aware of the duty of candour, but not clear about what the duty of candour meant for them in their role. However, two managers accurately explained what responsibilities they had under duty of candour.

Mandatory Training

- A breakdown of compliance for mandatory courses as at March 2017 for nursing staff in outpatients demonstrated nursing staff exceeded the trust 90% target, with 100% of nursing staff having completed and updated all mandatory training courses. The June 2017 trustwide outpatients and diagnostics imaging board report stated that St Barts was achieving 99% compliance with mandatory training.
- The June 2017 board report also highlighted that e-learning materials had been developed to meet staff mandatory training needs and most training was completed electronically.
- Mandatory training for qualified nursing staff included: venothromboembolism (VTE); pressure ulcer care; slips, trips and falls, and catheter acquired infections ('The four harms'); blood transfusions; fire safety; health and safety; medical gas safety; moving and handling; infection prevention and control; health and safety; moving and handling; and basic life support (BLS).
- Mandatory training was a regular agenda item at the trustwide outpatient services group performance reviews, which looked at outpatients key performance indicators (KPI). Minutes from the 19 January 2017 performance review recorded that compliance with mandatory training across all of the trust's hospital sites had been discussed.

Safeguarding

- There were systems and processes in place for raising safeguarding concerns. Most staff we spoke with understood the principles of keeping patients safe and how to raise and escalate concerns in relation to safeguarding. The safeguarding process was supported by staff training and most staff had received safeguarding training.
- Safeguarding level 1 training was included as part of the mandatory training package. All staff were required to

complete the level 1 safeguarding course for children and adults every three years. This course was delivered via e-learning. Doctors, nurses and other staff members dealing directly with patients were required to complete level 2 training every three years. Staff we spoke with told us they had completed training in either safeguarding adults or children, whichever was most relevant to their area of work.

- The trust set a target of 95% for completion of safeguarding training. A breakdown of compliance for nursing staff in outpatients in regards to safeguarding training in March 2017, demonstrated: 96% of nursing staff had completed level 1 adults safeguarding training, and 97% of nursing staff had completed level 1 children's safeguarding training. This was above the trust's target. However, nursing staff were not meeting the trust's target for safeguarding adults' level 2 training (88%) and safeguarding children level 2 training (89%).
- The trust's electronic incident reporting system prompted staff as to whether an incident involved safeguarding concerns. This meant staff had to consider safeguarding when recording incidents.
- Information about how to report any safeguarding concerns and safeguarding adult's information was displayed on noticeboards across outpatients and diagnostic imaging clinics. We saw the contact details of the trust's safeguarding team displayed on noticeboards across outpatients and diagnostic imaging services.
- There were up to date safeguarding policies in place and clear procedures to follow if staff had concerns. Staff told us they knew where to find information should they need to.

Cleanliness, infection control and hygiene

- The outpatients' matron took responsibility for monitoring the trust policy on hand hygiene and ensuring staff were trained in hand hygiene techniques.
- Training in infection prevention and control (IPC) was mandatory. Figures supplied by the trust indicated that 100% of staff had up to date training in IPC.
- Clinical areas appeared clean and there were systems in place to monitor cleanliness. However, clinic 5 did not have a sluice and staff were emptying urine into a toilet. This created an infection risk of bodily fluids splashing in the toilet area.

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- Equipment we looked at was visibly clean and stored appropriately. The trust used the “I am clean” stickers to identify clean equipment. We observed stickers on equipment in different outpatient areas identifying that equipment was clean and ready for use.
- We saw staff complying with the trust policy of being bare below the elbows. Hand gel was available in all the clinical areas we visited. However, we saw two members of staff wearing scrubs when crossing a road that ran between two hospital buildings. This created a risk of cross contamination between departments.
- We viewed a range of compliance audits and annual IPC inspection reports for outpatients and diagnostic imaging. Overall, we found staff compliant with infection prevention and control. The outpatients clinics had achieved 100% compliance with IPC in a February 2017 trust audit, this was better than the trust target of 95%. However, in the same audit the MRI scanner (94%) was slightly worse than the trust target.
- We also viewed individual department results of an IPC inspection for outpatients and diagnostic imaging, dated February 2017. Action plans resulting from the inspection were in place, these identified areas for improvement and timescales for addressing shortfalls in IPC. For example, the imaging department action plan included the replacement of hand hygiene guidance posters with new laminated posters in toilets. We saw evidence of completion of this, as the imaging department had laminated posters on display in the toilet areas we visited.
- There were systems in place for the segregation and correct disposal of waste materials such as x-ray solutions and sharp items. Sharps containers for the safe disposal of used needles were available in each clinical area. These were dated and signed by staff and not overfilled.
- The trust monitored cases of methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile (C diff) and produced an annual incidence report. We viewed the reports for both MRSA and C diff for the period April 2016 to February 2017 and found there were no identified incidences reported in outpatients and diagnostic imaging in this period.
- There was a programme of monthly hand hygiene audits in place which were monitored by department and ward level leads. For example, we viewed the hand hygiene audit results for outpatients for the period April 2016 to February 2017 and found the department

regularly achieved 100% compliance with hand hygiene during this period, compared to a trust target of 95%. The imaging department had achieved the trust's 95% target in the same period, with the exception of June 2016 when computed tomography (CT) and magnetic resonance imaging (MRI) had achieved 80%, this was below the trust target.

- The St Barts site report from the Health and Social Care Information Centre (HSCIC) for 2016, found the hospital to be better than the national average (98%) for cleanliness with the site achieving 99%.

Environment and equipment

- Outpatient services had relocated into the new King George V building in 2014.
- The hospital environment was monitored by a ‘summary of scores’ spreadsheet. We viewed the spreadsheet dated from April 2016 to March 2017. Overall, most outpatients and diagnostic imaging services were regularly achieving the trust target of 95%, in regards to both the clinical environment and the non-clinical environment. However, the catheterization laboratories (cath labs) had achieved 94% in May 2016, January 2017, and February 2017; this was below the trust's 95% target.
- Staff told us the automatic doors in the Heart Centre had not been activated, and this had led to radiographers having to use their backs to open doors when they were moving equipment. Staff told us they were concerned that this could result in a member of staff sustaining a back injury.
- There was limited signage in the x-ray department informing patients of the dangers of radiation. For example, radiation protections signs were on display, but did not carry the details of who the radiation protection supervisor was.
- Staff in imaging told us mobile imaging had been a problem due to the hospital only having one machine. However, this had been resolved as two mobile machines had been delivered in the week of CQC's inspection, which had full wireless connectivity.
- The St Barts risk register identified a risk due to the age of the ultrasound machines, and the potential of these producing suboptimal images which could have an effect on patients diagnosis. Staff told us there had not been any incidents as a result of the machines producing suboptimal images.

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- Safety testing for equipment was in use across the outpatients department. Equipment had stickers applied indicating when testing had been completed. We found all the equipment we reviewed to have in date safety testing.
- The outpatients department kept up to date medical device inventories. We saw annual maintenance schedules across diagnostic and imaging services which detailed what equipment needed to be serviced and when. The schedules were planned and issued by the electronic engineers department in collaboration with diagnostic and imaging services. The schedules also recorded whether the servicing would be completed by the trust's electronic engineering team, private contractors, or under manufacturers warranties.
- X-ray equipment had regular servicing carried out by the manufacturers. We saw evidence of manufacturers completed service reports. We also saw evidence of routine surveys of all x-ray equipment.
- We found the resuscitation trollies located throughout outpatients and diagnostic imaging were locked. Medicines and stock inside the trollies were appropriate and had been checked daily. Defibrillators were tested on a daily basis. Oxygen cylinders were in date. Portable oxygen and suction equipment in the outpatients department was checked daily.
- There was a programme of testing electronic equipment to ensure outpatients and diagnostics imaging services were compliant with portable appliance testing (PAT) regulations.
- Diagnostic and imaging staff used specialised personal protective aprons. These were available for use in all radiation areas and on mobile equipment. Staff also used personal radiation dose monitors which were monitored in accordance with legislation.
- Radiographers showed us the procedure for eliminating exposure to radiation and the personal protective equipment in place for staff to use.
- We viewed a patient led assessment of the care environment (PLACE) 2016 report for outpatients and cardiac MRI. Overall, the PLACE assessment found both outpatients and cardiac MRI were achieving a 'pass'.
- The St Barts site report from the health and social care information centre (HSCIC) for 2016, found the hospital to be better than the national average (93%) for 'condition, appearance and maintenance' with the site achieving 96%.

Medicines

- Staff managed prescribed medications safely. Medication training was provided by the trust and competency frameworks were in place to ensure staff were compliant with the trust's medicines policies.
- Emergency medication and emergency equipment was available on resuscitation trollies. These were recorded as being checked daily. We checked emergency drugs on trollies across outpatient and diagnostic imaging services and found these to be in date.
- We found medicines were stored in locked cupboards and there were no controlled drugs or intravenous fluids held in the outpatients and diagnostic imaging services. Lockable fridges were available for those drugs needing refrigeration, and temperatures were recorded daily when the department was open. Fridge temperature recordings were within the required range. However, we found a hypoglycaemia emergency box that was not in a locked cupboard in outpatients' clinic 1. However, this was mitigated by the door to the medicines room being locked. We also found the ambient temperature of the medicines room in clinic 1 was not being monitored. This should have been less than 25 degrees, but as the temperature was not monitored we could not be assured it was within the required temperature for the safe storage of medicines.
- Quarterly medicines storage audits were undertaken. The results demonstrated staff followed medicines storage policies appropriately, and where improvements were identified these were highlighted in the audit and acted upon. For example, a radiotherapy audit dated 1 March 2017 identified that controlled drugs (CD) cupboard keys should be kept separate from other medicines keys. We found CD keys were held separately from other medicine storage keys. Furthermore, stock lists had been provided to clinic 2 by the pharmacy in response to a medicines audit.
- Some nursing staff were nurse prescribers; these were members of staff who had undertaken further training to enable them to prescribe medicines in clinics. Staff told us they had medicines competencies regularly assessed.
- Prescription pads were stored securely and their appropriate use monitored.

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- St Barts used a comprehensive prescription and medication administration record (MAR) chart for patients that enabled the safe administration of medicines.
- Pharmacy staff reinforced medicine safety instructions and information to patients when they collected their prescriptions following their consultation. Many of the specialist nurses also provided information and support about medication as part of the patient's consultation. Pharmacists had access to GP summaries which meant prescribing errors were less likely.
- The contrast bottles in the diagnostic and imaging department were found to be in date. Allergies information was checked as part of the agreement to use a contrast media for a procedure.
- The radiology department used patient group directions (PGD), these are written directions allowing pharmacists to assess patients and supply medications without a prescription, for contrast media and bowel preparation for pneumocolon (examination of the large bowel). We found these were all in date and signed off. We also found medicines competency assessments had been completed for radiographers.

Records

- The trust had introduced systems to ensure that all patients had notes available when they attended clinic, as well as systems to track temporary records needing to be made up. Outpatients had a spreadsheet that monitored the availability of patients' medical records. We viewed the spreadsheet for the period March 2016 to February 2017 and found improvements in the availability of patients' notes over the period. For example, the percentage of patient notes available when the patient presented for an appointment was 95% in March 2016, this had improved and services were regularly achieving 98% to 99% from September 2016 to January 2017, there was a slight reduction in compliance in February 2017 with 97% of patient notes being available.
- When patients' original case notes were unavailable for their clinic appointment, St Barts had introduced a system involving a temporary set of case notes being created in advance. These notes included as much recent clinical information as possible being added to the temporary case notes, for example, referral letters, patients' recent clinical letters, and test results. The clinical team were also able to access some patient information from the trust's other electronic records systems. The clinician would make a decision on whether they had enough information to see a patient. The trust informed us that it was infrequent that a patient needed to be rebooked due to the availability of clinical information.
- Once the original set of notes became available the trust's health records amalgamation team would merge the temporary set of case notes with patients original case notes to ensure the patient record was complete and up to date. Reason for case note unavailability would be recorded, and where patterns or trends were identified they were escalated to the relevant teams for mitigation.
- In radiotherapy each patient had a paper booking form and a prescription form. Patient notes recorded that planned exposures had been justified and authorised. Patient notes also held information about exposures to radiation to provide guidance for staff in further treatment and imaging of a patient. However, the service were in the process of moving to electronic booking forms.
- We viewed the results and action plan from a radiotherapy audit dated 24 April 2016. The audit found 93% compliance with trust records requirements. This had a trust quality assurance classification of 'reasonable'. Areas for improvement included: diagnosis recording and records being signed by staff. We also viewed October 2016 audit results for the West Wing, which included medical oncology and the breast 'one stop shop.' We found the level of compliance in the West Wing audit was the same as the trust's 95% target.
- The trust was in the process of rolling out a paperless system and staff said this would reduce the risk of patients' case notes being unavailable. A senior charge nurse told us some clinics were paperless and some clinics were paper based. However, outpatient board meeting minutes for April 2014 noted that paperless clinics were not being enforced if clinicians were struggling to manage the roll out. The plan was for individual clinicians to decide whether they could safely move to a paperless system.
- Minutes of the trustwide outpatient services group performance review, 19 January 2017, recorded that a session was booked in November 2017 with a private provider of IT services, to ensure the functionality of the trust's electronic systems and that these met the national accessible information standards (AIS).

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Assessing and responding to patient risk

- There were arrangements in place to deal with foreseeable medical emergencies. Senior managers told us that escalation of risk was normally done from a clinic level. Clinic managers discussed risk with their line managers who would escalate risks to their service directors, then onto the risk register if required.
- Training for staff in basic life support (BLS) was mandatory in the outpatients department, with 99% of qualified nursing staff having received the training.
- Outpatients used the 'National Early Warning Score' (NEWS), (this is a tool that determines the degree of illness of a patient us). We reviewed five patients NEWS charts and found these had been completed appropriately with patients' observations being scored and totalled appropriately. This enabled staff in assessing whether a patient's condition had deteriorated.
- There were radiation protection supervisors (RPS) for each controlled radiation area, whose role met the Ionising Radiation Regulations 1999 (IRR99).
- The hospital had an 'in-house' radiation protection service which provided the radiation protection advisor (RPA), radiation waste advisor (RWA), and medical physics expert (MPE), with support for lasers and magnet use.
- Dose reference levels were evident for x-ray rooms. Automatic exposure factors were used in all x-ray rooms. All doses were recorded on the picture archiving and communication system (PACS, this is a medical imaging system which provides storage and convenient access to view images), and dose reports could be extracted from the system for analysis.
- An adapted version of the World Health Organisation (WHO) checklist was used for all interventional radiology procedures. An audit of the checklist in February 2017 found 100% compliance with 'team briefs' and staff signing in. However, there was 75% compliance for staff signing out and 50% compliance with 'team debriefs' being documented. As a result of the audit, information was cascaded to staff highlighting that 'team debrief' documentation needed to be completed for every list and staff should ensure they signed out.
- Staff told us if a patient became unwell in the King George V building the dedicated resuscitation team ('crash' team) would be called. Staff in imaging told us a

patient had recently had a cardiac arrest in the imaging department, and the crash team had responded quickly. This resulted in the patient being admitted to St Barts adult critical care unit (ACCU).

- St Barts had a rapid access, walk in chest pain clinic that provided early specialist cardiology assessment for patients with new onset chest pain, who were referred to the clinic by their GP.
- In 2017 the hospital had conducted a radiation safety survey across diagnostics and imaging departments to assess compliance with IRR99, the 'Ionising Radiation (Medical Exposures) Regulations 2000', (IRMER 2000), and 'Environmental Permitting Regulations 2010'. The safety survey ensured the hospital were taking steps to ensure required doses arising from medical exposures were kept as low as reasonably practicable. For example, we viewed the report and action plan in response to the March 2017 safety survey for radiotherapy. The radiotherapy action plan recorded the linear accelerator (LINAC), (this is a device most commonly used for external beam radiation treatments for patients with cancer), risk assessments were in accordance with the corresponding local rules from the IRR99 approved code of practice (ACOP), in regards to the estimated dose rates to which anyone could be exposed.
- There was a protocol for the management of contamination, monitoring, and spillage of radioactive material and a procedure for the disposal of radioactive waste. Local rules were visible on mobile imaging equipment.

Nursing staffing

- Care and treatment was delivered by committed and caring nursing staff. Nursing staff we spoke with told us there were enough nurses to cover outpatients' clinics when everyone was at work. Bank staff were used when additional cover was needed.
- Nursing services in the outpatients department were provided by the outpatient nurses and clinical nurse specialists (CNS).
- A safe staffing dashboard was displayed in the outpatients department. This showed details of the required levels of staffing, and actual levels present on each day. We found staffing levels and the required skill mix were adequate at the time of our inspection.
- An outpatients manager told us the service had: a band 6 nursing vacancy, with interviews arranged for 6 May

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2017. The service also had 1.5 whole time equivalent (WTE) band 5 nursing and 1.5 WTE band 2 health care assistant (HCA) vacancies. These vacancies were being advertised.

- There was a bank for nursing staff to ensure the hospital had cover for staff sickness and holidays. Many of the bank staff had worked at the hospital before and were familiar with the trust's processes. Managers in outpatients told us the service did not use agency staff.
- Outpatients' clinics did not use an acuity tool to set departmental staffing establishment levels or to support day to day staffing flexibility. Outpatients used a standardised 'Nursing Calculation Tool' which was used to establish the required staffing numbers for clinics. Clinic staffing establishment was reviewed on an 'ad hoc' or 'as required' basis. Clinic staffing levels were reviewed annually by the matron and the senior nursing team to ensure there was sufficient staff to meet the needs of the clinics. The service gave us an example of how the tool had been used in February 2017 in the West Wing to review and ensure the clinics staffing levels were appropriate. The review was in response to a change in nurse manager and the subsequent raising of a risk assessment concerning a lack of chaperones in the clinic.
- As a result of the risk assessment the West Wing clinic staffing requirements were mapped. The 'Nursing Calculation Tool' highlighted a need for additional health care assistants (HCA) in the clinic. This led to the West Wing clinics receiving additional funding from the trust for 1.4 whole time equivalent (WTE) HCAs.
- There were daily outpatients 'huddles' at 8.30am and 11.30am which all staff attended to discuss issues that may affect the service and review information on patients attending outpatients appointments. There was a further daily 'huddle' at 11.00am which was attended by band 6 and band 7 nurses to review the progress of clinics and discuss any issues that had arisen.
- We requested from the trust the nursing staff vacancy rate, turnover rate, sickness rate, and rates of bank and locum usage in outpatients and diagnostic imaging. The response we received from the trust was that they could not separate outpatients and diagnostic imaging data and could not provide this information. We are therefore unable to comment on this data.

Medical staffing

- The majority of outpatient clinics were covered by specialist consultants. There was a sufficient number of medical staff to support outpatient services.
- Safer staffing dashboards were used across outpatients and diagnostics imaging departments. For example, we saw a dashboard for imaging displayed in the department, this recorded that on the 9 May 2017 the minimum number of imaging staff required to ensure x-ray services were safe was five; the actual number of staff on shift was six. Whereas in CT the established number of staff required was four, the actual number of staff on shift was five. Whilst MRI established staffing numbers were four, and there were four staff on shift. The dashboard identified that a minimum of three imaging assistants were required in the department, but there were two on shift. However, this was mitigated by extra staffing capacity in CT and MRI.
- Staff told us there were not enough staff in the radiology and diagnostic department to manage the volume of work. For example, the hospital's risk register identified a shortage of mammographers in June 2017. The breast screening service had two band 6 mammographer vacancies. A recent advertisement for these posts had attracted one part time applicant. Staff told us it was proving difficult to attract mammographers as there was a national shortage of mammographers and there was competition from other trusts in London.
- Radiology and diagnostics had introduced an eight week rota, which included dedicated out of hours medical staffing. We viewed rotas for March 2017 and saw that all shifts were covered by named staff, including weekends and out of hours.
- Imaging did not use agency sonographers. Staff told us they would only use the trust's bank staff in the event of a sonographer going on holiday or on sick leave.
- Clinicians agreed the structure of the clinics and patient numbers. The individual specialties and clinicians managed and arranged medical cover for their clinics.
- Consultants were supported by junior colleagues in some outpatient clinics where this was appropriate.

Major incident awareness and training

- A trustwide outpatients, diagnostics and imaging board report dated 17 June 2017 recorded that across all trust sites 94% of staff had up to date mandatory training in emergency planning.
- We viewed training materials from a major incident training day which had been rolled out to clinic leads

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and senior nursing staff following a major incident in London in April 2017, involving an attack on a police officer. The training included a review of the incident and the trust's response, including lessons learnt, as well as training for staff in the event of IT failure and the loss of operating premises due to fire or flood.

- The trust had a major incident policy which staff were aware of. The policy identified key contact details and processes for staff to follow in the event of a major incident.
- There were business continuity plans in place to ensure the delivery of services were maintained. Staff in imaging told us there had been an IT failure on 20 April 2017 as a result of a major disk failure. This had led to PACS and the radiology information system (RIS, a system used for tracking radiology imaging), being unavailable. Staff told us a decision was made to classify the incident as a business continuity incident rather than a major incident, on the grounds that clinical staff could still view images by visiting the imaging department and view them on the imaging department's equipment.
- Following our inspection the service forwarded the CQC minutes from a 'Hot Brief' meeting held on 7 June 2017. The meeting was in response to the NHS ransomware cyber-attack on 12 May 2017. The minutes recorded the timeline of the incident and St Barts response to the incident, including a debriefing of: what went well; what didn't work well; what the service should do differently in the event of a similar cyber-attack; as well as reviewing positive outcomes as a result of the event. The minutes also recorded the next steps St Barts were taking in response to issues identified at the meeting.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not have sufficient evidence to rate effective. Our key findings were:

- Patients received care and treatment that was evidence-based and in accordance with national guidance. However, we found 15 policies in radiotherapy that were not up to date.

- There was compliance with the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER).
- Staff worked together in a multidisciplinary environment to meet patients' needs.
- There was a range of audits in place across outpatients and diagnostic imaging to monitor patient outcomes.
- IT failures on 20 April 2017 and 30 May 2017 had led to clinicians having to leave their clinical areas to view images in the imaging department.
- Consent was sought from patients prior to their receiving care or treatment. Staff received training in the Mental Capacity Act (2010) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- Overall, we found patients received care and treatment that was evidence-based and in accordance with national guidance.
- New guidance from the national institute for health and care excellence (NICE) was a standard agenda item at quarterly trustwide outpatient services group performance reviews.
- Protocols were in place that followed national guidance for radiology examinations, for example, orthopaedic x-rays. We found protocols and procedures adhered to the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER).
- Staff had access to radiation guidelines, local rules and national diagnostic reference levels (DRLs). There was an assigned radiation protection adviser and a radiology protection supervisor for each clinical area.
- A radiation safety inspection had been completed in May 2017 to ensure compliance with the Ionising Radiations Regulations 1999 (IRR99) and IRMER. We also saw evidence through audits that radiation exposure was monitored.
- We viewed a range of radiotherapy procedures. For example, we viewed the procedures for 'Pre Treatment Checks' and 'On Treatment Checks' these outlined the checking process that must be performed on all patients that had commenced radiotherapy and the frequency of these checks. However, we also found 15 radiotherapy policies and procedures that were out of date. Following our inspection the trust informed us that the ISSO 9001 accreditation to which the policies related had been updated in August 2017.

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- We viewed the outpatients annual audit schedule. This outlined the local audit projects in outpatient services, as well as the methods used for auditing and their frequency. For example, audit one on the schedule was to ensure the outpatients service were achieving the trust target of 98% of records availability. Audit results we viewed confirmed this was being regularly achieved.

Pain relief

- Pain relief could be prescribed within the outpatient's department and dispensed by the pharmacy department.
- Patients could be referred to the pain management clinic if assessed as needing pain relief by their consultant.
- Records confirmed that patients' pain needs were assessed before undertaking any tests.

Patient outcomes

- There was a range of audits in place across outpatients and diagnostic imaging to monitor patient outcomes. For example, we saw audit information demonstrating regular auditing of diagnostic reference levels in radiology and diagnostic services.
- The outpatients department also took part in regular monthly audits, for example, hand hygiene, cleanliness, and record keeping. Managers had responsibility for implementing and monitoring action plans to secure improvement when audits identified that remedial action was required.
- The top five clinics by number of attendances were: cardiology, clinical oncology, respiratory medicine, medical oncology and haem-oncology. Between December 2015 and November 2016, the rate of follow-up appointments to new appointments for St Barts (4%) was higher than the England average (2%). The follow up to new appointment rate at St Barts was also higher than any of the trust's other sites. This meant some patients waited longer for a follow up appointment than at other trust sites. Staff told us this was due to specialties offered at St Barts, and increased demand due to some patients requiring more follow up appointments due to longer term conditions.
- Outpatients had a traffic light system, red, amber, green (RAG) rated dashboard which monitored the services key performance indicators (KPI). We viewed the

dashboard dated May 2017. We found outpatients had met most KPIs in the previous 12 months in regards to patient incidents, serious incidents, patient health records, patient slips/trips/falls, and complaints.

Competent staff

- St Barts employed a range of specialist nurses covering most sub-specialities. The teams were skilled and knowledgeable about their specialist areas and were able to provide care, treatment, and advice to patients during their appointments. Specialist nurses told us they attended national forums and regional meetings to share good practice.
- All new staff completed a corporate and local induction. Induction checklists were recorded on staff electronic training records. For example, staff in radiology told us they had received a comprehensive induction, this included mandatory training.
- Nursing staff told us there was a competency framework for new staff to the service. This was monitored by managers through regular 1-2-1 meetings within the first three to six months.
- In radiotherapy, practitioner/operator registers were in place and kept updated. Training and competency records were kept in staff personal folders (radiographer) or electronically (physics). New IRMER duty holders were identified at monthly operations meetings. New staff members received documents at induction, which included information on: Local rules, IRMER procedures, treatment protocols, and quality assurance protocols. Radiographers had competency and training logs which were signed off when competent. Physics had a record of training which was kept on the electronic quality management system (QMS). A radiation safety inspection report and action plan dated March 2017 also identified the addition of local rules and IRMER statements of purpose (SOP) to the local induction checklist.
- Managers confirmed all radiology staff were up to date with IRMER training regulations.
- Across outpatients, diagnostics and imaging staff told us there were regular team meetings and 'away days.' For example, we saw a list of staff meeting dates in the imaging department. We also saw a list for monthly cross site imaging meetings.
- We viewed the local quality improvement plan for computerised tomography, (CT, is a scan that uses x-rays and a computer to create detailed images of the inside

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of the body), 2016 to 2017. This provided evidence that the CT team had produced a training programme to ensure staff were competent in CT scanning. This meant all staff in the CT team could offer this type of scanning twenty four hours a day, seven days a week.

- We spoke with a selection of staff across outpatient clinics who told us they participated in the annual trust appraisal. Managers in imaging told us 100% of staff in imaging had had an appraisal in the previous 12 months. However, we did not see records to confirm this.
- Diagnostic and imaging support staff had in-house competencies assessed and were able to access external courses if these were relevant to their job role.
- Outpatients staff told us they received regular bi-monthly individual supervision.
- Staff told us their electronic training records recorded any specialist training they had undertaken. Staff said they received emails from the trust's education and training department to notify them when training updates were due.
- Staff were able to obtain further relevant qualifications. Staff said there were development opportunities, and they were encouraged to broaden their skills base.
- Staff were supported with revalidation of their professional registrations with their professional regulatory bodies. Revalidation of nurses was routinely monitored by human resources (HR) and at a local level by managers. Revalidation of doctors was routinely monitored through the specialist directorates and at board level.

Multidisciplinary working

- Staff worked together in a multidisciplinary environment to meet patient's needs across outpatients, diagnostic and imaging.
- We saw good multidisciplinary team (MDT) working within the services. The majority of clinics had multidisciplinary team meetings related to specialities. For example, in the respiratory functions 'one stop shop' clinic, the team consisted of a range of professionals, including medical, nursing, and allied health professionals to provide appropriate care pathways for patients in one visit.
- There were regular MDT meetings in the outpatients department.

- Staff in the outpatients department told us there was increased cross site working with the trust's other hospitals. The outpatients' department matron managed both the outpatients department at St Barts and another of the trust's hospitals.

Seven-day services

- The outpatients department was open from 8.30am to 5pm, Monday to Friday. Occasional 'ad hoc' evening and Saturday morning clinics were organised in the main outpatients department to minimise waiting times. Evening and weekend 'ad hoc' clinics were mainly staffed by staff working additional hours.
- The phlebotomy service was available Monday to Friday 8am to 4.30pm. There were no out of hour's phlebotomy services.
- Therapy, diagnostic and support services worked over seven days to provide cover to clinical areas. There was access to specialist investigations such as MRI, CT scans, or to a radiologist to interpret scans out of hours. Plain film and CT scan were available out of hours for emergencies, inpatients and theatres.

Access to information

- Staff we asked were able to demonstrate how they could access policies and procedures via the trust's intranet.
- Staff told us access to patient information during clinics had improved and there was a reduction in the rate of temporary records being used.
- We viewed a comprehensive 'post major incident review' dated May 2017 in regards to IT failures on 20 April 2017 and 30 May 2017. The review examined the impact of the IT failures on service delivery.
- Staff in imaging told us the IT failure on 20 April 2017 was as a result of a major disk failure. This had led to the picture archiving and communication system (PACS, a medical imaging technology which provided storage and access to images), and the radiology information system (RIS, a system used for tracking radiology imaging), being unavailable and clinicians having to leave their clinical area to view images in the imaging department. This had taken time out of clinicians' daily schedules and had resulted in some patients having appointments rearranged.
- Staff told us there had been a backlog of images as a result of the April 2017, due to imaging reverting to a paper based system. Radiography staff said they were

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working overtime to input the backlog of information on the electronic patient care record system (CRS).

However, staff told us the paper based system had worked well when the IT system was inaccessible.

- Imaging had implemented daily meetings with the PACS team and other services across the trust to identify issues services may have been experiencing with images. The PACS team also used the meetings to update services on actions they were taking to mitigate the impact of the IT failure.
- The IT system was fully restored by 4 May 2017. However, some patients' historic images remained inaccessible. Staff told us work was in progress on an investigation into the IT failure, as well as a clinical harm review to look at the clinical impact of the April 2017 IT failure.
- Prior to the inspection CQC sent comment cards for patients to comment on outpatients and diagnostic imaging services. There were a total of 41 completed comment cards returned. Overall, 26 of the comment cards were positive about outpatients and diagnostic imaging services. However, we found three of the comment cards related to patients having to have rescheduled appointments due to the IT failure. One comment card recorded that a patient's images were not available for a patient's appointment due to the IT failure. The patient had not been informed of this until they had arrived at the hospital for their appointment. This resulted in the patient having to make a further appointment and an extra journey to get their results. The patient commented, "systems have been down for over a week; somebody should have called us."
- There were issues with IT during our inspection. Staff at the haem-oncology clinic told us there were issues accessing information on the trust's electronic 'in touch' system. This was a system that displayed patients' names and consulting rooms when prompted by staff. However, only one computer was working in the clinic and this had led to delays and patients waiting longer for their consultation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw training records demonstrating staff had access to training in the Mental Capacity Act (2010) (MCA) and Deprivation of Liberty Safeguards (DoLS).

- Staff in the outpatients department told us the service did not work on a principle of 'implied consent' and always ensured consent was formalised and recorded.
- Radiographers followed the trust policy on consent and recommendations from the Society and College of Radiographers to ensure documented consent was gained for each scan or procedure. We also saw staff gaining verbal consent from patients prior to scans and procedures.
- Patients told us that doctors discussed their treatment options during consultations. Where written consent was required, this would be obtained in the outpatient clinic. Patients we spoke with said they had been asked for their consent prior to receiving care or treatment.
- A senior charge nurse told us all patients with dementia had capacity screened on referral to outpatients, diagnostic and imaging services.
- The radiotherapy department was involved in the London Cancer Radiotherapy Department Cancer Survey 2016 to 2017. The survey included the question, "when you gave your consent to what extent did you understand what the benefits and side effects of radiotherapy were?" 90% of the surveys respondents confirmed they understood the benefits and side effects of their treatment prior to giving their consent.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good because:

- Staff offered care that was kind and promoted people's dignity. We saw relationships between people who use the service, those close to them, and staff were strong, caring and supportive.
- Most patients and relatives we spoke with told us they were involved in decision making about their care. Patients also understood the care and treatment choices available to them.
- There was a range of emotional support options for people to talk about their condition, including access to chaplains, social workers and community support staff.

Compassionate care

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- We spoke with over 20 patients and those close to them during our inspection. Most of them spoke highly of the care provided by staff.
- We observed care provided by nursing, medical and other clinical staff. Throughout the outpatient and diagnostic imaging departments we saw most staff being helpful, polite, professional, and putting patients and their carers at ease. For example, we saw numerous incidences of staff approaching people rather than waiting for requests for assistance, asking people if they needed assistance and pointing them in the right direction.
- Prior to the inspection, CQC sent comment cards and a secure box for patients to leave comments about outpatients and diagnostic imaging services. Overall, we found patients were positive about staff being compassionate. A typical comment was, “the staff are very caring. I have been treated well by the staff since I first came here in October 2015.”
- Outpatients departments had appropriate rooms for private consultations. This enabled patients to discuss their care and treatment in private.
- The King George V building had segregated male and female changing areas.
- In diagnostics and imaging 100% of patients who responded to the London Cancer Radiotherapy Department Cancer Survey, 2016 to 2017, answered positively to the question, “did you feel the changing facilities / arrangements allowed you to maintain your dignity?”
- The radiotherapy department received 100% confirmation from respondents to the question, “were you given enough privacy to ask questions?” in the same survey.
- Printed information was available to patients and those close to them across outpatient and diagnostic imaging services; for example, we saw leaflets in the radiology waiting room on various types of cancer and how to access financial support.
- We saw a noticeboard in the imaging department with patient comments displayed. One comment recorded, “explanations were given to me about everything.”
- In the Cancer Patient Experience Survey, 2015, published in 2016, the trust scored 67% for the question, “was the patient given understandable information about whether radiotherapy was working?” this was better than the England average of 60%. The trust (80%) scored lower than the England average of 84% for the question, “did the patient have all the information beforehand about chemotherapy treatment?”
- The London Cancer Radiotherapy Department Cancer Survey 2016 to 2017 found 85% of respondents confirmed they had been given a clear explanation of where to go and what to expect in their appointment letters.

Emotional support

- There was a range of emotional support options for people to talk about their condition, including access to chaplains, social workers and community support staff.
- We saw leaflets in the radiotherapy department for patients dealing with cancer, offering a ‘managing cancer psychology workshop.’ The workshops were being offered on Tuesdays from April to August 2017 at the hospital. The workshops offered support in dealing with stress, as well as relaxation techniques and improving patients’ resilience.
- Radiotherapy staff told us the service had offered on-site art therapy in 2016; but the funding for this had been withdrawn. However, patients could still access art therapy off-site. There was a leaflet in the radiotherapy waiting area for patients who wished to access art therapy.
- Staff told us they could refer patients to local counselling services if a need for counselling was identified.
- The St Barts hospital chaplaincy could provide emotional support and advice for patients, their relatives and friends.
- Administrative staff in clinics appeared friendly and assisted patients promptly.

Understanding and involvement of patients and those close to them

- Patients we spoke with were clear about why they were attending their appointment for, what they could expect, and who they were going to see. Overall, most patients told us they had their treatment options and choices explained to them.
- Most patients told us they had received information about their conditions and medicines.

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- The trust used the friends and family test (FFT) survey; this is a system of patient feedback on health services they have received. The trustwide outpatient services group performance review, 19 January 2017, reviewed FFT results on the outpatients dashboard. This indicated that outpatient departments were not meeting the trust target of above 90% at all times for patients recommending services to their friends and family. However, most outpatients' clinics were achieving over 85% in the period January 2016 to December 2016. The dashboard did not record the number of respondents to the surveys, so we could not assess how proportionate the FFT results were in terms of patient numbers.
- Staff told us chaperones were available to accompany patients if required. However, access to chaperones in the outpatients department was on the services risk register. The risks register did not record actions the services were taking to mitigate risks. Although the risk register was regularly reviewed at governance meetings.

Are outpatient and diagnostic imaging services responsive?

Good



We rated responsive as good because:

- Patients had access to a range of diagnostic imaging specialist investigations.
 - The outpatients department had developed some nurse-led clinics; there were also rapid access clinics for patients experiencing conditions such as asthma and chest pain.
 - The access issues resolution service (AIRS) was a dedicated helpline offering patients and GPs fast resolution of all booking and scheduling issues.
 - Interpreters were available to enable staff to communicate with patients where English was not their first language.
 - Between February 2016 and January 2017 the percentage of patients waiting more than six weeks to see a clinician was mostly lower than the England average.
 - St Barts had introduced a call reminder service to remind patients of their appointments.
- Outpatients' managers told us they had not had to cancel any clinics as a result of the IT failure on 20 April 2017.
 - The trust had consistently performed better or similar to the England average for cancer waiting times.
 - Diagnostics and imaging services were meeting waiting time performance criteria.

However:

- There were capacity issues in some clinics that meant there was potentially insufficient number of clinics to deal with demand. Clinic rooms were booked up quickly and there was limited spare room capacity.
- Between December 2015 and November 2016 the 'did not attend' (DNA) rate was mostly higher than the England average.

Service planning and delivery to meet the needs of local people

- St Barts had 305,617 new and follow up outpatient appointments between December 2015 and November 2016. The five most frequently used services at St Barts were: cardiology, clinical oncology, respiratory medicine, medical oncology, and haem-oncology.
- Outpatients and diagnostic imaging services were responsive when planning services to meet the needs of local people. The trust's clinical support services (CSS) worked across all the trust's hospital sites. Imaging worked across the trust's hospital sites, radiologists and sonographers worked across the trust's hospitals, and radiographers were based at St Barts.
- Managers and staff told us there were capacity issues in some clinics that meant there were potentially insufficient numbers of clinics to deal with demand. For example, cardiomyopathy.
- The trust had a central appointments office (CAO). The staff at the CAO were utilised to identify and book consulting rooms. Staff told us consulting rooms were booked up very quickly. A member of staff told us, "consulting rooms can be like gold mines."
- Staff in clinic 6 told us the clinic was usually used for haem-oncology services; but, consultation rooms that were not in use were sometimes utilised by other services, such as endocrine, diabetic metabolic, and diabetes nurse specialists.

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- The trust were discussing a project with local clinical commissioning groups (CCG's) and the trust to develop a strategy for providing clinics nearer to people's homes. For example, anticoagulant clinics.
- Patients had access to specialist investigations such as magnetic resonance imaging(MRI) or computer tomography(CT) scan. We viewed the local quality improvement plan for CT scan, 2016 to 2017. The plan highlighted issues the service had identified as needing to be resolved and actions the CT team had taken in response to mitigate these. For example, CT staff reported issues where patients were attending the CT department without a recent serum creatinine result, (creatinine is a waste product that comes from the normal wear and tear on muscles of the body and is a useful marker in identifying patients' kidney function). To comply with Royal College of Radiologists guidance patients with defined medical conditions and over 70 years of age should have a serum creatinine test result three months prior to their appointment. This led to delays on the day of patient's appointments due to radiographers having to contact teams to request bloods or in some cases contacted patients GPs. To resolve the issue the CT team had recruited a bank member of staff to check all serum creatinine results for patients. The service had also introduced a policy whereby radiographers would not scan a patient without a serum creatinine result; and the service would send patients a notice to assess, if they met the criteria for a blood test, three months prior to their appointment to ensure this was organized.
- The rapid access chest pain clinic provided a quick assessment and early diagnosis service to patients with new onset chest pain which was likely to be cardiac in origin. The clinic reviewed an average of 1700 new patients and 500 follow up patients annually.
- The advanced heart failure clinic offered comprehensive care for patients with heart failure.
- St Barts offered a dedicated service for patients affected by sudden arrhythmic death syndrome (SADS, these are patients with inherited cardiovascular disease).
- The respiratory services offered rapid access clinics for asthma.
- The trust had an access issues resolution service (AIRS). AIRS was a dedicated helpline offering patients and GPs fast resolution of all booking and scheduling issues. The

AIRS team provided a dedicated channel that patients or GPs could contact. AIRS performance was reviewed at quarterly trustwide outpatient services group performance reviews.

- The St Barts risk register recorded a risk from the specialist treatment planning computers and other computers connected to the 'CyberKnife' not having up to date antivirus definitions loaded in a timely manner. This was prevented by the manufacturer's antivirus policy. But, this created a potential risk that malware or a virus could get onto the system and spread through the network to other computers. However, the risk register did not record any actions the trust were taking to mitigate this.

Meeting people's individual needs

- Nursing staff told us morning 'huddles' were used to identify patients with special needs and enable staff to provide appropriate care. Staff told us older frail patients or patients with complex health needs were prioritised in clinics.
- There was written information available for patients in all the clinics we visited. Some of these leaflets had been produced by the trust and other items had been provided by external agencies such as NICE and Royal Colleges.
- A patient led assessment of the care environment (PLACE) report, May 2016, highlighted that wheelchair users and carers may not consistently be able to sit together in the outpatients waiting areas of clinic 2 and the West Wing due to limited seating capacity. In response to the PLACE assessment the trust acknowledged that seating was a challenge in clinic 2 and the West Wing due to the King George V building's design, but said that chairs would be rearranged as required to ensure wheelchair users and carers could sit together.
- Interpreters were available to enable staff to communicate with patients where English was not their first language. Staff told us the hospital had staff who spoke a variety of languages who could be called upon to interpret or communicate with patients.
- Written information for patients was available in several languages and large print. Staff told us they could contact the trust's accessible communications team to produce any of the trust's written information including appointment letters as soon as they were informed that a patient required this. However, in the imaging

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department radiation protection notices were in English, and this created a risk that patients who did not speak English would not understand the radiation risks from some procedures.

- All outpatients and diagnostic imaging services in the King George V building could be accessed on foot or by using the lift.
- Staff used a “forget me not” process for identifying patients that had additional needs, for example, dementia. Records were marked with a flower to identify when a patient needed additional support.
- Patients said most staff were helpful, professional, polite and kind. For example, staff in the outpatients department had been concerned about a patient with learning difficulties getting home. We saw staff arranging a taxi to take the patient home.
- We saw two reception staff having a conversation with each other and not using English. This could have made patients waiting at reception feel uncomfortable.

Access and flow

- St Barts had a total of 305,617 outpatient appointments between December 2015 and November 2016.
- St Barts devolved its outpatients booking function from the trust’s central team as the site had not procured an electronic call handling system. However, work was in progress on an audit of effectiveness of the outsourced booking functions. This involved the outpatients booking team recording all calls handled for a snapshot period to determine average call handling by day and week.
- Clinics had flowcharts which demonstrated the patients’ journey. For example, the clinic 2 flowchart recorded that patients checked in with reception, would then see a nurse, and would then have tests completed in either clinic 3 or clinic 5. We viewed the clinic 1 flowchart for a ‘one stop shop.’ These recorded that patients would check in and receive all their care and treatment in clinic 1.
- The flowcharts recorded that most referrals came from patients GPs, and the trust’s other hospitals.
- GP referrals were electronic via the trust’s ‘choose and book’ system. Staff told us they also received paper based referrals from other services, which were scanned onto patients’ electronic records.
- Patients that were already known to the service and patients from other hospitals were referred via a single point of referral (SPOR).
- Staff told us cancer appointments were over booked as a “norm.” Staff told us this did not have any impact on patients being seen for an appointment. Staff said they could offer patients referred to cancer services a next day appointment. Cancer patients were not booked via the central booking hub. All cancer patients’ appointments were authorised by a member of the medical staff.
- In radiotherapy the identification of referrers was described in the IRMER procedures. There were no electronic IRMER referrals. Referrals were made in writing and kept in the patient notes.
- Radiotherapy had documented referral pathways in place. For example we viewed the pathway for total body irradiation (TBI) for a patient referred from the haem-oncology team. The referral pathway clearly detailed the process for the haem-oncology team in referring a patient for radiotherapy.
- Two week wait appointments were offered for new breast surgery, lung cancer and haem-oncology referrals.
- A manager in outpatients told us clinics regularly did not run on time. The manager told us cardiomyopathy was the clinic most likely to run over time, due to the service re-profiling as a result of services transferring from University College Hospital London (UCLH).
- Waiting times varied across outpatient clinics. Most patients we spoke with were tolerant and accepted if they were not seen at their scheduled appointment time. However, staff told us some complaints had been received about delays in clinics. Some patients also told us there was a lack of co-ordination between tests and consultations. For example, we spoke with a patient who told us they had an hour and a half wait between having an ECHO and attending their scheduled clinic consultation.
- Between November 2016 and January 2017 the trust reported 10% of patients waited over 30 minutes to see a clinician. Six clinics were recorded as starting late in the time period; there were approximately 130 clinics a day taking place on site.
- Between February 2016 and January 2017 the percentage of patients waiting more than six weeks to see a clinician (1%) was lower than the England average (1.5%), except for June 2016 where it slightly peaked at 2%.
- Between November 2016 and January 2017 the trust averaged between 2% and 4% for clinic cancellations

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within six weeks, but peaked in November 2016 with 10% of clinics being cancelled. In the same period the trust averaged between 9% and 6% for clinic cancellations over six weeks. The main reasons for cancellations as reported by the trust were: template changes including clinic moves (66%); doctor unavailability due to leave/study/ sick leave (27%); clinic size (4%); and audit days (3%). The trust stated that in October 2016 there was a one off move of patients from the QE2 building to the King George V building which had an impact on a number of diagnostic clinics, and this artificially increased the number of cancellations in November and December 2016.

- Nursing staff told us it was rare for clinics to be delayed due to medical staff not turning up on time for clinics. The service also used a clinic cancellations 'tracker' tool to monitor the reasons for clinics being cancelled. We viewed the tool and found in March and April 2017 the reasons recorded for clinic cancellations were medical staff being on annual leave.
- There was a policy requiring doctors to give six weeks' notice before taking annual leave, to ensure there was sufficient time to plan appointments around doctors' availability. The policy highlighted that appointments should not be booked on days when doctors were on annual leave or on clinical audit days. Doctors we spoke to were aware of the policy.
- In diagnostics between February 2016 and January 2017 the percentage of patients waiting more than six weeks to see a clinician was lower than the England average (1%), except for in June 2016 where it slightly peaked (2%).
- We viewed the imaging waiting times dashboard for August 2016 to January 2017, for CT, MRI and ultrasound. Imaging had mostly met the trust waiting times targets in this period, regularly achieving 100%. Ultrasound did not achieve the target in September 2016 at 97% and MRI did not achieve the target in December 2016 at 98%.
- Between December 2015 and November 2016 the 'did not attend' (DNA) rate for St Barts was mostly higher than the England average (7%). For example, the rate peaked at 8% in May 2016 and averaged 7% for all the other months in 2016, with the exception of November 2016 when the rate was 6%, which was below the England average.
- St Barts had introduced a call reminder service to remind patients of their appointments and reduce the

number of DNA appointments. The service worked from 5.00pm to 8.00pm Monday to Friday. The service would telephone patients to remind them of their appointment. If patients couldn't make their appointments these would be offered to other patients. Patients could also opt in to receive text reminders five days in advance of their appointments.

- Managers we spoke with told us the IT failure on the 20 April 2017 had not affected the bookings system. Outpatients' managers told us they had not had to cancel any clinics as a result of the IT failure at St Barts.
- In cancer waiting times for 2016 to 2017 the trust had consistently performed better than the 93% operational standard and England average for people being seen within two weeks of an urgent GP referral. The trust was performing better than the 96% operational standard and in line with the England average for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The trust was performing similar to the 85% operational standard and better than the England average for patients receiving their first treatment within 62 days of an urgent GP referral.
- Managers collected information on patients waiting times which fed into the monthly outpatient services dashboard. We viewed the dashboard for the 19 January 2017. The dashboard recorded most outpatients clinics at St Barts having achieved the trust target of 80% of patients being seen within 30 minutes of arriving for their appointment in the period from May to December 2016. However, clinic 1 was an exception, as the clinic had not met this target in any month during the same period, with 76% of patients being seen within 30 minutes. Clinic 1 had also not met the trust target of 100% of patients being seen within 60 minutes. The percentage of patients being seen within an hour of arriving for their appointment at clinic 1 was an average of 98% from May to December 2016.
- The 19 January 2017 trustwide outpatient services group performance review minutes recorded that patient flow in outpatient clinic 1 remained of concern and said that staff had been advised to communicate delays to patients and guide patients through the process of tests followed by consultations.
- Waiting times at the haem-oncology clinic were on the hospital's risk register, due to a demand and capacity mismatch, this created a risk of patients having long waits to be seen.

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- We viewed data provided by St Barts on clinical interaction; this is determined to be the first point at which the patient is seen by a clinician following check-in for an appointment. On average patients waited in East Wing for three minutes and 18 seconds; whilst in King George V Building the average wait was 16 minutes and 17 seconds.
- We spoke with patients in a range of outpatient's clinics. Some patients said they were not always told of any delays and how long they may have to wait. One patient that regularly attended outpatient's said, "it sometimes takes two to three hours for tests and consultations to be completed."
- Managers told us the policy was that reception staff would inform patients of delays in clinics when they arrived for their appointment. We saw reception staff in imaging informing patients verbally of delays in CT scan. We also saw reception staff in clinic 6, haem-oncology, informing patients of a 20 minute delay due to IT issues.
- We saw notices in clinics advising patients of the approximate waiting times for clinics. For example, the imaging department displayed a notice advising patients that there was a, "one hour delay in CT currently."
- There was a downward trend in outpatients offering 'ad hoc' clinics. These had reached a peak with 11 'ad hoc' clinics in August 2016, reducing to one 'ad hoc' clinic in December 2016.
- Minutes of the trustwide outpatient services group performance review, 19 January 2017, recorded that staff were being encouraged to record delays in clinics on the electronic incident report, this was being monitored by the group, who worked with outpatient services to prevent delays. The report recorded that there had been an increase in the number of delays being reported on the electronic incident report, but that the group were aware that, "it was some way off the real figure." The outpatient services performance review also reviewed all clinics to identify themes and trends. We viewed the dashboard of late running clinics, January 2016 to December 2016. Medical oncology had the most late running clinics reported as an incident, with four being reported in the period; clinical oncology and cardiology both reported three late running clinics in the same period.
- The 19 January 2017 trustwide outpatient services group performance review minutes recorded the number of outpatients' appointments cancelled at St Barts was higher than the trust's other hospital sites. These ranged from 17% in September 2016 to 22% in November and December 2016. The group was monitoring trends, with the trend for St Barts being upward. However, the trend for patients cancelled multiple times was downwards. The performance review minutes also recorded the trend for clinic rescheduling as downwards.
- We viewed the local quality improvement plan for CT scan, 2016 to 2017. The plan recorded that the CT scan team had received funding to recruit a dedicated CT specialist Band 7 that would work across St Barts and another of the trust's hospitals, to reduce the waiting times for CT colon scans, as the service were exceeding the two week wait requirement.
- St Barts had seen an increase in the number of unwell walk in patients attending outpatients' clinics. There had been 131 walk in patients in the previous two years. This had been added to the risk register due to walk in patients taking staff from their rostered duties and taking an hour to process. A senior charge nurse told us the risk had been mitigated by the introduction of signage on the street making the public aware that the King George V building did not offer a walk in service. St Barts were also discussing having a GP led 'walk in' centre.
- St Barts referral to treatment times (RTT) were not being reported to NHS England at the time of our inspection by prior agreement. However, the trust were monitoring RTT times via a weekly performance and access meeting which was chaired by the deputy director of operations (performance and quality), general managers and associate general managers covering the site's specialties, as well as the site's head of informatics. The meeting reviewed incomplete performance, appointment letters turnaround, consultant clinic waiting times for new and follow-up appointments, DNA rates, diagnostic imaging appointment waiting times and other access issues or concerns. This ensured patients waiting for appointments were not overlooked or had unduly long waits in the interim.

Learning from complaints and concerns

- Between April 2016 and March 2017 there were 103 complaints relating to outpatients, diagnostic and imaging services. The trust took an average of 25 days to investigate and close complaints. This was in line with the trust's complaints policy, which stated complaints

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had a standard 25 working days turnaround. However, this could be increased to 40 or 60 days where the complaint was complex. Of the 103 complaints, the category with the highest number of complaints (33%) was related to communication, (verbal, written and electronic), this was followed by diagnosis or treatment with 23 complaints (22%).

- Complaints were reviewed at regular trustwide outpatient services group performance reviews. We viewed minutes of the review meeting dated January 2017. The minutes contained a performance dashboard covering the period January 2016 to December 2016. The dashboard indicated that outpatients had received one reportable complaint in the months of May, July, August, October and December 2016. There were no reportable complaints recorded in the rest of the 12 month period. There had also been two non-reportable complaints in February 2016 and one in December 2016.
- Staff told us that they were aware of reported complaints and actions in response to complaints. Staff said learning from complaints was disseminated at staff meetings and 'huddles.'
- The outpatients' performance dashboard recorded for the period January 2016 to December 2016 that 100% of complaints had been acknowledged within three days, this was better than the trust target of 80%, with the exception of January 2016 when the rate was 75%. The dashboard also recorded that outpatients had met the 25 days agreed response time, achieving 100% compliance in the period, this was better than the trust target of 80%, with the exception of September 2016 when the rate was 50%.

Are outpatient and diagnostic imaging services well-led?

Good



We rated well-led as good because:

- Staff told us there had been improvements in leadership at both an executive and local level in outpatients and diagnostic imaging. Local leaders were visible and staff felt that concerns they raised would be addressed.

- Quality reports and dashboards were sent to managers of outpatients and diagnostic imaging on a monthly basis; this included quality performance information and internal key performance indicators (KPI).
- Governance systems internally within the directorate demonstrated information was shared and lessons were learnt about events within outpatients. However, shared learning across the directorate was more limited.
- Most staff knew about the trust's values and could explain what these meant to their role.
- Staff told us relationships between outpatients and diagnostic imaging had improved. Staff felt there was an open culture within outpatient and diagnostic imaging services.

However:

- The risk register did not contain action plans to explain what actions had been taken to mitigate identified risks or identify timescales for completion of actions to mitigate the risks.
- There was a risk to on-going service development as clinic space was at a premium, and as demand increased the outpatients' model may make meeting the demands on services unsustainable.
- There was a risk to on-going service development in regards to the rolling out of a paperless records system due to the reliability of the trust's IT systems.

Leadership of service

- Organisational flowcharts were displayed on staff noticeboards across outpatient and diagnostic imaging services, these clearly set out the structure of accountability in outpatients and diagnostic imaging services. The outpatient and diagnostic imaging service fed into: Barts heart centre, Barts cancer centre, clinical support services (CSS), and the clinical academic group (CAG). These fed into specialist improvement groups, which fed into the monthly outpatients' board.
- Senior local leaders attended the monthly outpatients' board meetings. The outpatients' board fed into the trust board via the associate director of nursing, who was accountable to the director of nursing and governance and the managing director. Managers told us that the structure of the outpatients CAG meant senior managers often had responsibility for other services across the trust's hospitals.
- Staff comments on the visibility of the executive management team were mixed with some staff saying

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they were visible, and others saying they were not. However, most staff said there had been improvements in leadership in the past two years. A consultant said, “the leadership is now very good.”

- Staff we spoke with told us the local leadership for outpatients and diagnostic imaging services was good. Staff felt local leaders were approachable and concerns they raised would be addressed.
- Staff told us that the associate director of nursing and the matron for outpatient services were helpful and supportive. Staff said they could approach their line manager and senior managers with any concerns or ideas.
- The outpatients’ leadership were experienced and understood the service. For example, the matron had worked for the trust for 31 years.

Vision and strategy for this service

- The trust’s vision and values were displayed throughout the hospital. Most staff knew about the trust’s values and could explain what these meant to their role, as they were linked to staff annual appraisals.
- St Barts had a ‘vision, scope, and governance’ document for outpatients and diagnostic imaging. The document highlighted the services mission statement: “to deliver excellence for our patients and families. For the majority of our patients, outpatients represent the ‘front door’ of the hospital, and the team place significant importance on ensuring excellent patient experience.” Managers told us the trust’s strategy was to get services working cohesively across sites, with the vision being, ‘one trust.’
- Within outpatients, the leads for outpatients had a clear vision for the service to meet demand over the next year and were seeking further senior management support to deliver their local strategy.
- We viewed radiotherapy presentations from workshops the department had conducted with staff to develop a strategy for radiotherapy.

Governance, risk management and quality measurement

- Governance systems in outpatients and diagnostic imaging demonstrated that information was shared and lessons were learnt about events internally in outpatients and diagnostic imaging, but shared learning across these services was more limited.

- Managers had access to a ‘scheduling management’ tool. This listed all outpatient clinics on a daily basis and the name of the clinical leads for clinics. The tool enabled staff and managers to monitor activities in outpatients’ clinics.
- There were monthly outpatient and diagnostics board meetings. These were chaired by St Barts clinical director, covering both business-as-usual and improvement initiatives. The meetings had a standard agenda which included a review of: the quality and operational performance report, incidents, complaints, and patient feedback. The meetings also discussed any updates from outpatients and diagnostic imaging services.
- Staff in diagnostic imaging had monthly imaging clinical governance group meetings in which they discussed learning from incidents and complaints, policies, clinical issues and trust information.
- There was a fortnightly outpatient and diagnostics improvement group, chaired by the associate director of operations. The group focused on initiating work streams to address any feedback services had received from both staff and the public.
- Radiotherapy had a monthly clinical governance and risk (CGR) meeting in which radiation safety issues were discussed and minuted. The group had written terms of reference (TOR) that set out the scope of the group, as the group also acted as the radiotherapy radiation protection committee.
- We found the risk register listed risks to services, but did not record action plans or identify timescales for completion of actions on the risk register. We found services had taken action in most cases to mitigate risks on the register, but these were not recorded on the risk register. This meant the risk register was a list of risks and not a register of risks and action plans to reduce the likelihood of risks occurring.
- We saw from reviewing a range of meeting minutes that the risk register was reviewed at every monthly outpatients board meeting. Risks raised by staff were added to the board meetings agenda and discussed at the meeting, prior to being added to the risk register.
- Quality reports and dashboards were sent to the managers and matrons of outpatients and diagnostic imaging on a monthly basis; these included quality performance information and key performance indicators (KPI).

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Culture within the service

- We spoke with staff across outpatients and diagnostic imaging services about bullying, harassment and whistleblowing. All the staff we spoke with felt that there was an open culture within the service and said they had not experienced any bullying or the need to formally raise concerns.
- Managers told us there had been issues with team dynamics following the merger of St Barts with the London Chest and Heart Hospital in 2015. Some staff in diagnostic imaging told us there had been historic cases of bullying dating back to the merger. However, managers said these had been resolved due to changes in staff.
- Staff in the imaging department told us relationships between outpatients and diagnostic imaging had improved. Staff said diagnostic imaging staff had started to attend the daily outpatients 'huddles' to improve communication between outpatients and diagnostic imaging staff.
- The trust had policies in place to ensure people were not discriminated against. For example, staff told us they were aware of the trust's whistleblowing policy and they felt able to raise concerns through the trust's internal processes.
- Nursing staff we spoke with told us they felt respected by most medical staff.
- Staff in outpatients told us they felt they had a separate identity from other services in the King George V building, as they wore a uniform and not 'scrubs.' Staff said they felt this gave them a separate identity to other staff in the building.
- The trust held an annual staff survey. We viewed the combined staff survey results for St Barts and the Royal London Hospital, 'outpatient services and health records,' 2016. The response rate to the survey was 49%. The survey results for both sites were: three out of 10 staff who responded to the survey said they had been victims of bullying, harassment or abuse, whilst two out of 10 respondents said they had experienced discrimination at work. However, it should be borne in mind that the staff survey results did not separate the responses of St Barts staff from the responses of staff at the Royal London Hospital, or the responses of outpatients' staff from health records staff.

Public engagement

- The trust told us they used volunteers to provide support to patients in outpatients. This included manning information points throughout outpatients. We observed volunteers directing patients to various departments.
- Patient Advice and Liaison Service (PALS) information was available on notice boards in waiting areas. The notice boards informed patients of the PALS service and also invited patients to provide feedback and comments on outpatients and diagnostic imaging services.
- St Barts had a patients forum which met quarterly with hospitals staff.
- Information was displayed on message boards throughout outpatients and diagnostic imaging services to: provide the public with messages about services; encourage feedback; and inform the public on how they could get involved in trust initiatives, such as research or volunteering with the trust.
- The trust gained patients views about services in a number of ways. Including an independent patient survey and specialist service feedback initiatives. For example, we viewed the London Cancer Radiotherapy Department Survey 2016 to 2017. There had been 238 St Barts patient questionnaires returned from the survey, 90% of these responded that they would recommend the radiotherapy department to their friends and families.

Staff engagement

- The staff survey results 2016, for St Barts and the Royal London Hospital, found six out of 10 staff who responded to the survey said that they would recommend the trust as a place to work.
- The trust had a support group for black and minority ethnic (BAME) staff. BAME staff we spoke with told us the culture at the hospital had improved. Staff said following the trust's merger there was a culture of nepotism, with BAME staff being overlooked for career development and promotion opportunities. However, the BAME staff we spoke with said this had improved.
- Staff received monthly 'Team Talk' newsletters. Staff told us the newsletter kept them abreast of developments across the trust. However, some staff told us they didn't have time to read the newsletter.
- Staff told us the trust had a 'social team' as part of the trust's staff engagement programme.
- Staff told us the trust had an annual Christmas staff party, which all staff not on duty could attend.

Outpatients and diagnostic imaging

Innovation, improvement and sustainability

- There was a risk to on-going service development as space was at a premium in King George V building. As demand increased the current model, space design and layout of the building may make meeting this demand unsustainable.
- The hospital's risk register identified a risk of an inability to support clinical trials involving radiotherapy due to a failure to fund research in radiotherapy physics, even though it was a trust objective for more clinical trials. However, we did see that radiotherapy were involved in some clinical trials.
- There was a risk to on-going service development in regards to the rolling out of a paperless records system due to the reliability of the trust's IT systems.
- The outpatients and diagnostic imaging services had innovative approaches to support and deliver appointments through avenues such as telephoning patients prior to appointments to ensure clinic time was fully utilised.
- Locally staff had been innovative and creative in managing and delivering approximately 130 clinics a week. This demonstrated how staff were commitment to sustaining the delivery of patient care.

Outstanding practice and areas for improvement

Outstanding practice

Medical Care:

- Senior teams encouraged staff to participate in research and develop innovative projects to improve care in their clinical area. For example, staff in ward 6 had been recognised as finalists for a Health Service Journal award in November 2016 for their work in redesigning a specialist service. In addition, staff teams from wards 4C, 5D and 6D had conducted falls prevention research that led to the introduction of falls champion badges for staff who had demonstrated skills development in falls prevention and who could train or coach colleagues. A research ambassador group supported staff to engage in research in line with national ethics guidance.
- Staff in the sexual health clinic were encouraged to apply to present their work at the annual British Association of Sexual Health and HIV conference as a strategy to share best practice and new learning. For example staff had attended a 2016 conference to present a reflection on their clinical practice in the management of syphilis and to present the work of a satellite screening partnership clinic with a nearby private pharmacy.
- The trust was participating in the East London Cancer Board initiative. This was collaboration between 20 organisations and 50 professionals who sought to agree priorities for improvements and drive positive change in local cancer services. In January 2017 the board announced its key areas of focus and planned work together including incorporating patient experience narratives and identifying opportunities for new care pathways such as for prostate cancer follow-up care.
- An experimental medicine cancer centre had recruited 934 patients to trials developing practice-changing medicine for four cancer types.
- An international cancer specialist organisation had selected the hospital as one of 20 global sites of excellence in immune-oncology to advance the development of cancer immune therapy.
- Staff in the chemotherapy assessment unit provided a 24-hour telephone triage and advice service for patients who were feeling unwell during their treatment and patients who had completed a course of treatment within the previous six months.
- The sexual health research team had been awarded the British Association for Sexual Health and HIV Cathy Harman Award for Innovation and the Rosalind Franklin Appathon Award for work in developing, piloting and evaluating the first NHS online automated clinical care pathway for management of people with genital chlamydia.
- The heart centre demonstrated an average 'door to balloon time' of 60 minutes, which was significantly better than the national average of 90 minutes.

Surgery:

- Staff we spoke with stated they felt it had been a significant achievement by the leadership of surgery to bring three services together into one organisation, standardise processes efficiently, and continue to maintain the quality of care while doing so. Staff stated that the move into surgery services at St Bart's Hospital had been well managed and the transition was relatively smooth.
- Surgery services were in the process of introducing a robotic surgical team with a fully adapted robotic surgery theatre. This would allow the surgery services to offer less invasive cardiothoracic surgery procedures, which led to faster recovery times, minimised trauma, and reduced pain. The robotic surgical programme would be the only dedicated cardiothoracic robot in the UK. The Robotic Epicentre for teaching and training in the UK will move to St Bart's Hospital in 2017.
- Surgery services had clinical research collaboration with a leading electronics company to develop visual applications for thoracic surgery. To support this, surgery services had developed a hybrid theatre, which could allow on-table visualisation of very small cancerous lesions, allowing more precise excision and reducing loss of healthy lung tissue.

Outstanding practice and areas for improvement

- St Bart's Hospital was the first site in Europe to perform Electromagnetic Navigation Bronchoscopy, and was the only centre offering this in the UK as a routine service. Surgery services are also a training centre for this procedure in Europe.
- The hospital's Grown Up Congenital Heart disease (GUCH) programme had recently received national accreditation and is one of the largest in the world. The service provides supported transition from childhood to adulthood for those born with heart disease via a well-established transition programme with a leading London paediatric hospital.

Critical Care:

- The service had set up a well-governed and safe Extracorporeal Membrane Oxygenation (ECMO) service to provide both cardiac and respiratory support for patients and had put in a bid to become a national funded service.
- Since the merger of the three hospitals the service had developed a well governed critical care service with excellent medical and nursing leadership.

Areas for improvement

Action the hospital SHOULD take to improve

Medical Care:

The trust should:

- Ensure that nursing care bundles, including patient risk assessments, are completed consistently and without omissions.
- Ensure that adequate contingency plans are in place to reduce the risks of medicines management errors in the absence of pharmacy support.
- Ensure all teams meet the 90% target for completion of safeguarding training.
- Ensure all teams meet the 90% target for completion of mandatory training.
- Ensure there is adequate expertise on-site to ensure patients at risk of conditions associated with tissue breakdown or pressure sores receive appropriate care and treatment.
- Ensure further emphasis on making sure that all staff accurately and appropriately use the national early warning scores (NEWS) when assessing patients.
- Ensure staff working in laboratories have appropriate training in using personal protective equipment and protecting themselves from the risks associated with coming into contact with infectious material.
- Ensure FP10 prescription pads in the sexual health clinic are stored and managed in line with NHS Protect security of prescription forms guidance 2015.

Surgery:

The trust should:

- Ensure there are processes in place to monitor consistent recording of temperatures for medication refrigerators on surgery wards.
- Ensure NEWS scores are correctly scored and there are sufficient structures in place to frequently monitor performance in this regard.
- Ensure patients who have appointments cancelled are offered an alternative.
- Ensure there is screening for patients who may have dementia, and that additional support is available for patients with dementia or other complex needs.
- Improve communication with patients regarding their discharge planning from surgery wards.
- Improve signage in the outpatients building for pre-admission appointments.
- Ensure they are meeting the trust target for appraisals of non-medical staff within surgery services.

Critical care:

The trust should:

- Ensure sepsis six pathway is fully integrated into practice and staff are educated appropriately.
- Ensure the first floor critical care units submit data to the Intensive Care National Audit and Research Centre (ICNARC) dataset to ensure patient outcomes are benchmarked against similar services nationally.
- Consider increasing the number of dieticians to meet national guidelines.

Outpatients and Diagnostic Imaging:

The trust should:

Outstanding practice and areas for improvement

- Ensure clinics running late are reported as incidents in line with trust policy.
- Ensure clinic 5 has access to a sluice facility.
- Improve signage in the x-ray department informing patients of the dangers of radiation.
- Record ambient room temperatures are recorded in all rooms where medicines are stored.
- Ensure risk registers are fit for purpose and record actions and timescales to mitigate risks.