Care Quality Commission

Epsom and St Helier University Hospitals NHS Trust

St Helier Hospital and Queen Mary's Hospital for Children

Quality Report

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Date of inspection visit: Announced visit 10 and 13 November 2015. We also undertook unannounced visits to the hospital on 21, 23, 25 and 27 November 2015.
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

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

Summary of findings

Renal	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

St Helier Hospital and Queen Mary's Hospital for Children is part of Epsom and St Helier University Hospitals NHS Trust. The trust provides local acute services for people living in the southwest London and northeast Surrey. St Helier Hospital provides acute hospital services to population of around 420,000.

St Helier Hospital and Queen Mary's Hospital for Children is home to the Southwest Thames Renal and Transplantation unit. There is also a Children's Hospital on this site (Queen's Mary's Hospital for Children). All emergency surgery is undertaken at St Helier Hospital and the majority of elective surgery is carried at the trust's other location, Epsom General Hospital.

Epsom and St Helier University Hospitals NHS Trust employs around 5,024.8 whole time equivalent (WTE) members of staff. Many staff work across both sites, so it is not possible to assign an exact number of staff for each site.

We carried out an announced inspection of St Helier Hospital and Queen Mary's Hospital for Children between 10 and 13 November 2015. We also undertook unannounced visits to the hospital on 21, 23, 25 and 27 November 2015.

Overall, this hospital is rated as requires improvement. We found urgent and emergency care, medical care, critical care, maternity and gynaecology, services for children and young people required improvement. Outpatients and diagnostic services, end of life care and renal services were good, however surgery was inadequate.

Overall, we found the safety, effectiveness, caring, responsiveness and well-led all required improvement.

Our key findings were as follows:

Safe

- Staff were encouraged to report incidents, but there was inconsistent feedback and learning from incidents.
- Staff were not always carrying out daily checks of resuscitation equipment in all areas.
- Staff were aware of their responsibilities to protect vulnerable adults and children. They had access to the trusts safeguarding policy, understood safeguarding procedures and knew how to report concerns. However, the children's 'At Risk' register in the ED had not been updated for three months.
- Inadequate nurse staffing levels on some surgical wards and inadequate numbers of midwives meant there was a risk to the quality of patient care. There was also a large number of vacant medical staff posts and high use of locums in paediatrics. However, the hospital had recently undergone a recruitment drive which had enabled it to fill some of its nursing and medical vacancies.
- The environments we inspected were visibly clean. However, the fabric of the St Helier building was reported as difficult to maintain due its age and the trust reported that this was likely to impact on the overall patient experience. This was due to the fact that staff reported difficulties in a range of areas including ensuring the building was hygienically clean; spacing between bed spaces was not in line with nationally recommended standards and a lack of appropriately equipped side rooms and isolation facilities for patients identified as being at risk of acquiring an infection, or whom had developed an healthcare acquired infection.
- The trust recognised that in relation to infection rates, they were performing worse when compared both nationally and to peer hospitals of a similar size. Again, reasons behind the poor infection rates were partly attributed to the fabric of the buildings. We were concerned that, in light of the fact the physical environment was not always fit for purpose, there had not been sufficient focus on staff consistently applying standard, evidence based practice such as decontaminating hands both before and after patient contact; staff not abiding by bare below the elbow policies; staff not applying isolation protocols in a timely way and staff wearing theatre clothing such as scrubs and theatre shoes in communal areas of the hospital such as the public coffee area located on the ground floor of St Helier hospital. Root cause analysis into incidents associated with patients acquiring healthcare-associated infections

included a lack of isolation facilities (side rooms) as a contributing factor to the spread of MRSA in three additional patients during 2014/2015. The NHS estates and facilities dashboard placed the trust in the lower quartile for the percentage of side rooms available and in the lowest (worst) quartile for the amount of functional and suitable space available for the delivery of clinical care.

- The estates critical maintenance backlog was such that, when considering the negative financial performance of the trust for 2015/2016 and the projected budgeted deficit reported for 2016/2017, it was unlikely the trust was going to be able to deliver any significant impact to the backlog which was reported as a risk adjusted backlog of circa £37 million; this placed the trust as having the 16th highest estates backlog nationally and in 3rd position when compared to peer groups across London of a similar size and activity. The trust was in the highest quartile (worst when compared nationally) for the total reported backlog for maintenance.
- Following the inspection, the trust shared additional information of concern with us regarding the structural integrity of some parts of the St Helier campus. Concerns were identified regarding the external render of B and C block and the fact that large sections of render had become loose over time posing a potential risk of falling debris to people passing beneath. The trust had commissioned a range of structural assessments to determine the extent of the issue and to determine immediate remedial actions including the fencing off of certain areas of the estate. We have asked the trust to provide the commission with the necessary assurances and have shared the information with a range of partner regulatory bodies so as to ensure sufficient focus is given to the concerns identified. At the time of publication of this report, we are continuing to monitor the situation and will consider any appropriate regulatory action as we consider necessary.
- The hospital had a mandatory training programme, however in most instances the completion rate was low. Staff spoke of pressures of work, particularly low staffing numbers that prevented them from attending training days.
- Staff accessed the service's clinical guidelines on the Trust's intranet but were not always reviewed and updated. The service contributed to national audits and undertook local audits.

Effective

- National audits that the trust took part in indicated that they adhered to best practice standards as well as or better than the England average, however there was a limited range of evidence for local audits.
- There was a lack of agreed guidelines specific to the critical care unit and multidisciplinary working was not well embedded.
- The hospital took part in national audits in the maternity service but we saw trust wide and not unit-specific data. The use of merged data from both maternity units was unhelpful in terms of monitoring unit performance, because of the difference between the two units in terms of size, culture, activity, staffing and demographics.
- Pain scores were not routinely recorded and patients were not always administered timely pain relief. There was inconsistency in the pain scoring tools staff used to assess patients whilst in the ED.
- Staff we spoke with were clear about their responsibilities in obtaining consent from people, however we saw no evidence of documentation of a 'best interest' decision making process for patients who did not have capacity to consent in some areas.
- We found staff appraisal completion rates were low.
- There was a lack of clarity amongst some staff with regard to how the Deprivation of Liberty Safeguards should be used.

Caring

- Staff treated patients with compassion, dignity and respect. Interactions between staff and patients were professional kind and friendly. Patients were positive about the care and treatment they received.
- Whilst Family and Friend Test feedback was positive, the response rate was notably low.
- In critical care, patients were not always given the opportunity to be involved in their care.
- In most cases, staff involved patients, their carers and family members in decisions about their care.
- Bereaved mothers were sensitively supported by staff in maternity.

Summary of findings

Responsive

- The ED consistently performed at a rate better than the England average in meeting national standard of a doctor seeing 95% of patients within four hours of their arrival for the 12 month period November 2014 to October 2015.
- Patient information and advice leaflets were only available in English.
- Patients living with a learning disability were 'flagged' on the records system. However the department did not use a system for identifying patients living with dementia and there were no care arrangements for meeting their specific needs.
- In surgery, the trust had fallen below the standard for the referral to treatment times (RTT).
- Flow through the maternity wards was poorly organised, and women were not always in the most appropriate wards.
- In outpatients, there was limited audit of patient waiting times for clinics.
- Staff were aware of the complaints policy and told us how most complaints and concerns were resolved locally.
- There was inconsistent feedback and learning from and complaints.

Well-led

- Many staff had worked in the departments for many years. However, some were unaware of the trust's vision of 'Put the Patient First'.
- Governance arrangements in the medical directorate were adequate, and staff commented on very good multidisciplinary teamwork; collaborative care and line management support although a number of staff commented on the disjointed cross site working.
- Positive comments were received from many staff regarding the new senior management.
- The hospital had a number of innovative projects underway, including those relating to patients living with dementia.
- Risks for the service had been identified in various governance meetings and from a series of incidents but there lacked cohesiveness and a trust board understanding of how to address these issues in a timely manner.
- In critical care, the leadership team had struggled to achieve good team dynamics because of behavioural issues from certain staff members and have not been successful in their attempts to manage this. The service had been unable to agree a strategy and an external advisor had been appointed by the trust to assist the critical care workforce in achieving this. The culture on the unit was very hierarchical and challenges were not always welcome.
- In maternity, risks for the service were poorly identified and not managed in a timely way. There was little challenge in governance meetings. The culture was hierarchical and did not involve staff in developing systems. There was a lack of strong leadership or vision and there was not an effective communication route from ward to board.
- In renal, the service was well led with a clear vision and strategy and effective governance and risk management processes. Managers in the service were aware of shortfalls and took steps to addressed them. Staff spoke positively of the leaders and culture within the service.

We saw areas of outstanding practice including:

- The leadership of the outpatients and diagnostic imaging teams was very good with staff inspired to provide an excellent service, with the patient at the centre.
- The diagnostic imaging department worked hard to reduce the patient radiation doses and had presented this work at national and international conferences.
- The OPAL team had clearly had a positive impact in increasing the quality care of the elderly, particularly those living with dementia.

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

Importantly, the trust must:

- Ensure child protection notifications are always up to date.
- Ensure there are adequate numbers of nurses and midwives to deliver safe and quality care.
- Implement agreed guidelines specific to the critical care units.

Summary of findings

- Ensure the management, governance and culture in the critical care units, supports the delivery of high quality care.
- Obtain feedback from patients/relatives in the critical care units, so as to improve the quality of the service.
- Make sure the 'Five steps to safer surgery' checklist is always fully completed for each surgical patient.
- Identify, analyse and manage all risks of harm to women in maternity services
- Ensure identified risks in maternity services are always reflected on the risk register and timely action is taken to manage these risks.
- Improve the care and compassion shown to patients in the medicine, surgical and critical care areas.

In addition the trust should:

- Ensure that the consultant hours in the emergency department meet the RCEM recommendation.
- Ensure staff were not always carry out daily checks of resuscitation equipment in all areas.
- Ensure the children's 'At Risk' register in the ED is kept up to date.
- Ensure that the trust's infection control procedures are complied and theatre staff do not wear theatre gear such a gowns and head covers in public areas.
- Improve staff attendance at mandatory training
- Ensure clinical guidelines on the trust's intranet are always reviewed and updated.
- Ensure there are agreed guidelines specific to the critical care unit and that multidisciplinary working is well embedded.
- In maternity, ensure monitoring data is separated by location.
- Ensure 'best interest' decisions are documented for patients who did not have capacity to consent.
- Ensure staff appraisals are completed as required.
- Ensure all relevant staff are clear about how the Deprivation of Liberty Safeguards should be used.
- In critical care, ensure patients are always given the opportunity to be involved in their care, where appropriate.
- Improve the referral to treatment times in surgery.
- Improve the 31 day cancer waiting times for people waiting from diagnosis to first definitive treatment and the 62 day waiting time for people waiting from urgent GP referral to first definitive treatment.
- Improve the flow of women through the maternity wards and ensure women are cared for in the most appropriate wards.
- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments, the auditing of patient waiting times and the timely and appropriate follow up appointments.
- Improve the cohesiveness of risk management and address them in a timely manner.
- In critical care, ensure good team dynamics and better working relationships amongst staff; an agreed strategy for the unit that includes the critical care workforce across the two sites and that all risks are identified and on the risk register.
- In maternity, ensure risks are properly identified and managed in a timely way, leadership
- Review arrangements for admission of women to maternity wards so that a member of staff can greet women and prevent unauthorised access.
- Ensure policies reflecting national evidence-based guidance are communicated to all staff.
- Ensure staff were able to use the structured communication tool, SBAR (Situation, Background, Assessment, Recommendation), effectively.
- Review the skill mix on the maternity wards.
- Increase the number of sonographers in radiology.
- Ensure that the paediatric emergency department comply with Royal College of Paediatric and Child Health guidelines.
- Ensure the servicing of equipment is undertaken on a regular basis and that broken equipment is removed from clinical areas.
- Ensure pain scores are routinely recorded in the emergency department.
- Improve the response times to complaints in the medical directorate.

Summary of findings

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We have rated the ED as requires improvement. The department was not meeting the Royal College of Emergency medicine (RCEM) recommendation that consultants should provide 16 hours emergency cover seven days per week. The ED was reliant on using bank and agency staff, for the 12 month period April 2014 to March 2015 the ED used an average 29% of bank and agency staff. In the children's ED for the same period an average 25% of bank and agency staff were used. At the time of our inspection, the nursing vacancy rate in the department was 19%. Some of the servicing on equipment was out of date (thermometers) or not working for example ophthalmoscope/otoscope which would be vital to use when assessing head injuries. On resuscitation trolleys daily checks were not being regularly completed, and some of the water used for injections had expired Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They had access to the trusts safeguarding policy, understood safeguarding procedures and knew how to report concerns.However, the children's 'At Risk' register had not been updated for three months. This meant that staff were unable to check if children attending the ED in the last 3 months had previously been entered on to the 'At Risk' register. Pain scores were not routinely recorded and patients were not always administered timely pain relief. There was inconsistency in the pain scoring tools staff used to assess patients whilst in the ED. Multi-disciplinary working was in evident in the ED. Staff we spoke with were clear about their responsibilities in obtaining consent from people, however we saw no evidence of documentation of a 'best interest' decision making process for patients who did not have capacity to consent. The ED consistently performed at a rate better than the England average in meeting national standard of a doctor seeing 95% of patients within four hours of their arrival for the 12 month period November

Summary of findings

2014 to October 2015.During the same period, the number of patients waiting for between four and 12 hours to be admitted to a hospital ward was better than the English average. However, initial assessments of patients did not occur in a timely way. For the 12 month period November 2014 to October 2015 the average time patients waited for an initial assessment was 25 minutes. In the children's ED for the same 12 month period the average waiting time was one hour and 31 minutes for an initial assessment.
Patient information and advice leaflets were only available in English.Patients living with a learning disability were 'flagged' on the records system. However the department did not use a system for identifying patients living with dementia and there were no care arrangements for meeting their specific needs.
Some staff we spoke with had worked in the department for many years. However, staff we spoke with were unaware of the trust vision of 'Put the Patient First'.
Staff treated patients with dignity and respect. Interactions between staff and patients were professional kind and friendly. Patients were positive about the care and treatment they received. They told us that they felt involved in their care. In the A&E survey 2014, the trust scored about the same as other trusts for treating patients with dignity and respect whilst they were in the ED.

Medical care (including older people's care) — **Requires improvement**

We rated medicine as good for being effective and well led; but as requiring improvement for being safe, caring and responsive. We foundmandatory training and staff appraisal completion rates were low; not all patient records were accurate; some wards repeatedly fell below the trust's infection control thresholds' and patients were able to access areas of wards that might compromise their safety. We also found staff were not always carrying out daily checks of resuscitation equipment.
The medical directorate's use of locum staff, both medical and nursing, had consistently been above the trust average. The hospital had recently undergone a recruitment drive which had enabled it to fill some of its nursing and medical vacancies.

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There was a lack of clarity amongst staff with regard to how the Deprivation of Liberty safeguards should be used. Staff generally provided care in a compassionate and kind way that preserved patients' dignity, and said they felt supported by their line managers to provide high quality care. Patients' feedback was largely positive however relatives' comments were less so.
In all but neurology and dermatology, the medical directorate achieved the 18 week referral to treatment thresholds. The average length of stay trust wide was similar to the England average, but longer at St Helier for non-elective geriatric medicine.

Surgery

Inadequate

We have judged surgery services overall as inadequate. Low nurse staffing levels on some wards meant there was a risk to the quality of patient care. The shortage of staff had led to harm for some patients. There was no escalation plan to address staffing shortages as they arose. There was inconsistent feedback and learning from incidents and complaints. Processes to ensure people's safety were not robust or consistent across the service.
Not all staff had received the training they required or had their annual appraisal which meant we could not be assured that staff were competent in their roles.
National audits that the trust took part in indicated that they adhered to best practice standards as well as or better than the England average, however there was a limited range of evidence for local audits.
The majority of patients told us staff were caring, the patient experience survey for April 2015 to April 2015 had an equal amount of positive and negative comments about the care patients had received on surgical wards.
The trust had fallen below the standard for the referral to treatment times (RTT). Bed management meetings did not discuss the patient's needs and staff told us that patients experienced moves to different wards at night.
Risks for the service had been identified in various governance meetings and from a series of incidents

Summary of findings

but significant issues identified were not addressed and action had not been taken. There lacked cohesiveness and a trust board understanding of how to address these issues in a timely manner.

Critical care	**Requires improvement**		We rated the critical care unit as 'requires improvement' overall. Although staff were reporting incidents, there was no system in place to ensure that all staff were learning from incidents. We identified gaps in record keeping and found that intravenous (IV) fluids were not being stored securely. The unit was small and cramped and staff told us this made it difficult to have all the equipment required around the patient bedspace. There was a lack of agreed guidelines specific to the critical care unit and multidisciplinary working was not well embedded. The unit had a larger number of delayed discharges and out of hours discharges compared to similar units and staff in other parts of the hospital reported delays in accessing critical care. Patients were not always given the opportunity to be involved in their care. There was a poor response to patient feedback surveys and the unit did not offer a follow up clinic for patients post discharge. The leadership team had struggled to achieve good team dynamics because of behavioural issues from certain staff members and had not been successful in their attempts to manage this. The service had been unable to agree a strategy and an external advisor had been appointed by the trust to assist the critical care workforce in achieving this. The culture on the unit was very hierarchical and challenges were not always welcome. The unit had good outcomes for patient when compared to similar units and staffing was in line with national guidelines, although agency nurses were used frequently. Staff, including agency, received a good induction and competency based assessment prior to caring for patients independently. Doctors in training received good teaching and support from consultants and patients we spoke with spoke highly of the staff and the care they received on the unit.
Maternity and gynaecology	**Requires improvement**		We judged maternity as requiring improvement. Poor deployment of staff combined with inadequate numbers of midwives meant there was

Summary of findings

a risk to women's care. Processes for addressing staffing shortages were not well planned and did not take account of skill mix. There was inconsistent cascade of learning from incidents and complaints and the service was slow to implement change.
The hospital took part in national audits using trust wide and not unit-specific data.The use of merged data from both maternity units was unhelpful in terms of reflecting unit performance, because of the difference between the two units in terms of size,culture, activity, staffing and demographics. St Helier performed better on normal birth because it had a well-established birth centre, and had fewer instrumental births, but the hospital had much higher caesarean section rates and numbers of mothers smoking during pregnancy.
St Helier carried out a narrow range of audits and did not collect data on all standard indicators and some data was misleadingly reported, such as midwife to birth ratio which was reported on the basis of establishment rather than actual numbers of midwives to care for women.
The majority of patients told us staff were caring.Bereaved women were sensitively supported.
Flow through the maternity wards was poorly organised, and women were not always in the most appropriate wards.Little work had been done to find out what women wanted in their antenatal and postnatal care, and to design the service around their needs. There was no dedicated telephone line or triage for women in labour.
Not all high level risks were reflected on the risk register and action to manage risks was slow. There was little evidence of challenge in governance meetings. The culture was hierarchical and did not involve staff in developing the service.
There was a lack of strong leadership or vision. The communication route from ward to board was not effective.There was a lack of good quality data on many aspects of performance, and audits were not used to drive improvement or monitor change.
The gynaecology service had weaknesses in incident reporting, and a high level of agency staffing leading to poor completion of patient observations and a past record of poor hygiene. Referral to treatment times were not always met.

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Services for children and young people

Requires improvement

We had concerns about staffing levels and the dependency levels of children. Throughout the inspection managers and staff told us they had concerns about staffing levels. We were told the trust had implemented the 'Safer Staffing' model for ensuring there were sufficient staff on duty to meet children's needs and the service met nationally recommended staffing ratios but we found examples of staffing ratios falling below these levels. There was also a large number of vacant medical staff posts and high use of locums to cover for medical staff who were off sick, posts were unfilled or on maternity leave.

There was a system in place for reviewing staffing levels if the dependency levels of children increased but it was not clear if additional staff were always provided when dependency levels increased. Staff recorded observations about children every two hours to monitor their condition. Records showed these observations were being carried out but we also found examples where the system for escalating concerns about a deteriorating child were not being followed.

Child protection notifications from the trust were not up to date. There was a three month backlog in notifying safeguarding concerns. Staff on the ward were unaware of this and there was a risk that staff were not aware that a child was on the child protection register. We did not find any interim processes in place to reduce the risk of a child being treated and discharged without staff realising there were any safeguarding issues.

Uncertainty about the future structure of the trust had contributed to difficulties recruiting and retaining staff resulting in staffing pressures on the ward. Developing a strategy for the service had also been problematic without clarity about the organisation's future. Managers had responded to the uncertainty by developing a five-year business and service strategy.

An executive director provided board level leadership for children's services.

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End of life care

Good

The Specialist Palliative Care (SPCT) team provided end of life care and support six days a week, with on call rota covering out-of-hours. There was visible clinical leadership resulting in a well-developed, motivated team.

Patients told us the ward based staff and the palliative care clinical nurse specialists were caring and compassionate and we saw the service was responsive to patients' needs. The SPCT responded promptly to referrals. There was fast track discharge for patients at the end of life wishing to be at home or their preferred place of death.

Staff throughout the hospital knew how to make referrals to the SPCT and referred people appropriately. The team assessed patients promptly, to meet patient needs. The chaplaincy and bereavement service supported patients' and families' emotional and spiritual needs when people were at the end of life.

Most hospital staff were complimentary about the support they received from the SPCT. Junior doctors particularly appreciated their support and advice, and said they could access the SPCT at any time during the day. They recognised that the SPCT worked hard to ensure that end of life care was well embedded in the trust.

The director of nursing had taken the executive lead role for end of life care, along with a non-executive director (NED), to ensure issues and concerns were raised and highlighted at board level. The trust's board received EOLC reports, outlining progress against key priorities within the EOLC strategy, including audit findings, themes from complaints and incidents, evidence of learning and compliance with end of life training requirements.

The SPCT provided a rapid response to referrals, assessed most patients within one working day. Their services included symptom control and support for patients and families, advise on spiritual and religious needs and fast-track discharge for patients wanting to die at home.

The National Care of the Dying Audit 2013/2014 (NCDAH) demonstrated that the trust had not achieved three out of seven organisational key performance indicators. At the time of the inspection, the trust had not fully rolled out the replacement of the LCP, and this delay meant that

staff were not fully supported to deliver best practice care to patients who were dying. The leadership failed to apply enough urgency to have an individual plan of care in place.

Outpatients and diagnostic imaging

Good

Overall, we found that outpatients and diagnostic imaging were good. The service was rated as good for safety, caring, responsive and well-led. The effective domain was inspected but not rated. Some aspects of the delivery of safe patient care in relation to radiation safety were excellent.
Patients, visitors and staff were kept safe as systems were in place to monitor risk. Staff were encouraged to report incidents and we saw evidence of learning being shared with the staff to improve services. There was a robust process in place to report ionising radiation medical exposure (IR(ME)R) incidents and the correct procedures were followed. The pathology department had a comprehensive quality management system in place with compliance targets set at higher than the national average to improve safety and quality. There was evidence of excellent practice for the monitoring and administering of patient radiation doses to be as low as possible.
The environments we inspected were visibly clean and staff followed infection control procedures. Records were almost always available for clinics and if not, a temporary file was made using available electronic records of the patient. Staff were aware of their responsibilities within adult and children safeguarding practices and good support was available within the hospital.
Nurse staffing levels were appropriate and there were few vacancies. The diagnostic imaging vacancies were higher, particularly ultra sonographers. There was an ongoing recruitment and retention plan in place.
There was evidence of service planning to meet patient need such as the emergency eye service offered Monday to Friday 8.30am to 4.30pm for patients with sight threatening eye conditions, requiring urgent specialist ophthalmic treatment. National waiting times were met for outpatient appointments and access to diagnostic imaging. A higher percentage of patients were seen within two weeks for all cancers than the national average, but

the cancer waiting times for people waiting less than 31 days from diagnosis to first definitive treatment and the proportion of people waiting less than 62 days from urgent GP referral to first definitive treatment were both below the national average.
Staff had good access to evidence based protocols and pathways. There was limited audit of patient waiting times for clinics, but patients received good communication and support during their time in the outpatients and diagnostics departments. Staff followed consent procedures and had a good understanding of the Mental Capacity Act 2005.
We observed and were told that the staff were caring and involved patients, their carers and family members in decisions about their care. There was good support for patients with a learning disability or living with dementia.
Staff were aware of the complaints policy and told us how most complaints and concerns were resolved locally.
The outpatients and diagnostic imaging departments had a local strategy plan in place to improve services and the estates facilities. From December 2015, the current outpatient services that are in Clinical Services Directorate will move to a new Outpatients and Medical Records Division. Staff expressed some concern over these changes.
Governance processes were embedded across outpatients and diagnostics. The directorate was commended on its risk register in a recent review of risk registers in the trust. Senior managers told us the newly appointed quality manager had made significant improvements in making sure priorities, challenges and risks were well understood. Good progress was evident for improving services for patients.
We found good evidence of strong, local leadership and a positive culture of support, teamwork and innovation.

Renal — **Good**

Overall, we found renal services were good. Reviews of care through incident investigation and morbidity and mortality were completed throughout the service and opportunities for

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learning were shared with staff. Infection control practices were robust in all areas. Staffing levels and skill mix were appropriate in all areas across the service with low agency staff usage.
Patient outcomes were in line or exceeded with national standards and effectiveness was regularly assessed and benchmarked. There was effective multidisciplinary working, with specialist nurses and allied health professionals and joint clinics were held with relevant specialties including diabetes. However we noted that standards for vascular access for haemodialysis were not met.
Most patients' spoke positively of the care they received within the hospital, and individual patient needs were met. Delays in transport were noted as a particular concern by patients' and their carers.
The environments in the dialysis units were cramped and in some areas, including at St Helier, facilities for patients were limited.
The service was well led with a clear vision and strategy and effective governance and risk management processes. Managers in the service were aware of shortfalls and took steps to address them. Staff spoke positively of the leaders and culture within the service.

St Helier Hospital and Queen Mary's Hospital for Children

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to St Helier Hospital and Queen Mary's Hospital for Children

St Helier Hospital and Queen Mary's Hospital for Children is one of two registered acute hospital locations of Epsom and St Helier University Hospitals NHS Trust, which we visited during this inspection. The other hospital we visited was Epsom General Hospital.

St Helier Hospital and Queen Mary's Hospital for Children has 621 beds and is in the London Borough of Sutton. The lead clinical commissioning group is Sutton CCG.

Our inspection team

Our inspection team was led by:

Chair: Bill Cunliffe, Retired surgeon

Head of Hospital Inspections: Nick Mulholland, Care Quality Commission (CQC)

The hospital was visited by a team of 60 people, including: CQC inspectors, analysts and a variety of specialists. There were consultants in emergency medicine, medical care, surgery, obstetrics and renal. The team also included nurses with backgrounds in medicine,surgery, critical care, and palliative care. There were also midwives, specialists with board-level experience, a student nurse and two experts by experience.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

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

Detailed findings

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, NHS Trust Development Authority, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospital, including doctors, nurses, allied health professionals, administration and other staff. We also interviewed senior members of staff at the hospital.

Facts and data about St Helier Hospital and Queen Mary's Hospital for Children

Context

- St Helier Hospital and Queen Mary's Hospital for Children is based in Carshalton, South West London and serves a population of 480,000 in the London boroughs of Sutton and Merton. The hospital also provides specialist renal and neonatal intensive care services, to a wider area covering parts of Sussex and Hampshire.
- St Helier Hospital and Queen Mary's Hospital for Children offers a range of local services, including: an emergency department, medicine, surgery, critical care,maternity, paediatric services and outpatient clinics. The hospital is also home to the Southwest Thames Renal and Transplantation unit.
- In the 2011 census, the proportion of residents who classed themselves as white British was 78.6% in Sutton and 64.9% in Merton.
- Sutton ranks 196th out of 326 local authorities for deprivation (with the first being the most deprived). Merton ranks 222nd.

Activity

- The hospital has approximately 641 beds including six critical care beds.
- Many staff work across both sites, so it is not possible to assign an exact number of staff for each site. The workforce was supported by bank/agency staff and locum medical staff between March 2014 to April 2015.
- There were approximately 57,473 inpatient admissions in 2014/15.
- There were approximately 360,877 outpatient appointments between July 2014 to June 2015.
- The emergency department saw 84,814 patients in 2014/15.
- There were 917 deaths at the hospital between April 2014 and May 2015.

Key intelligence indicators

Safety

- Between August 2014 and July 2015 there were 76 serious incidents at St Helier Hospital, two of which was classified as a never event.
- Between August 2014 and July 2015, there were 55 cases of pressure ulcers at St Helier Hospital between.
- Trust wide between August 2014 and July 2015, seven cases of MRSA, 18 of MSSA and 44 C diff cases were reported.
- There were 69 falls and 21 CAUTIs reported to the Patient Safety Thermometer between July 2014 and Jul 2015.

Effective

- HSMR rate is 90.9 trustwide with a rate of 90.3 during theweek and 92.6 at the weekend. St Helier is at 95.9 overall and 93.1 during the week and weekend at 103.7.
- The SHMI for this trust for August 2014 to September 2015 was 98.
- There were no mortality outliers in this trust.

Caring

- The From the CQC inpatient survey 2014, this trust performed about the same as other trusts for 10 of the 12 questions.

Responsive

- Between April 2014 and March 2015, this trust received 523 complaints; 316 of which were related to St Helier Hospital and Queen Mary's Hospital for Children; there are no significant outlying years from 2010/11 to 2014/15.
- Out of 23,843 patients waiting to start treatment at the end of September, 92.1% of patients were not waiting

longer than 18 weeks. Half of patients were waiting lessthan seven weeks and 92 out of a 100 patients werewaiting less than 18 weeks. The trust figures are in linewith England figures.

- Half of patients who had to receive treatment that involved admission to hospital waited 12 weeks before being treated, longer than the England average wait of 9.6 weeks. 19 out of 20 patients started their treatment within 26 weeks, the same as the England average.
- Half of patients who had to receive treatment that did not involve admission to hospital waited nine weeks before treatment started. Patients waited roughly three weeks longer to start treatment than the England average of 6.1 weeks. 19 out of 20 patients waited 23 weeks to begin treatment roughly three to four weeks longer than the England average.
- The trust has met the operational standard for 93 % of cancer patients to wait less than 31 days from diagnosis to first definitive treatment between April 2013 and March 2015 for most quarters of the period. The trust consistently failed to meet the standard for 85% of cancer patients to wait less than 62 days from urgent GP referral to first definitive treatment from quarter four 13/14 to quarter four 14/15.

Well-led

- Staff sickness absence rates in this trust for the period April 2014-May 2015 were 5.7% and there was a turnover rate of 13.8% over the same period.
- Results from the staff survey in 2014 showed that this trust performed better than average for four questions,worse than average for 14 and in the bottom 20% of trusts for three questions. For the remaining eight questions analysed, the trust had a similar performance to other trusts. The response rate in this trust was 39%,which was lower (worse) than the national average.

Inspection history

This is the first comprehensive inspection of St Helier Hospital and Queen Mary's Hospital for Children.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

The emergency department (ED) at St Helier Hospital is open 24 hours a day seven days a week. There is a dedicated children's A & E and Urgent Care Centre (UCC).

The emergency department treat patients who have suffered a serious injury or accident, or who have developed a sudden serious illness or medical condition. Patients with minor injuries or illnesses may be treated in the minors area of the department.

The UCC treats patients with conditions such as broken bones, deep cuts requiring stitches and some illnesses or symptoms that need urgent treatment, such as skin infections or abscesses.

Between April 2014 and March 2015 there were 84,814 attendances in the ED. Around 35% (29,685) of patients were aged 0-16 years old.

Walk-in patients reported to one of three reception cubicles in the reception area where patients could register on arrival. Adult patients would be streamed by a nurse; if they needed to be seen in the ED they would be referred to a RAT consultant or referred to the UCC. Children attending the children's ED would register at the main reception desk and then be directed to follow a trail which was highlighted using an animal foot print which took them to the ED.

Patients who arrived by ambulance utilised a separate entrance and where taken to the resuscitation area or were seen by the rapid assessment and treatment (RAT) team who took a handover from the ambulance crew.

The ED was divided into different areas. The UCC had four consulting rooms and two treatment rooms. The resuscitation area had four trolley bays which included a bay designated for children which had been brightly decorated. In majors, there were ten cubicles including four rooms that could be used to isolate patients and the rapid assessment unit had three bays. The ambulatory ward had five chairs and there was a women's room with en suite shower and toilet, a relative's room and viewing room. The ED also had a designated room for patients who presented with mental health needs. The observation ward had four beds and patients could be admitted for up to 24 hours. It was divided into two areas; each area accommodated two patients of the same gender. There were shower and toilet facilities in each area.

The department had a separate children's ED which was brightly decorated. The department had five trolley bays and one cubicle. The waiting room was also a children's play area with toys and visual stimulus appropriate for young children. One bay in the resuscitation unit was designated for children.

We visited the ED over three days during our announced inspection and returned unannounced during a weekday evening. We observed the care and treatment and looked at 21 patient records. We spoke with 43 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crew. We also spoke with 19 patients and relatives who were using the service at the time of our inspection. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also used information provided by the trust.

Urgent and emergency services

Summary of findings

We have rated the ED as requires improvement.

The department was not meeting the Royal College of Emergency medicine (RCEM) recommendation that consultants should provide 16 hours emergency cover seven days per week. The ED was reliant on using bank (mainly own staff) and agency staff, for the 12 month period April 2014 to March 2015 the ED used an average 29% of bank (mainly own staff) and agency staff. In the children's ED for the same period an average 25% of bank (mainly own staff) and agency staff were used. At the time of our inspection, the nursing vacancy rate in the department was 19%.

Some of the servicing on equipment was out of date (thermometers) or not working for example ophthalmoscope/otoscope which would be vital to use when assessing head injuries. On resuscitation trolleys daily checks were not being regularly completed, and some of the water used for injections had expired

Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They had access to the trusts safeguarding policy, understood safeguarding procedures and knew how to report concerns.However, the children's 'At Risk' register had not been updated for three months. This meant that staff were unable to check if children attending the ED in the last 3 months had previously been entered on to the 'At Risk' register.

Pain scores were not routinely recorded and patients were not always administered timely pain relief. There was inconsistency in the pain scoring tools staff used to assess patients whilst in the ED.

Multi-disciplinary working was in evident in the ED. Staff we spoke with were clear about their responsibilities in obtaining consent from people, however we saw no evidence of documentation of a 'best interest' decision making process for patients who did not have capacity to consent.

The ED consistently performed at a rate better than the England average in meeting national standard of a doctor seeing 95% of patients within four hours of their arrival for the 12 month period November 2014 to October 2015. During the same period, the number of patients waiting for between four and 12 hours to be admitted to a hospital ward was better than the English average. However, initial assessments of patients did not occur in a timely way. For the 12 month period November 2014 to October 2015 the average time patients waited for an initial assessment was 25 minutes. In the children's ED for the same 12 month period the average waiting time was one hour and 31 minutes for an initial assessment.

Patient information and advice leaflets were only available in English.Patients living with a learning disability were 'flagged' on the records system. However the department did not use a system for identifying patients living with dementia and there were no care arrangements for meeting their specific needs.

Some staff we spoke with had worked in the department for many years. However, staff we spoke with were unaware of the trust vision of 'Put the Patient First'.

Staff treated patients with dignity and respect. Interactions between staff and patients were professional kind and friendly. Patients were positive about the care and treatment they received. They told us that they felt involved in their care. In the A&E survey 2014, the trust scored about the same as other trusts for treating patients with dignity and respect whilst they were in the ED.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

The department was not meeting the Royal College of Emergency medicine (RCEM) recommendation that consultants should provide 16 hours emergency cover seven days per week. Emergency medicine consultants on duty in the department Monday to Friday from 8am until 10.45pm on weekdays and there was a minimum of eight hours daytime cover at weekends. 'On call' cover was available outside theses hours, seven days per week.Initial assessments of patients did not always occur in a timely way.

At the time of our inspection the nursing vacancy rate in the department was 19%. The ED was reliant on using bank (mainly own staff) and agency staff, for the 12 month period April 2014 to March 2015 the ED used an average 29% of bank (mainly own staff) and agency staff. In the children's ED for the same period an average 25% of bank (mainly own staff) and agency staff were used.

Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They had access to the trusts safeguarding policy, understood safeguarding procedures and knew how to report concerns.However, the children's 'At Risk' register had not been updated for three months. This meant that staff were unable to check if children attending the ED in the last 3 months had previously been entered on to the 'At Risk' register.

Some of the servicing on equipment was out of date (thermometers) or not working for example ophthalmoscope/otoscope, which would be vital to use when assessing head injuries. On resuscitation trolleys, daily checks were not being regularly completed, and some of the water used for injections had expired.

Incidents

- There were no never events reported between August 2014 and July 2015 at St Helier's ED. Never Events are 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.However, the ED reported a serious incident on 6th October 2015 which was being investigated and due for submission by 31 December 2015.
- For the period May 2015 – August 2015, there were 243 adverse incidents reported in the ED. The largest number of incidents recorded (108) related to patients coming into the ED with pressure ulcers, followed by medical devices (14), security (13) and medication errors (10). Minutes of ED clinical governance meetings demonstrated that trends were being monitored and lessons learnt were identified and circulated to staff.
- Nursing staff told us that they would report incidents and would receive feedback via email or through their weekly Friday morning meetings. Staff told us pressure ulcers were the most common incident reported. The trust reported all pressure ulcers even if they were not hospital acquired. We saw that the ED's quarterly newsletter in October listed the top five incidents reported through the ED as pressure ulcers, care and treatment, communication issues, staffing issues and security incidents.
- We observed that at the end of the medical handover, incidents from the previous day were discussed and used as a learning opportunity. There was also learning from incidents across site. Junior doctors reported that serious incidents that occurred at Epsom General Hospital were also discussed and used as a learning opportunity.
- The trust advised that the adult ED's mortality and morbidity was discussed as part of clinical governance meeting for the medicine directorate. We looked at minutes of the medicine directorate governance/risk committee meetings and the ED clinical governance minutes for St Helier's and found that the morality and mobility was not recorded in the minutes. This meant that the hospital was not able to demonstrate that they reviewed the care of patients who had complications or an unexpected outcome.
- Paediatric mortality and morbidity meetings included the children's ED and reviewed the care of patients who had complications or unexpected outcomes. Minutes of these meeting demonstrated that key leaning points and actions were identified to inform future practice.

Duty of Candour

- Information received from the trust indicates there were four incidents in the St Helier's ED between November 2014 to September 2015 dealt with under the duty of candour.One of the investigations had been competed; but the trust were unable to clarify if verbal communication had been given to the family and the

information received did not clarify if the family had be written to. Three investigations were pending; all the incidents had been rated as moderate in terms of severity. A root cause analysis (RCA) was currently being undertaken for one incident, having received an expert opinion. The outcome of an RCA comprehensive report was pending to determine the severity of another. For the third incident, following an initial report, the incident had been up graded to serious and an RCA comprehensive inspection was being undertaken following discussions with the family. In two of these three incidents, the trust indicated they had written to the relatives.

- We asked staff about their understanding of the regulations concerning duty of candour. Staff we spoke with were not able to demonstrate an understanding of duty of candour.

Cleanliness, infection control and hygiene

- The ED was visibly clean and tidy. We observed support staff cleaning the department throughout the day.
- Personnel protective equipment (PPE) such as disposable aprons and gloves, hard washing facilities and hand cleaning gel were available throughout the department.
- There was prominent signage reminding people of the importance of hand washing over hand basins. We observed that staff generally washed their hands in line with the World Health Organisations guidance "Five moments of Hand Hygiene. We saw hand hygiene audits had been undertaken in June, September and October 2015. These showed that there were concerns, but these were being addressed with the staff concerned. We observed hand hygiene was variable and nursing staff generally washed their hands before and after interventions with patients. However we observed one incident of nurse staff not washing their hand between treating patients and another incident where a doctor, who had been writing notes and examining the patient, did not wash their hands before a procedure of the insertion of a urinary catheter. However, we noted they washed their hands immediately following the procedure.
- In clinical areas, clinical and infectious waste was appropriately segregated and there were arrangements for their separation. We observed that staff complied with these arrangements.
- Disposable curtains were used between bed spaces and were labelled with the date they were put up (October 2015 and date to be renewed February 2016). The labels on the curtains indicated that the curtains would be changed within 6 months from the date they were put up.
- We found the sluice areas were generally clean. There was a daily commode cleaning check list in place; however, we noted that this had not been signed off for the previous day and found that one of the commodes had not been cleaned properly.
- We observed sharps management generally complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use. However, we found that in the majority of clinical areas, they were not closed appropriately following use or available in different parts of the department.
- In the A&E survey 2014 the trust scored about the same as other trusts (8.8) for how clean was the A&E department. This was for both St Helier's and Epsom General Hospital.
- In the National Cleanliness Audit for October 2015 the department scored 99% and in the Patient Led Assessment of the Care Environment (PLACE) 2015, the department scored 96% for cleanliness.
- Infection and Prevention Control training formed part of the mandatory training programme that was updated yearly. In the ED, 95% of staff had completed training in infection control.

Environment and equipment

- Environment and cleaning audits of the ED was undertaken monthly. We looked at six audits for the period May 2015 to November 2015 which showed that the department was scoring 99% on a monthly basis. Action points were identified for each of the audits but had not been signed off as having been completed before the next audit. Cleaning staff and senior nursing staff we spoke with were not aware that cleaning audits were undertaken.
- The Estates and Facilities directorate undertook a 'walk about' of the ED in October 2015. They had identified 50 action points to be completed none of which had been completed.
- The adult waiting area was clean with sufficient seating. The physical environment of the ED did not enhance

patient safety; the layout of the department was 'cramped' with narrow corridors especially in majors. We found it was not easy to navigate the department and would be difficult for locum/agency staff, who were not familiar with the department. The nurse in charge of the whole ED did not have sight of all the bays in majors from where they were stationed or other areas of department and was reliant on staff to update them. A senior nurse told us it was difficult for the nurse in charge to have an oversight of the whole department (UCC, majors, CDU, observation bay and streaming), because of the layout of the department. Nursing staff advised us that they would try to restrict the use of the bay closest to the nurse's station to protect patient confidentiality. The doctors work station in the ED was located in majors separate from the nurses station which hindered communication.

- The ED was divided in different areas. The UCC had four consulting rooms and two treatment rooms. The resuscitation area had four trolley bays which included a bay designated for children which had been brightly decorated. In majors, there were ten cubicles including four rooms that could be used to isolate patients and the rapid assessment unit had three bays. The ambulatory ward had five chairs and there was a women's room with en-suite shower and toilet a relative's room and viewing room. The ED also had a designated room for patients who presented with mental health needs. This room could be secured to protect the patient and staff from harm. The room had two exit doors which were alarmed and no ligature points.
- The observation ward had four beds and patients could be admitted for up to 24 hours. It was divided into two areas; each area accommodated two patients of the same gender. There were shower and toilet facilities in each area.
- The department had a separate children's ED which was brightly decorated. The department had five trolley bays and one cubicle. The waiting room was also a children's play area with toys and visual stimuli appropriate for young children. One bay in the resuscitation unit was designated for children. The department was small and congested, given the large number of children attending.
- The ED were able to isolate three treatment rooms in the UCC which could be utilised in the event of a patient presenting with a highly infectious disease such as Ebola. The treatment rooms all had connecting doors which meant rooms could be designated for putting on or removal of protective clothing. There was also a designated decontamination room which was separate and some distance from the treatment rooms. The decontamination room could be accessed from outside the ED. It contained a leaking shower and smelt of damp. At the time of the inspection, this room was being used as a store room for a hoist. Staff advised that lack of storage in the ED was an issue.
- There was adequate resuscitation and medical equipment in the adult ED. Each bay within the resuscitation area was designated and configured in the same way, which allowed staff working in the area to be familiar with the layout which contributed to improved efficiency during trauma and resuscitation events. We looked at the resuscitation trolleys across the ED and found they were clean, but daily checks were not being completed regularly.
- In the children's ED, there was an unlocked trolley with a check list stating 'crash trolley' for weekly checking. The trolley had airway and blood sample equipment; we were later advised the trolley was just used for airways. This could be confusing to agency staff if the use of the trolley was not clear. The main children's resuscitation trolley was in the resuscitation area. We looked at the children's resuscitation trolley and found that whilst daily checks were being undertaken there appeared to be two systems in place. Some of the equipment was out of date and some of the water used for injections had expired (2014).
- We saw Electrical Medical Equipment (EME) had a registration label and Portable Appliance Testing (PAT) labels were attached to electrical systems showing that they had been inspected. We found some of the servicing on equipment was out of date (thermometers) or not working, for example ophthalmoscope/otoscope, which would be vital to use when assessing head injuries.
- The ED restricted unauthorised access and there was the facility to 'lock down' the department to isolate it in the event of an untoward incident.
- In the department scored 89% for the condition, appearance and maintenance in the Patient Led Assessments of the Care Environment (PLACE) 2015.

Urgent and emergency services

Medicines

- Medicines and intravenous fluids were stored in locked cupboards and fridges. The keys were held by the nurse in charge.
- We observed IV medication being prepared in a clean environment and double checked by two nurses.
- Patient's allergy status, prescription charts and medicine administration records were completed in the 21 patient records we looked at.
- Controlled drugs (CD) were stored securely. In the resuscitation and clean utility, we found there were several gaps in the recording of daily checks. The CD register was completed with two signatures for each drug that was administered.
- On the observation ward, we found 1% lidocaine was mixed with normal saline on the resuscitation trolleythatwas out of date. This was not on the resuscitation check list and staff we spoke with was unsure why it was there.
- We found some paediatric emergency medicines were out of date. The contents of the paediatric emergency resuscitation trolley were sealed in drawers which did not have an external expiry date. As this was not routinely checked, there was no way for staff to be assured that the contents were in date.
- Some of the contents of an 'anaphylaxis box' kept in the emergency department were out of date. The 'anaphylaxis box' which also contained medicines such as rectal diazepam for use in an emergency also had no external expiry date or regular check record.

Records

- A paper record was generated by reception staff (known as a 'cas' card) registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- Patients were registered on the ED's electronic computerised system "Whiteboard" whichwasintroduced about a year ago. The system tracked the patient's journey through the department and flagged the time patients spent in the department to ensure that most patients met the four hour target to admit, discharge or transfer. Patient records detailed the time when the patient was first registered on the system, when patients were triaged, seen by a clinician, diagnosed and when a decision was taken to admit. We observed that this was not updated in real time. Reception staff told us 'Whiteboard' was designed to be completed contemporaneously but was often completed retrospectively when staff were busy. Reception staff said the electronic 'Whiteboard' records were compared to paper records on a daily basis to make sure information about patient progress and time in the department were accurate. Reception staff said they could see the advantage of using 'Whiteboard' if it was "used properly and completed at the times things happened"; but currently it was a burden producing and checking duplicated information.
- In addition, we observed an actual (physical) whiteboard in use in the ED for staff to monitor the patients in the department and their breach avoidance target. At handover, we observed that medical staff would refer to this rather than the computerised system as this had been kept up to date.
- We looked at 21 sets of patient records which included 11 paediatric patients and four patients in the observation ward. Records showed that the patients had been streamed or had an initial assessment. National Early Warning Scores (NEWS), Paediatric Early Warning Scores (PEWS) and pain scores were recorded when required however, the recording of patient's allergies was not consistent. We were found the records were clear and easy to follow.
- Risk assessments should be completed within six hours of admission. On the observation ward where patients can stay for up to 24 hours, we found that only two risk assessments for pressure ulcers had been undertaken. Risk assessments for falls, manual handling and nutrition had not been completed. All the patients whose records we looked at had been on the observation ward for more than six hours.
- Staff must complete Information Governance (IG) training once within each financial year and compliance starts at 0% as at April and builds through the year until the following March to achieve the trust target of 100%. Since April 2015, 72.3% of staff had completed IG training.

Safeguarding

- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They had access to the trusts safeguarding policy, understood safeguarding procedures and how to report concerns.

We also saw that staff used the trusts electronic system for reporting incidents to report safeguarding concerns across the ED. Staff advised that they would receive follow up emails.

- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral. We were given examples of concerns they had identified and referrals made.
- The children's 'At Risk' register had not been updated for three months. This meant that staff were unable to check if children attending the ED within this period had previously been entered on to the 'At Risk' register. Senior managers advised that they were aware and had placed this on the trust wide risk register. When speaking with senior managers responsible for the ED, they were not able to tell us what actions had been taken to address this.
- In the children's ED, there was a trust wide safeguarding children newsletter on the notice board for all staff with key information to raise awareness and provide information on training.
- The children's ED held weekly safeguarding meetings which were attended by an ED paediatric consultant, clinical nurse specialist, a representative from the local authority multi-agency safeguarding team and the ED safeguarding administrator. Minutes demonstrated that concerns were discussed, actions were identified and outcomes were recorded.
- Safeguarding training was part of the mandatory training programme that staff and different levels of training were provided according to the job role. The trusts target was 95% of staff having completed the training. For safeguarding adults, 95% of staff had completed training and for safeguarding children, 87% of staff had completed level one, 85% had completed level 2 and 82% had completed level 3. Reception staff told us they attended training in safeguarding children at level one.

Mandatory training

- The trust wide target for completion of mandatory training was 95%. In the ED 85% of staff had completed all mandatory training. The training included blood transfusion, which 83% of staff had completed, infection control which 81% of staff had completed and manual handling (two yearly) which 83% of staff had completed. However for venous thromboembolism(VTE) training, only 52% of staff had completed this training. The trust was unable to provide the details of the percentage of medical staff and nursing staff that had completed this training.
- Staff had also received training in health and safety/risk management and fire training with 81% of staff in the ED had completed the training.
- Staff were required to undertake basic life support (BLS) training annually, 83% of staff in the ED had completed the training.
- Across the trust a total of 86 staff had completed advance life support (ALS), 25 staff had completed advance paediatric life support (APLS) and ten staff had completed advance trauma life support (ATLS).
- Staff we spoke with had either completed their mandatory training or were in the process of completing it. Staff told us that they had adequate study leave to complete the training.

Assessing and responding to patient risk

- From November 2014 to October 2015, St Helier's ED did not always meet the 60 minute to treatment target. The median time to treatment of adults in the ED was one hour and 25 minutes. For adults attending the UCC the median time to treatment was one hour and 12 minutes. In the children's ED, the median time to treatment was one hour and 35 minutes. For children attending the UCC, the median time to treatment was one hour and twenty seven minutes.
- St Helier's ED did not always meet the 15 minute to initial assessment target for patients arriving by ambulance. From November 2014 to October 2015 for adults attending the ED the median time to initial assessment was 19 minutes. The target of 15 minutes was met in November and December 2014 and March 2015. In the children's ED, the median time to initial assessment was 29 minutes. The target of 15 minutes was only met in July 2015.
- Patients walking into the ED were initially registered to be seen by a nurse who carried out an initial assessment (streaming). Patients were either directed to be seen in the UCC by an emergency nurse practitioner or the consultant/GP that provided a front door rapid assessment and treat (RAT) for admission into the ED. There were condition specific guidance in place for what conditions should be treated in the UCC and ED.
- Children attending the ED were registered at reception and directed through to the Children's ED; and were not

seen by the streaming nurse. The department received the booking information from the receptionist and prioritise triage accordingly. Reception staff asked for presenting symptoms and if they had concerns about a child they called the children's ED. Reception staff had not received any specific training to ensure that high risk patients were seen more quickly and reliedon their experience and knowing triggers,for examplechest pain or fainting.

- The ED had two RAT processes in place, one for patients who walked into the departmentan anotherfor patients arriving by ambulance. Patients arriving by ambulance would be seen by a member of the RAT team who took a handover from the ambulance crew. Based on the information, received a decision was made regarding which part of the department the patient would be treated. An initial assessment was undertaken which included the assessment of deteriorating patients using NEWS. Patients with NEWS of seven or above would be accessed for admission to the resuscitation unit.
- There was no RAT process in place for the Children's ED. Children arriving at the ED by ambulance were taken straight to the resuscitation unit for assessment.
- Between November 2014 to October 2015 there were 79 black ambulance breaches. A black breach is when an ambulance has to wait over one hour to admit a patient to the ED. The trust reported that the highest number of breaches occurred in December 2014 (29), August 2015 (13) and September 2015 (16). There was a three month period from May to July 2015 when no black breaches were recorded. An ambulance crew reported that it was not uncommon for ambulance crews to be waiting 30 minutes to hand over patients.
- The number of patients waiting for between four and 12 hours to be admitted to a hospital ward from the ED for the period November 2014 to October 2015 was better than the English average and below 5% except for the winter period of December 2014 to February 2015.
- The percentage of patients who left the department before being seen has been recognised by the department of health as being an indicator that patients are dissatisfied with the length of time that have to wait to be seen. During the period November 2014 to October 2015 between 2.0% and 4.1% of patients left the ED without being seen compared to 0.2% and 3% nationally.

Nursing staffing

- The ED had planned staffing ratios. The resuscitation unit had two registered nurses which could take a maximum of four patients (1:2); this had recently been increased and the posts were being recruited to. The baseline nurse levels varied across the week and included the resuscitation unit with 11 nurses working in the department Saturday to Tuesday during the day, increasing to 12 nurses in the afternoon and into the evening. From Wednesdays to Fridays there are 10 nurses working in the department in the morning increasing to 11 in the afternoon through to the evening. At night across the week, nine nurses were on duty. In majors staffing levels were either 1:5 or 1:6 which meant that the department was not meeting the Royal College of Nursing (RCN) baseline emergency staff tool (BEST) for staffing levels for part of the week.
- The Nurse in Charge (NIC) was based in majors and was responsible of the running of the ED; their post was not supernumerary and was included in the staffing establishment.
- During our inspection we saw that the ED was very busy and that staff were deployed in relation to their skills and experience to ensure that the different areas of the ED were always staffed safely. For example, where there were gaps in staffing, nursing staff were brought in from another part of the hospital would cover the observation ward to support the department or an ENP would be moved from the UCC to cover the ED.
- The nursing vacancy rate in the department at the time of our inspection was 19%. Senior nursing staff advised that they were in the process of recruiting and four nurses would be joining the department who were currently working at the hospital.
- The ED was reliant on using bank (mainly own staff) and agency staff. When we visited the department there were four bank and agency nursing staff on duty. One agency member of staff we spoke with informed us that they had been covering regular shifts three to four times per week over the last year. When agency staff were used we found there were no robust arrangements for ED staff to be assured of the competency of staff working for agencies and there were no systems for this to be checked. ED staff were reliant on the agency staff being clear about their levels of competency and skill. This presented a risk that agency staff might perform tasks which they did not have the requisite skills and knowledge.

- Between April 2014 and March 2015 the ED used an average 29% of bank (mainly own staff) and agency staff. Staff reported staffing was a problem and that some agency nurses were not ED trained.
- Healthcare assistants (HCA) supported the nurses in the ED. HCA levels varied across the week with three HCAs working in the department Saturday to Tuesday during the day, decreasing to two HCA in the afternoon and into the evening. From Wednesdays to Fridays, there were two HCA's working in the department covering the shifts 24 hours per day.
- In the children's ED, staffing levels complied with the Royal College of Paediatrics and Children's Health (RCPCH) Nursing by having a minimum of two children's nurses in the ED 24 hours a day seven days per week. All nursing staff were registered children's nurses.
- Between April 2014 and March 2015 the children's ED used an average 25% of bank (mainly own staff) and agency staff. Staff advised that shifts were generally covered by their own staff or regular agency staff who were registered children's nurses with ED experience.
- Handovers were twice daily at 7.45am and 7.45pm led in both ED's by the nurse in charge in the location. We observed two nursing handovers and found staff had the opportunity to ask questions and clarify plans and that relevant information regarding the care and management of patients was communicated. No medical staff attended the nursing handover.
- The UCC had a separate emergency nurse practitioner rota with ENPs providing cover from 8am to 10pm seven days per week.

Medical staffing

- There were emergency medicine consultants on duty in the department Monday to Friday from 8.00 am until 10.45pm on weekdays and there was a minimum of eight hours daytime cover at weekends. 'On-call' cover was available outside these hours seven days per week. The ED was not meeting the Royal College of Emergency medicine (RCEM) recommendation that consultants should provide 16 hours emergency cover seven days per week. The trust advised funding had been identified to increase consultant numbers to 20 to ensure 16 hours emergency cover, seven days per week.
- During the day, the rapid assessment shift between 12 noon to 8pm was usually covered by a consultant seven days per week and GP's worked in the UCC 8am to 7pm Monday to Friday. Middle grade doctors covered shifts 24 hours seven days per week. The night shift from 10pm to 8.15am was covered by one registrar, one F2 and one ACCS/GPVTS.
- In the children's ED, there was a separate paediatric rota with emergency paediatric consultant cover from 8am until 10pm Monday to Friday, 1pm until 10pm Saturday and Sunday. Paediatric consultants from the Queen Mary's Hospital for Children provided cover from 8am to 1pm Saturday and Sunday. There was registrar and FY2 cover from 8am to 10pm seven days per week.
- Physician associates covered the observation ward from 8am to 8pm seven days per week and were supervised by the consultant who undertook the morning ward round.
- There were consultant led board rounds four times per day at 8am, 12 noon, 4pm and 10pm. We observed one handover and found that all patient management plans and treatment options were discussed; this was also a teaching opportunity for junior doctors. At the end of the hand over, their cases from the previous day and learning from incidents were discussed. The NIC also attended the doctor's board round.
- Between April 2014 and March 2015, the ED used an average 17.6% of locum doctors and consultants to cover the department.

Major incident awareness and training

- The trust had a Major Incident Plan dated October 2014 with an expiry dateof November 2015. The plan was due for review in October 2015. The ED also had an action card for ED doctors. We observed that the document was not dated and had no review date.
- Across the trust, a total of 28 staff had completed Chemical Biological Radiological and Nuclear training (CBRN) and three staff had completed hazardous material training (HAZMAT).
- Decontamination equipment was available to deal with casualties contaminated with chemical, biological or radiological material or hazardous materials and items. In the major incident store we found that some grab bags had labels highlighting what equipment needed to be added, which weredated September 2015. There were three storage boxes on the top shelf labelled 'out of date equipment do not use' and a box of chest drains which were out of date had a note on it saying 'on order'.
- Staff reported they received annual major incidents training which included children's CBRN.

Urgent and emergency services

Security

- We visited the security staff office and spoke with two members of the team. Security staff working in the hospital was provided under contract form a commercial company and were present in the hospital 24 hours a day. Security staff told us they made "fairly regular checks" on the ED during their patrols, but did not have a specific agreement for frequency of patrol in the ED. They were on call if the department required assistance. Security staff held Security Industry Authority (SIA) licences for 'manned guarding', 'door supervision' or 'security guard' (SIA is the organisation responsible for regulating the private security industry in the UK). Staff told us they had quarterly training updates from the company employing them and also had additional training provided by the trust; for example, dementia, information governance and safeguarding training.
- CCTV was in use in some of the publicly accessible and high risk areas in the department such as corridors and waiting rooms. Patient areas were not subject to surveillance.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

The ED had an audit programme in place for 2015/2016 which contributed to the Royal College of Emergency Medicine (RCEM) national audit programme. This showed the trust was engaged in auditing the effectiveness of the care they provided and provided a bench mark in the ED's performance against best practice.

The children and adult ED's guidelines were available on the trust intranet; not all the guidelines had been updated by the review date. In the children's ED, hard copies of guidelines were available for staff; however we found that the guidelines that were printed off were not the latest edition.

Pain scores were not routinely recorded and patients were not always administered timely pain relief. There was inconsistency in the pains scoring tools staff used to assess patients whilst in the ED.

Multi- disciplinary working was in evident in the ED. Staff we spoke with were clear about their responsibilities in obtaining consent from people, however we saw no evidence of documentation of a 'best interest' decision making process for patients who did not have capacity to consent.

Evidence-based care and treatment

- There was an ED audit programme for 2015/2016 which we saw with anticipated completion dates for December 2015 and January 2016. Sixteen audits were identified to be carried out in 2014/15, two of which were national audits which we saw had been completed. This showed that the trust were engaged in auditing the effectiveness of the care they provided. Junior doctors were expected to undertake one audit per rotation as part of their ongoing training and development.
- The children and adult ED's guidelines were available on the trust intranet; not all the guidelines had been updated by the review date. Senior staff advised they reflected best practice, however we found that they did not reference the national guidelines of professional bodies; the Royal College of Nursing & Midwifery (RCN), the RCEM and the National Institute for Health and Care Excellence (NICE). Adherence to clinical guidelines was encouraged through the development of illness specific algorithms for the management of sepsis, stroke and TIA and low risk acute coronary syndrome.
- We observed the trust guidelines in use for Pulmonary Embolism, Sickle Cell and Acute Coronary Syndrome, were out of date and had been due for review in 2011; this may mean that treatment guidelines may not reflect current best practice.
- We saw that guidelines were available in the children's ED for bronchiolitis dated 2015; and were were told that the pathway for bronchiolitis is dated July 2015. Other guidelines used in the department included guidelines for self-harm which were due for renewal in 2014.
- In the children's ED, hard copies of guidelines were available for staff, however we found that the guidelines that were printed off were not the latest edition. There was no warning to staff that printed copies might not be the most current or evidence of a watermark stating "Not controlled if printed". This meant that there was no control to provide assurance that the guidelines were current and presented the risk that staff may have used out of date guidelines in the care and treatment of patients.

- Patients with a diagnosis of a suspected stroke would be transferred to the hyper-acute stroke unit (HASU) at St George's Hospital for treatment.

Pain relief

- There were guidelines in place administering analgesia in the ED. The guidelines had been developed to provide guidance on the type of analgesia and frequency of re-evaluation of pain in accordance with the patients pain score.
- Adult patients who arrived by foot were seen by the streaming nurse. We observed that patients were asked if they had taken any form of analgesia and the time they had taken it. If patients required further analgesia this was offered.
- Signs were on display in the main waiting area that encouraged patients to ask for pain relief if they needed it while they were waiting.
- Pain scores were not routinely recorded; records showed that pain scores were not recorded for adults in five out of 14 records and in three children's records. For example, one record showed the initial assessment was recorded before the documented time of arrival and that a patient had been admitted at 10.49am, the initial assessment was documented at 10.43am. Pain relief had been given to the patient at 10.15am by the ambulance crew. No further pain relief was documented until 2.20pm. No pain score was documented. The patient was admitted to the observation ward for pain management.
- Relatives we spoke with informed us that the patient had been given pain relief on arrival but the patient was not reassessed until two hours later by a doctor.
- There was inconsistency in the records which referred to a pain score of 0 – 4 and we observed staffing asking patients on a scale of 1 to 10. Age appropriate tools were in used for children and there was specific pain tools to assess patients with a cognitive impairment.
- The ED had guidelines for analgesia; the guidance did not cover children andpatients under palliative care.
- In the children's ED, patient group directives (PGD) were in place for paracetamol and ibuprofen, which meant that nursing staff were able to administer analgesia.
- The trust scored about the same as other trusts in the A&E survey (2014) for patients had to wait for medicine after they requested it and patients feeling that hospital staff did everything they could to help control their pain.

Nutrition and hydration

- The ED had a supply of fresh sandwiches and hot drinks that they could offer patients. There were also two water fountains in different parts of the department.
- On the observation ward the meal service was like other wards in the hospital with patients able to choose from a menu that provides a range of meal options that included vegetarian and soft meals.
- The ED did not have set times for patients to be offered food or drink, but would offer patients food and drink on an ad-hoc basis dependant on the time they had spent in the department. The ED nurses were responsible for offering patients food and drink, one nurse we spoke with advised patients would be offered sandwiches or drinks 'if they had time.'
- We asked eight patients if they had received food and drinks whilst they were in the department, only three patients had. The patients advised that they had to ask for sandwiches and drinks. One patient we spoke with advised it had been a while since they had drink. They had been in the department for over 6hrs and were waiting for patient transport to take them home.
- In the A&E survey 2014 the trust scored about the same as other trusts for patients being able to get suitable food and drinks when they were in the A&E department.

Patient outcomes

- The ED had an audit programme in place for 2015/2016 which contributed to the RCEM national audit programme. These included VTE risk in the lower limb immobilisation in plaster cast, vital signs in children, and procedural sedation in adults. The audits provided a bench mark in the ED's performance against best practice
- In the 2014/15 RCEM audit of the management of mental health in the emergency department, St Helier's ED performance was below the RCEM key indicator requirements.The fundamental standard for 100% of patients to of had a risk assessment and for this to be recorded in the patient's clinical record was onlymet in 68% of cases. The standard of 100% of patients being assessed with one hour by a mental health practitioner was met in only 5% of cases.
- In the 2014/15 RCEM audit of older people records, St Helier ED performed lower than the RCEM key indicator requirements. The fundamental standard for 100% of patients over the age of 75 having an early warning

score documented was only met in 1% of all cases. The standard for 100% of patients over the age of 75 having a cognitive assessment undertaken was only documented in 31% of patients.

- In the 2013/14 RCEM audit of severe sepsis and septic shock, St Helier ED performed lower than the RCEM key indicator requirements. The requirement that 50% of patients were administered antibiotics in the ED within one hour was not achieved as the department only provided this in 34% of cases. The RCEM standard for 75% of patients receiving the first intravenous crystalloid fluid bolus within one hour of being in the ED was only met in 66% of cases. %.
- In the 2013 RCEM audit for consultant sign off, the trust performed worse than the national average with 5% of patients being seen by a consultant and 38% of patients being seen by a senior doctor at St Helier ED. The audit looked at three patient groups, adults with non-traumatic chest pain, febrile children less than one year old and patients making an unscheduled return with the same condition within 72 hours of discharge.
- During the period Jan 2013 to May 2015, the standardised relative risk for unplanned re- attendance rate to the A&E within 7 days was 7.5% which was similar to the national average but above the standard of 5%.

Competent staff

- Staff told us they participated in the appraisal process. The trust reported that 85.9% of non-medical staff across both ED's had an appraisal which was less than the trusts target of 90%.
- Staff attended training which was recorded on a central electronic training record called WIRED.
- In the children's ED staff had access to a practice development nurse. There was also a preceptorship offered to newly registered nurses to continue professional development, and develop competence to practice.
- Staff advised there was no formal process for 121's or clinical supervision. Nursing staff felt they would benefit from a practice educator being available in the ED. Staff were able to access training via e-learning.
- New staff to the department described a good induction process which included them being supernumerary for the first two weeks so they familiarise themselves with the department.
- Nursing staff reported that they felt supported by colleagues and senior staff.
- Junior doctors and registrars reported that they had regular teaching each Wednesday. The liaison mental health team also had input into junior doctors training
- Medical staff reported good working relationships with other staff and felt supported by consultants and felt able to go to them for help if necessary.

Multidisciplinary working

- There was effective multidisciplinary working in the ED. This included effective working relationships with specialty doctors, nurses and GP's
- We observed staff from the 'swoop' team (this was not an acronym, but a descriptive name for a rapid response team) assessing patients in the observation ward to support early discharge. We saw risk balanced discharge forms completed by the 'swoop' team recording detailed assessment of patients' needs to support a discharge home. The 'swoop' team were a community services (Royal Marsden Community / SMCS) team supporting admission avoidance and early discharge.
- The mental health liaison team worked under a service level agreement from South West London St Georges Mental Health Trust. The team consisted of a consultant, doctor, two nurses and administrator who were available on site between 9am and 5pm, Monday to Friday. An on call psychiatrist was available on site out of hours and weekends. There was also an on call home treatment nurse based at the hospital from 11.00pm to 9.00am who supported assessments in the ED. The target time for the mental health liaison team was one hour. Nursing staff in the ED confirmed the liaison team were very responsive and the target time was consistently met.
- The children's ED had access to the children's and adolescent mental health services (CAMHS) from South West London St Georges Mental Health Trust Monday to Friday 9.00am to 4.00pm. Out of hours referrals were picked by the mental health liaison team.
- The alcohol outreach service was operational evening and twilight shifts on Friday's and Saturday's, with a late shift on a Sunday and on one evening in the week.
- Medical and nursing staff of all grades we spoke with all described excellent working relationships between healthcare professionals. We observed that the healthcare team worked well together to provide care to patients.

Urgent and emergency services

Seven-day services

- The UCC, children's A&E and all areas of the ED were open seven days a week. Support services were also available seven days a week including for example x-ray, scanning and pathology.
- ED consultants were not present in the department 24 hours a day. However they were present seven days per week from 8.00am to 10.45pm and provided cover 24 hours per day, either directly within the department or on call. Middle grade doctors were available at all times.
- The mental health liaison team were available on site seven days per week and providedsupport the ED.

Access to information

- The department had an electronic white board and a (physical) white board for staff to monitor patients through the department. We observed that the (physical) white board was updated by staff on a regular basis. The board was used to record the location of patients, and the length of time they had been on the ward. However, we observed that the electronic white board was not being updated in real time which meant that patients who had been discharged or transferred to wards were still on the electronic system. We observed that during handover staff would use the information from the (physical) white board as this was more up to date.
- Diagnostic results such as blood results and imaging were available electronically which we saw staff were able to access quickly.
- We saw there were systems to ensure the transfer of information when a patient moved between the ED and that wards and these were supplemented by a verbal handover.
- We saw that the patient flow team and site matrons routinely collected information throughout the day from the ED to inform the management of the hospital and the flow of patients. This meant the hospital was tracking the availability of beds across the hospital so that patients who were waiting to be admitted on to the wards were prioritised.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical staff we spoke with were able to demonstrate a good understanding of Mental Capacity Act (MCA) and consent
- Where staff had concerns about a patient's mental capacity staff could contact the site mental health liaison team who were available to attend at short notice.
- While we observed that staff upheld the principles of the MCA during care and treatment, the mental capacity of patients was not recorded in 10 records we reviewed in detail. Information in some of the records we looked at indicated patients may have had impaired mental capacity. For example, the notes of one patient recorded "appears confused" and another patient had a history of dementia. An abbreviated mental test score (AMTS) was recorded in four out of the 10 notes we looked at. We saw no evidence of documentation of a 'best interest' decision making process for patients who did not have capacity to consent. For example, patients under the influence of drugs or alcohol, living with dementia or who had a reduced conscious level
- We observed staff giving explanations of procedures and seeking verbal consent from patients. For example, we observed (heard) a doctor explain the insertion of a urinary catheter to a patient and obtain their consent. We observed several occasions when nursing staff explained and sought consent for procedures and interventions. We noted the ED used the Department of Health standard consent forms.

Are urgent and emergency services caring?

Good

Staff treated patients with dignity and respect, interactions between staff and patients were professional kind and friendly. Patients were positive about the care and treatment they received. They told us that they felt involved in their care. In the A&E survey 2014 the trust scored about the same as other trusts for treating patients with dignity and respect whilst they were in the ED.

Staff provided emotional support to patients and their families. The department had a relatives roomand viewing room which provided a private space where distressedrelatives could spend time with their loved one.

Compassionate care

- We observed that interactions between nursing staff and patients were professional, kind and friendly.

Urgent and emergency services

Discussions about care and treatment were sensitive and discreet to support patients' confidentiality.Patients were addressed by their preferred names or formally with the use of 'sir' or 'madam'.

- We observed that staff treated people with dignity and respect. For example, privacy curtains were drawn during interventions;
- We spoke with 19 patients and their relatives, they were generally positive about the care and treatment they received, one patient commented that they thought the nursing staff were 'wonderful'.
- One patient told us that they had been seen very quickly, they had been seen by the triage nurse and brought through to majors; they were waiting for their blood pressure to be taken before they could be discharged. They were very pleased with the service and thought it was 'brilliant'.
- In the A&E survey 2014 the trust scored about the same as other trusts for treating patients with dignity and respect whilst they were in the ED.
- The ED had Friend and Family Test (FFT) feedback forms and boxes located throughout the department. Results for September 2015 were displayed at the entrance to the department. This showed that 2214 patients were eligible to complete the feedback and that 155 responses had been received which was 7%. Of those 86% of patients indicated that they would recommend the service.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they had been involved in planning their care and had understood the information provided to them.
- The trust scored better than other trusts in nine out of 24 questions in the A&E survey 2014, these included involving patients in decisions about their care and treatment, having enough time to discuss their medical problem with the doctor or nurse, being listened too by the doctors and nurses and that family or someone else close to them had an opportunity to talk to the doctor.

Emotional support

- We observed staff provide emotional support to patients and their families. They answered patients questions and provided reassurance.
- The ED had a relatives room and separate viewing room.This provided an space where families could go to discuss issues with medical staff or amongst themselves relating to care or emotional support. It also provided a privatearea where distressed relatives could spend time with their loved one. Staff reported the relatives and viewing rooms had recently been redecorated with assistance from local undertakers.
- There was a hospital chaplaincy service, staff were aware of how to contact spiritual advisers so that the spiritual needs of patients and their families could be met.
- In the A&E survey 2014 the trust scored better than other trusts for patients being able to discuss their fear and anxieties about their condition or treatment with a doctor or nurse in the ED.

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

(for example, to feedback?)

Requires improvement

The ED consistently performed at a rate better than the England average in meeting national standard of a doctor seeing 95% of patients within four hours of their arrival for the 12 month period November 2014 to October 2015. During the same period, the number of patients waiting for between four and 12 hours to be admitted to a hospital ward was better than the English average. However, initial assessments of patients did not occur in a timely way. For the 12 month period November 2014 to October 2015 the average time patients waited for an initial assessment was 25 minutes. In the children's ED for the same 12 month period the average waiting time was one hour and 31 minutes for an initial assessment.

Patient information and advice leaflets were only available in English. Patients with a learning disability were 'flagged' on the records system however the department did not use a system for identifying patients with dementia and there were no care arrangements for meeting the specific needs of patients with dementia. Patients were able to access psychiatric support through the mental health team and there was a designated room for patients who presented with psychiatric needs.

Urgent and emergency services

Service planning and delivery to meet the needs of local people

- St Helier's ED provides services to the catchment area of Southwest London including the boroughs of Sutton and Merton. Sutton was ranked 196th most deprived district out of 326 (1 being the most deprived and 326 being the least) in the 2010 indices of Multiple Deprivation.
- Patient information and advice leaflets were available in English, but not available in any other language or format. Telephone translation services were available for patients for whom English was not their first language and some staff spoke more than one language.

Access and flow

- Walk in patients reported to one of three reception cubicles in the reception area where patients could register on arrival. Adult patients would be streamed by a nurse, if they needed to be seen in the ED they would be referred to a RAT consultant or referred to the UCC. Patient waiting times were displayed in the waiting area.
- Children attending the children's ED would register at the main reception desk and then be directed to follow a trail which was highlighted using an animal foot print which took them to the ED. We observed that the children's ED was quite a distance from the reception area. During our observations we noted that the children's department was busy, staff advised that there were no beds in the hospital which meant where a decision to admit had been taken that children remained in the ED. Whilst we were in the department on the day of the inspection there was no triage activity and there were patients who were waiting to be triaged.
- For the 12 month period November 2014 to October 2015 the average time patients waited for an initial assessment was 25 minutes. In the children's ED for the same 12 month period the average waiting time was one hour and 31 minutes for an initial assessment.
- Patients who arrived by ambulance utilised a separate entrance and where taken to the resuscitation area or were seen by the rapid assessment and treatment team (RAT). If patients required immediate treatments calls were phoned through from the ambulance service in advance so that an appropriate team could be alerted and prepared for their arrival.
- Patients arriving by ambulance would be seen by a member of the RAT team who took a handover from the ambulance crew. Based on the information received a decision was made regarding which part of the department the patient would be treated. Ambulance crews spoken with stated that the RAT system was good when the department was not busy and that it was no uncommon for the crews to be waiting 30 minutes to hand over. For the period November 2014 to October 2015 there were 527 occasions when ambulance crews waited over 30 minutes to hand over patients. The winter months of December 2014 and January 2015 accounted for 37.7% of the reporting against the 30 minutes target.
- From November 2014 to October 2015 the ED consistently performed at a rate better than the England average in meeting national standard of a doctor seeing 95% of patients within four hours of their arrival. There were four months when the 95% standard was not achieved December 2014 (92.3%), January 2015 (94.5%), September (93.9%) and October (94.7%).

Meeting people's individual needs

- Reception staff told us the nurse in charge had a contact number to access a translation service for patients who did not speak English. In practice, staff said they did not use the service and would, for example, use identification produced by patients to complete their registration and 'book them in.' We were told there were a number of staff in the department and in the rest of the hospital who could speak various languages and they were called to the department when necessary.
- Patient information and advice leaflets were available in English, but were not available in any other language or format.
- When a patient with a learning disability was admitted to the ED, their electronic patient record 'flagged' their specific need and the trust's learning disability nurse was alerted to the patient's presence in the hospital.
- Staff had access to training in the needs of people living with dementia. The department did not use a system for identifying patients with dementia. There were no specific care arrangements for meeting the specific needs of patients with dementia in the department.
- Patients were able to access psychiatric support through the mental health team and there was a designated room for patients who presented with psychiatric needs.

- In the ED there was a designated women's room with a separate toilet and shower which was used for women who presented with gynaecological problems.
- Staff working in the observation ward confirmed there was zero tolerance for mixed-sex breaches. Staff said they would decline patients rather than accommodate mixed sex. The observation ward was staffed by two associate physicians (AP); this provided continuity for patients admitted to this area. We observed an ED consultant reviewing the patients in the observation ward with the AP on duty. The AP was knowledgeable about the progress of each patient and gave a detailed history including investigations.
- To facilitate the discharge of a patient from the observation ward within 24 hours, the SWOOP team had undertaken an assessment of the patients home and had equipment installed. This enabled the patient to return home with a care package in place.
- In the children's ED there were age appropriate toys and activities in the waiting area.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. If a patient or relative wanted to make a formal complaint they were directed to the nurse in charge of the department. If concerns were not able to be resolved locally patients were referred to the patient advice and liaison service (PALS) who would formally log their complaint and attempt to resolve their issue within a set period of time. PALS information was available in the waiting areas.
- Information received from the trust shows that since January 2015 St Helier's ED had received 56 complaints, we saw that 42 of the complaints had been investigated and outcomes of the investigation reported. There were 13 complaints still under investigation. The top complaint received was for clinical care and treatment (38).
- ED clinical Governance meeting minutesfor January, May and October 2015, showed that complaints were discussed. We found when talking to nursing staff they were not aware of the complaints that had been made.
- We requested information from the trust on how learning from complaintswas shared with all staff at St Helier'sED. The information we received did not demonstrate how information was shared.

Are urgent and emergency services well-led?

Requires improvement

There was a five year strategy in place for the development of the ED services at St Helier's. These included plans to increase consultant cover to 16 hours seven days per week and increase the number of middle grade doctors from eight to 12.

ED clinical governance meetings minutes demonstrated that complaints and incidents were reviewed and quarterly medicine quality reports demonstrated the ED performance was also monitored within the medicine directorate.

All of the staff we spoke with told us that they were happy with the management and leadership of the unit. Junior doctors we spoke with told us that they were happy with the support they received from consultants and that they felt their rota was manageable.

The culture of the service encouraged staff to be loyal to the department; some staff we spoke with had worked in the department for many years. However, Staff we spoke with were unaware of the trust vision of 'Put the Patient First'.

Vision and strategy for this service

- There was a two to five year strategy in place for the development of the ED services at St Helier's. These included plans to increase consultant cover to 16 hours seven days per week and increase the number of middle grade doctors from eight to 12. Proposals to increase the nursing establishment by one WTE to ensure that there were always two nurses for the resuscitation area 24/7 were already in place. The senior management team also had plans to developed the cross site working with the Epsom General Hospital, consultants were currently working across both sites.
- Staff we spoke with were unaware of the trust vision of 'Put the Patient First' and provide great care to every patient every day. Posters with the trust vision were on display in the ED. Senior staff we spoke with advised that two members of staff had attending training 'Put

the patient first' and there were plans for this to be cascaded to other staff in the department. They commented that it was hard to leave department for study days'.

Governance, risk management and quality measurement

- The ED was part of the medical directorate and the trust had just appointed a clinical director with responsibility for ED services at St Helier's and Epsom General Hospital. The emergency paediatric consultants working in the Children's ED came under the Women's and Children's services and the children's nursing staff came under the adult ED and therefore the medical directorate
- The ED held clinical governance meetings attended by the clinical lead and other ED consultants, matron and a paediatric consultant. Minutes demonstrated that complaints and incidents were reviewed.
- Quarterly medicine quality reports demonstrated the ED performance was also monitored within the medicine directorate. This included reviewing incidents, looking at clinical effectiveness, complaints and feedback through the FFT.
- The ED risk register identified risks in the ED and the children's A&E. The initial risk level and current risk level was recorded and had a review date. The ED had 13 risks identified four of which were initially assessed as being extreme risk and had been downgraded to high risk, progress against these was recorded demonstrating active management of identified risks.

Leadership of service

- The leadership and management of the ED came under the medicine directorate across both sites; the Children's ED came under the women's and children's directorate however the nursing staff was under the responsibility of the matron for the adult ED. The trust had recently appointed an ED clinical director who would be responsible for the ED at St Helier's and at Epsom General Hospital. There were no plans for the Children's ED to come under the leadership of the ED clinical director.
- All of the staff we spoke with told us that they were happy with the management and leadership of the unit. There were clear lines of accountability in place and staff were aware of who they could go to for help or to escalate a problem. Staff told us that the matron and senior nurses were all very approachable and had an 'open door' policy if they needed any extra support.
- Junior doctors we spoke with told us that they were happy with the support they received from consultants and that they felt their rota was manageable.

Culture within the service

- Staff told us they felt respected and valued by their colleagues and the leadership team within the ED. Junior and middle grade doctors we spoke with told us they felt supported by their colleagues and had good working relationships with other medical teams. They were also able to access ongoing training.
- Some staff we spoke with had worked in the department for many years. Senior nursing staff described the staff as hard working and thought that they provided a good standard of care.
- Staff reported that they were comfortable reporting incidents and raising concerns and were encouraged to do so.

Public and staff engagement

- The ED used the friends and family test to engage with patients and gather feedback. We saw the low responses rate within the department was discussed at clinical governance meetings and it was recognised that the ED should be proactive in encouraging patients to respond. During our visit we did not see staff offering the Friends and Family test to patients.
- Information leaflets were available for patients on a range of minor conditions.
- Staff we spoke with were aware of the trust's whistleblowing policy and would feel comfortable using it if necessary. We also saw information displayed advising staff of the whistleblowing procedure. This suggested that the trust had an 'open culture' in which staff could raise concerns without fear.

Innovation, improvement and sustainability

- Funded through winter resilience monies the new MDT SWOOP team made up of therapists, nursing staff and social workers who were available in the hospital 8.00am to8.00pm Monday to Friday and 8.00am to 6.00pm at the weekend. The SWOOP team focused

mainly on the observation ward within the ED toprevent patients being admitted to the hospital enabling patients to return home with appropriate equipment and care packages in place if required.

- Senior staff in the ED advised that funding had been approved to change the layout of the majors so that the NIC had sight of all patients on the ward and move the doctor's station closer to the nurse's station to further improve communication between the medical and nursing staff.

Medical care (including older people's care)

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

Information about the service

At Epsom and St Helier Hospitals, medical care services are managed by the directorate of medicine. Specialties include gastroenterology, respiratory medicine, cardiology, endocrinology, elderly care and stroke. Medical care services provide 31,000 spells of care each year across both sites. St Helier Hospital is the largest site, providing services to a catchment area of Southwest London, including Sutton and Merton, and is also home to the Southwest Thames Renal and Transplantation Unit that provides acute renal care and dialysis and is integrated with the St George's Hospital transplantation programme.

To help us understand and judge the quality of care in medical care services at St Helier Hospital, we used a variety of methods to gather evidence. We spoke with 10 doctors including consultants, 31 nursing staff including ward managers, matrons, specialist nurses and health care assistants; four therapists and a pharmacist. We spoke with support staff including ward clerks, cleaners, discharge coordinator and housekeeping staff. We also spoke with 27 patients and four patient relatives. We interviewed the directorate management teams for medicine. We observed care and the environment and looked at records, including patient care records. We looked at a wide range of documents including audit results, action plans, policies and management information reports.

During our announced inspection we visited wards A5, A6, B1, C3, C5, C6, AMU and Mary Moore.

Summary of findings

We rated medicine as good for being effective and well led; but as requiring improvement for being safe, caring and responsive. We found mandatory training and staff appraisal completion rates were low; not all patient records were accurate; some wards repeatedly fell below the trust's infection control thresholds' and patients were able to access areas of wards that might compromise their safety. We also found staff were not always carrying out daily checks of resuscitation equipment.

The medical directorate's use of locum staff, both medical and nursing, had consistently been above the trust average. The hospital had recently undergone a recruitment drive which had enabled it to fill some of its nursing and medical vacancies.

There was a lack of clarity amongst staff with regard to how the Deprivation of Liberty safeguards should be used. Staff generally provided care in a compassionate and kind way that preserved patients' dignity, and said they felt supported by their line managers to provide high quality care. Patients' feedback was largely positive however relatives' comments were less so.

In all but neurology and dermatology, the medical directorate achieved the 18 week referral to treatment thresholds. The average length of stay trust wide was similar to the England average, but longer at St Helier for non-elective geriatric medicine.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated safe as requiring improvement. We found mandatory training and staff appraisal completion rates were low; not all patient records were accurate; some wards repeatedly fell below the trust's infection control thresholds' and patients were able to access areas of wards that might compromise their safety.We also found staff were not always carrying out daily checks of resuscitation equipment.

Patients were cared for in clean environments; the age of the building and difficulties in maintaining the environment to suitable standards was identified as a possible contributing factor to the hospitals poor performance against national infection rates. The trust's own infection control audits indicated wards repeatedly fell below the hospital's compliance score.

The equipment we saw had been maintained although there was nothing to indicate on it when it has last been cleaned. Staff spoke of outdated IT equipment and a shortage of general equipment such as hoists.

Patient records we reviewed were legible, up to date and displayed a multidisciplinary input. We observed however that on several wards staff were not keeping food, fluid and patient weight charts up to date or accurate.

There were systems to support staff to recognise and appropriately treat patients whose condition was deteriorating. However, we found that staff were not always fully applying the escalation pathways when patients had been recognised as being at risk of deterioration.

Overall the numbers of nurses, doctors, therapists and other staff on the wards were adequate, at the time of our inspection, to meet patients' needs. Senior managers told us staffing levels were kept under review and changed in response to emerging concerns or circumstances. The trust had taken steps to recruit additional staff, including recruiting from overseas.

Staff received mandatory training designed to ensure they could carry out their jobs safely however in the majority of areas the uptake fell below the trust's own threshold.

Incidents

- The medical directorate reported one never event in the 12 months prior to this inspection. We were able to discuss this with staff and they were aware of the learning from it.
- In the last five quarters (April 2014 – June 2015), 5355 incidents were reported by medical directorate across the trust. Data provided for quarter one of 2015 (April to June) indicated there had been 1221 incidents, equating to 407 each month. This was a slight increase on the previous quarter (1186 incidents). Five of these incidents resulted in severe or permanent harm to the patient, two of which occurred at St Helier Hospital.
- Staff of all grades, from nurses to cleaning staff, were aware of the process to record and report incidents, using an electric reporting system. However some health care assistants, although knowing the process, said they did not have access to report incidents directly themselves. The trust's policy stated that the 'reporting of incidents was the responsibility of each member of staff and not limited to, or exempt to any healthcare professional group. All incidents should be reported using the trust online incident reporting system, which could be accessed all trust PCs'. Staff were not required to have a system log in, or user account to report incidents.
- Information from incidents was shared in ward meetings. Nursing staff told us they requested feedback when they reported incidents and that this feedback was forthcoming. Some health care assistants fed back that they did not generally receive feedback on incidents.
- The medicine directorate had recently appointed a new quality assurance lead who was currently reviewing all medical mortalities to determine if there were any trends. This data would then be fed into regular morbidity and mortality meetings and learning points disseminated from them. Staff commented on the usefulness of the tri-annual morbidity and morbidity meetings describing them as 'open and honest'.

Duty of Candour

- We spoke with a number of staff at all grades. All were aware of the duty of candour, including a recently

appointed overseas nurse, and what the implications of it were. Several staff were able to give examples of where they shared information with patients under the remit of this new legislation, and were enthusiastic about being open and honest.
- From its implementation date to July 2015, the medical directorate had made five duty of candour disclosures.

Safety thermometer

- Medical care services at St Helier Hospital used the NHS Safety Thermometer to collect local data on specific measures related to patient harm and 'harm free' care. Ward managers were knowledgeable about the data.
- We saw that key elements of the data were incorporated into performance dashboards for the directorate of speciality and elderly medicine, and details of for example, the last fall, acquired infection and pressure ulcer were displayed) on every ward we visited.
- Patient falls accounted for the highest number of incidents reported. There was one fall in May 2015 at St Helier which resulted in moderate harm to the patient. There were none in June 2015 and two in July 2015. The directorate acknowledged that the number of unwitnessed falls remained a concern and measures such as using bed and chair sensors were being implemented. Further work was also being undertaken including placing specific wards under "Special Measures" as they had been identified as "Outliers" in a range of clinical quality metrics. One ward for example had undergone a change of nursing leadership in order to address the increase in clinical incidents which had resulted in some form of harm; additionally, the ward received intensive input from specialist nurses including those from the practice development team and tissue viability team to help support nursing staff and the health support workers.
- Between April and July 2015 the number of patients receiving a venous thromboembolism risk assessment at St Helier hospital was 94.5%, just below the trust threshold of 95% (a venous thromboembolism (VTE) is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis or DVT. If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism or PE).
- The trust's safety thermometer data indicated that the number of patients acquiring catheter-related urinary tract infections had remained constant until May, when there had been an increase. This only equated to less than 0.2 incidents per 100 patients surveys however.
- Since April 2015 the numbers of patients experiencing pressure ulcers had decreased. There had however been two grade 3 hospital acquired pressure ulcers at St Helier in July 2015. Meetings had been held on the ward to review care standards and initiate any necessary remedial action.

Cleanliness, infection control and hygiene

- We observed that the environment was visibly clean, tidy and organised.
- Ward managers were satisfied with the level of cleaning where there was a permanently allocated cleaner. However they felt the consistency and quality dropped when agency staff were used.
- Cleaning staff told us they had received training in infection control, although not all understood the term 'clinical waste'. They told us they were provided with appropriate equipment including personal protective equipment (PPE).
- There was an ample supply of clinical and general waste bins. On two visits to one ward, we noted that the door to the waste disposal area had been left unlocked.
- Hand hygiene gels were available in multiple locations around the hospital and we observed staff followed the 'bare below the elbow' protocols. However the hospital's own quarterly audits indicated that staff often fell below the compliant target (85%) for using correct hand hygiene techniques. The hospital's quarter two audit (July – September 2015) showed this had fallen to 57% on one ward.
- From the data supplied in the hospital's quarterly infection control audits we saw that wards including C3 and the AMU, repeatedly fell below the hospital's infection control compliant target of 85%. The hospital's quarter two audit (July – September 2015) showed compliance rates as low as 10% (ward A5) for the cleanliness of equipment; and a number of wards including A5, A6, B6 and AMU failing to achieve minimal compliance in the management of meticillin-resistant Staphylococcus aureus (MRSA) positive patients.
  - The trust placed it's own wards into 'special measures' due to either falling below a minimal compliance level on the quarterly audit or following a trust case of

MRSA bacteraemia or C. diffcile. Ward A6 was put into 'special measures' following a trust apportioned MRSA bacteraemia in April 2015. Ward C5 was put into 'special measures' following a trust apportioned C. difficile case in April 2015.

- The cleanliness of commodes was audited by the hospital's infection control team. The quarter two audit (July – September 2015), showed the score for the commode cleanliness in the medical directorate fell between 50 and 100%. We found commodes and sanitary ware to be visibly clean.
- We observed that clinical and domestic waste was segregated in different coloured bags and that waste in ward areas was correctly stored.
- Since April 2015 there had been five cases of clostridium difficile reported in the medicine directorate. This equated to 7.7 per 100000 bed days at St Helier hospital.
- The uptake of mandatory training in infection control amongst the clinical team had dropped to 74% in July 2015; however overall, for the year to date, the medical directorate had an infection control training rate of over 95%.

Environment and equipment

- The wards we visited were clean and tidy. The building itself was noted to be old but efforts were being made to refresh and refurbish it where possible. For example, new lockers had been provided on one ward, and a new air flow system, including oxygen, had been fitted in all rooms. Staff commented that a lot of work had gone into improving the state of the building.
- The trust acknowledged that the current environment in which patients received care and treatment fell below current national standards due to the age of the hospital. In the trust estate strategy, it was identified that the current poor quality of the hospital may have been associated with the trusts overall poor performance in relation to hospital acquired infections, with the trust lying in the bottom quartile for MRSA and the third quartile for C.diff both nationally and when compared to trusts of a similar size. Further, it was identified that the lack of space between bed spaces may have been a contributing factor to the spread of infections, with reference made to 4 outbreaks of norovirus in 2013/2014 which affected 10 wards and a further 5 outbreaks affecting 7 wards during 2014/2015. A lack of adequate isolation facilities led to delays in patients identified as testing positive for C.diff between April 2014 and January 2015 being isolated in a timely way; this had the potential to increase the risk of the C.diff infection being spread to other patients in the hospital. It was identified that during 2014/2015, a contributing factor to 3 patients acquiring MRSA bacteraemias was a failure to isolate a patient with MRSA due to inadequate numbers of side rooms .
- Currently, only 22 out of 376 beds at St Helier hospital meets the national standard for ensuring that beds are spaced at least 3.6m apart from each other.
- Medical equipment within the medical directorate was managed by the trust electro-medical engineering department. They maintained a database of all equipment identified by individual asset numbers. We were told the medical devices committee had identified there were a number of weaknesses in the system and assurances could not be provided that all medical devices were being maintained to the required standard. Staff on the wards did not raise this as a specific issue. They told us that if they needed equipment it was usually delivered from the store by the following day, although some of the therapists fed back there were often delays because equipment such as hoists were already being used.
- A number of staff commented on insufficient, inefficient and outdated IT equipment.
- We saw resuscitation equipment readily available in each clinical area. There were systems to ensure most equipment was checked daily to ensure it was ready for use. We saw from records that staff on most wards complied with these systems. On A6 ward we found staff were not carrying out a daily check of the resuscitation trolley. We also found that the checklist being used on some wards, for example C2 and C3, to record a daily check of the resuscitation trolley did not include space for staff to record if the oxygen tank was full and in date.
- We saw that all portable electronic equipment had portable appliance testing labels attached, indicating that it had been safety tested in the previous year. There was nothing however to indicate the date equipment had last been cleaned.
- We noted that the stroke ward was supplied with a range of rehabilitation equipment.
- There was a risk of unauthorised access into the sluice rooms on AMU and C block, because they were not lockable and hazardous fluids were within easy reach.
- We also found scissors on one work surface. Staff were not always signing the bedpan washer record.

Medical care (including older people's care)

- We noted on one ward a patient slumped against their bed rails, and a volunteer trying on their own to lift and help sit them up. Staff told us the patient could not support their upper body, and therefore could not sit out of bed. We asked why a reclining chair had not been provided - this was something staff said they had not considered and it was not equipment the hospital had.

Medicines

- Staff used electronic prescribing. Nursing staff commented that they found it much easier, and that there was less scope for error. There was a contingency plan in place in the event the electronic system failed.
- We observed nurses administering medicines and found that Nursing and Midwifery Council (NMC) standards for medicines management were being adhered to with the exception of one nurse leaving medication unattended on the trolley; and another who dropped a patients medication on the floor, but then retrieved it and gave it to the patient. These issues were raised with the individual members of nursing staff at the time.
- We saw that management of controlled drugs met legal requirements. We checked order records and controlled drug registers and found these to be in order. We spot-checked some medicines and found that stock balances were correct. We saw there were arrangements for ward staff to check stock balances daily, and saw records of this being done.
- We found that medicines were almost without exception stored securely in locked cupboards and trolleys.
- There was a ward-based pharmacy service. Patients' prescriptions were checked by a pharmacist to ensure their medicines treatments were safe, effective and met current guidance. We saw pharmacists' carrying out these checks and ward staff told us that the pharmacists were readily available for advice and guidance.

Records

- We reviewed over 20 patient records on various wards, and found that generally they were legible, comprehensive, up to date, appropriately signed and reflected the care and treatment patients received. There were some gaps in data, and some records were missing one or two of the following: VTE assessment; evidence of discussion with family; ceiling of care/ DNACPR; nutritional status; nursing assessment; pressure ulcer risk assessment; falls risk assessment. We also found that diabetic charts were not always fully completed.
- Medical care services had integrated patients' records shared by doctors, nurses and other healthcare professionals. This meant that all professionals involved in a patient's care could see the patient's full record. We evidenced multidisciplinary input in the records we reviewed.
- We found that some medical records were stored in notes trolleys in ward areas to which the public had access however we observed that staff ensured that the trolleys were kept locked.
- Patients' daily observation charts, including food and fluid charts were kept near the patients beds. We noted that on a number of wards staff were not always fully completing these, even when there were concerns regarding the dietary intake of patients.
- Information governance training was mandatory for nursing staff. The percentage of staff who had undergone this varied from ward to ward. Thirty three percent had completed it in the diabetic unit whereas over 87% had done so on the cohort ward.

Safeguarding

- Training in safeguarding children and adults formed part of the mandatory training programme. The level of staff training in safeguarding was 100% with three exceptions – the emergency department and the cohort ward and ward A1. The number of staff who had completed level two child protection training ranged from 69% to 100% depending upon which ward they worked on.
- With the exception of cleaning staff, all other staff we spoke with were all aware of their responsibility to report potential abuse and knew how to do this.
- Staff gave us examples of the management of safeguarding concerns that demonstrated that processes were followed and that staff were engaged in the process.

Mandatory training

- In the medical directorate, completion of mandatory training at St Helier Hospital averaged 83.9%. Trust wide the target was 95% for all mandatory training except

information governance, where the target was 40%. Compliance with mandatory training was below target in six out of ten of the mandatory courses, including resuscitation and health and safety.
- Staff were aware of the mandatory training they were required to undertake. Bank nurses said they were provided with training if they were rostered for more than 30 hours each week.
- Ward managers we spoke with demonstrated the systems they used locally to monitor attendance of their staff at mandatory training, to ensure training was completed or refreshed when necessary.

Assessing and responding to patient risk

- The medical directorate maintained a trust wide risk register. The majority of identified risks were relevant across both sites and not specific to one location. The register had 37 entries. Eleven of these were assessed as presenting a moderate risk; 22 were high risk and four were deemed an extreme risk. The latter related to environmental issues; problems recruiting medics and nurses; patient falls which could result in severe harm or fatality and delays in discharge because of inadequate patient transport
- The risk of patients wandering into sluice rooms had not been assessed. None of these rooms were lockable and hazardous fluids were within easy reach.
- The trust identified that there was a risk of delayed review by a senior doctor of in-patients becoming acutely unwell between 5pm and 9pm. To address this a medical registrar twilight shift had been introduced.
- The hospital did not have a critical care outreach team. A number of staff commented they felt this would be beneficial but nevertheless they felt the hospital offered safe care.
- Staff used the national early warning system (NEWS) to assist them to recognise and respond appropriately to signs of patient deterioration. The trust was also in the process of introducing an electronic early warning monitoring system. Staff commented positively on the wards where it had already been introduced. However some did highlight that the equipment was not always available in the quantity required and it had not yet been electronically linked to the doctors hand held electronic devices.
- Management of the acutely ill patient was on the trust's risk register and outcomes fed into the regular mortality and morbidity meetings to discern if trends were emerging and to take learning from issues that may have arisen. The trust's NEWS audit indicated that the number of breached observations had steadily declined since May 2015. For the week of 23 August 2015 seven wards at St Helier breached by more than 15% during the day; while six breached by between 10 and 15%. During an unannounced inspection we identified three patients whose physical observation parameters (blood pressure, heart rate, blood oxygen levels, respiratory rate, temperature) were deranged and therefore had escalated early warning scores. A review of the patients medical notes and discussions with nursing and medical staff had identified that none of the three patients had been escalated in line with the local trust policy. One patient had scored 5 at 18:05 on 24 November; the score increased to 6 at 19:45; there was no review from a senior doctor until 10:30 on 25 November 2015.
- Advanced nurse practitioners were rostered at night to support junior doctors. Senior managers told us that where appropriate escalation plans were agreed in advance.
- Where patients were at risk from falls wards had introduced bed and chair sensors and provided patients with anti-slip socks.
- Ward managers were able to discuss with us safety thermometers and the learning shared from the outcomes.
- We reviewed over 20 patient medical records and noted they contained completed risk assessments relating to, for example, pressure scores, falls, nutrition and catheter care.

Nursing staffing

- The numbers of staff planned and actually on duty were displayed at ward entrances in line with Department of Health guidance.
- The hospital had a 'matron of the day' who reviewed staffing levels and liaised with ward managers to agree the best use of available staff.
- The trust told us it followed NICE guidance in determining staffing levels (which state that while there is no single nursing staff to patient ratio that can be safely and adequately applied across the wide range of wards in the NHS, the guideline recognises that if each registered nurse is caring for more than 8 patients during the day time on a regular basis, there is an increased risk of harm), and carried out the Safer Care

nursing tool three times per year on all general medical wards. On general wards the ratio was between 1:6 and 1:7; with a maximum of 1:8 excluding the nurse in charge. The medical assessment unit had a ratio of 1:6 excluding the nurse in charge.

- Data provided by the trust showed that in August, on the wards sampled at St Helier the fill rate of nurses during the day was between 78.6% and 153.5% for the day; and 90.4% - 100% at night.
- The trust had recently carried out a successful recruitment day at the hospital. In addition a number of nurses had been recruited from overseas. These nurses worked at band 4 level until they obtained their Nursing and Midwifery Council registration. Data supplied by the trust showed that for the last financial year, the medicine directorate was carrying a 23% nursing staff deficit. As an example, the escalation ward had a WTE of 19 nurses but only had 10 permanent staff in post.
- Some staff felt overseas nurse recruitment added pressure to the existing staff team as many did not (yet) have a full command of English. Some patients also commented on having difficulties in understanding some of the nurses. We saw the trust had taken steps to address this latter issue by providing the overseas nurses with regular English lessons.
- We spoke with a number of newly recruited overseas nurses. We found their English comprehension and verbal skills limited, and they unanimously welcomed the provision of English lessons. All were positive about their recruitment and experience to date, and felt well supported by the hospital.
- Trust data for April 2014 – March 2015 indicated the average use of agency and bank nurses by the medical directorate at St Helier was above the trust average of 14.3% on most wards with the highest use being on wards C3 (cohort) and C6 (gastro) at 48.4% and 46.6% respectively.
- Staff turnover varied from ward to ward. Some had not had any staff changes in the past 12 months, but over 50% had left the diabetic unit.
- Agency and bank staff told us they were made to feel welcome and part of team. Some ward based staff commented on the regular use of agency staff.
- We saw arrangements for nursing staff to hand over the care of patients between shifts and found the handovers were adequate.

Medical staffing

- The trust had above the England average for medical registrars (42% compared to the England average of 39%) and consultant (36% compared to 34% nationally) WTE posts. It fell below the England average for junior (foundation year 1-2) doctors (17% compared to 22%).
- Trust data for April 2014 – March 2015 indicated the average use of locums by the medical directorate at St Helier was above the trust average for eight of those 12 months. It peaked at 18.6% in April 2014 (trust average 11.9%), and was at its lowest, 10.4%, in September 2014 (trust average 11.8%).
- Over the last financial year the medical directorate had carried an 11% vacancy rate. The trust had actively recruited medical staff, from within the UK and overseas and progress had been made, although the trust acknowledged that this remained an area of risk. Data supplied for July 2015 showed, for example, one specialist registrar post was being filled by a locum and there was a vacancy for an orthogeriatrician.
- Junior medical staff told us they could access advice from a consultant at any time, and that, when required, consultants medically reviewed patients. Junior doctors generally told us they had good support and back-up from senior doctors.
- Depending on the ward, we found consultants did not review all patients every day, except where it was determined that not doing so would affect a patient's care pathway. However, the medical team reviewed patients daily during the week, and this was recorded in patients' notes. This meant that although patients were reviewed by a doctor, this was not necessarily a consultant; this had the potential to delay patients' progress through their treatment pathway.
- Nursing staff told us they were encouraged to upskill and become advanced nurse practitioners; and some were in the process of obtaining prescribing qualifications.
- We did not observe a shortage of allied health professionals such as therapists. Although staff did not raise concerns with us we noted that as of July 2015, the hospital had a 16% vacancy rate in this area.
- We saw that the acute medical unit had a consultant on call over the weekend, with a separate consultant on call for the medical directorate. One junior doctor was specifically allocated to the unit.

Medical care (including older people's care)

Major incident awareness and training

- The trust had a major incident plan in place, which was last updated in October 2014. This was available for all staff on the trusts intranet pages.
- The hospital had an escalation ward to enable it to meet the increased winter time demand. The ward was open at the time of this inspection.

Are medical care services effective?

Good

The medical directorate carried out a range of internal audits, and shared the results, action plans and learning from them. The directorate also participated in a number of external national audits. The results of these were mixed, with the hospital falling below the England average for some, but exceeding it in others. It was notable that there was a considerable difference in performance between the two hospital sites with regard to diabetic care, with St Helier achieving much lower compliance.

Staff expressed frustration with the patient record system. Having separate paper based records for each site was confusing, time consuming and posed operational risks.

Staff were aware of Deprivation of Liberty Safeguards but were under a mis-assumption that these needed to be applied in order to obtain additional staff where a patient needed 1:1 care.

Staff were able to demonstrate use of national guidance from, for example, the National Institute for Health and Care Excellence. They knew how to access the hospital's policies and procedures however the trust's own audits reflected that compliance with these was sometimes low.

We observed wards had protected meal times and patients who needed assistance to eat were given it. On some wards staff were not accurately completing patients food, fluid and weight records.

Staff were positive about working at the hospital. They said supervision was difficult to fit in due to work demands, but they had regular appraisals. This was not supported in the data provided by the trust however, as the number of appraisals carried out fell below the trust's threshold.

Patients could access the expertise of the full range of healthcare professionals, and there were arrangements to ensure the multidisciplinary team worked well together with access to the information they required to care for patients effectively. Staff spoke highly of the positive collaborative working within the medicine directorate.

Evidence-based care and treatment

- Staff were able to demonstrate to us how they used national good practice guidance, such as that from Department of Health and the National Institute for Health and Care Excellence (NICE). Examples were provided relating the recommended duration and frequency of physiotherapy for patients recovering from a stroke. Staff talked confidently about the guidance and how they worked to ensure their practice was compliant.
- Staff were able to access the hospital's policies and procedures electronically. Although they demonstrated they knew where to find these, the trust's own audits indicated that compliance with these varied. For example, five wards (AMU, Mary Moore, A5, B6 and C4) at St Helier were non-compliant with the management of patients with diarrhoea in July/August 2015.
- We saw that the hospital carried out its own internal audits on a quarterly basis, evaluating, for example pressure ulcers, infection control, privacy and dignity, nutrition and hydration. Results of these audits were documented and shared with staff alongside actions to take forward. Staff were able to talk knowledgably about them and the goals they needed to achieve.
- In July 2015 an audit of blood culture collection standards was carried out by the trust. The medical directorate provided 20% of samples, and of that number staff had appropriately documented the collection of the blood in 83%. In 50% of samples from medical wards, documentation of adherence to care standards (when taking the sample) was absent. This information was distributed to clinical directors with a request it be discussed during phlebotomy / blood culture collection educational sessions scheduled for junior doctors and nurses during their trust induction.
- Stroke services at St Helier formed part of the London model whereby acute strokes/suspected strokes were transported directly to the specialist unit at St George's hospital and returned for rehabilitation at St Helier.

Medical care (including older people's care)

Pain relief

- Patients we spoke with said that staff gave them painkillers when they were required.
- We found that staff had access to pain-assessment tools and they were able to explain how they would use these. The tools were not consistently used across the medical wards however.

Nutrition and hydration

- We looked at patients' records that showed that patients were assessed for the risk of malnutrition using a recognised, validated tool – the malnutrition universal screening tool (MUST).
- When nutritional screening demonstrated a risk, we saw that appropriate actions, such as the maintenance of food charts, the provision of dietary supplements or referral to the dietician, were taken in most cases. On two wards we found that staff were not keeping accurate records. One patient's fluid intake chart showed they had had just 30ml of juice in a 24 hour period. Staff told us they did not have time to complete the charts. We noted one patient had, apparently, lost a considerable amount of weight since admission. When we queried this we were told it was probably not accurate as staff did not know how to appropriately complete the chart.

Patient outcomes

- There were 110 deaths in medicine in April 2015 and an average of 108 per month. The number of deaths has risen by four since March. This was above the expected number. The number dropped to 87 in June 2015 and 75 in July 2015, below the expected number.
- The standardised relative risk of non-elective readmission to St Helier Hospital in general medicine was 10% worse than the England average (110 locally versus 100 nationally). Further, the standardised relative risk of non-elective readmission for nephrology and geriatric medicine was worse than the England average at 151 and 121 respectively.
- Elective re-admissions in general medicine was better than the England average (77 versus 100 nationally) however, the elective re-admission rates for clinical haematology and nephrology was worse than the England average at 120 and 335 respectively.
- The national heart failure audit in 2013 showed St Helier hospital was worse than the average for all four in-hospital measures and in line or better than the national average against five of the seven discharge measures.
- In the Sentinal Stroke National Audit programme (SSNAP) the hospital had achieved a varied score across each quarterly audit since January 2014 ranging from the top to the bottom scores. Areas of particular concern identified as part of the audit were the stroke unit and specialist assessments. It had scored well in discharge processes and occupational therapy. At the time of the inspection, the hospital was rated as attaining a score of A (top score) in SSNAP.
- In a national audit of care of patients with non-ST segment elevation infarction (a form of heart attack), as part of the Myocardial Ischaemia National Audit Project (MINAP) in 2013/14 the hospital performed in line with the national average in one indicator but below average in the remaining five.
- In the National Diabetes Inpatient Audit (NaDIA) for September 2013, the hospital performed worse than the England average in 17 of the 21 measures. Areas below the England average included staff knowledge, overall patient satisfaction and foot risk assessments. The diabetic nurse specialist commented that foot examinations were the responsibility of the medics and not something they would check had been done when reviewing a patient.
- Medical outliers (patients admitted to a ward different from a medicine ward) were common. On the first day of our inspection there were 40. This was flagged as a concern on one of the surgical wards as staff told us they did not have the resources to, for example, constantly monitor patients at risk of falling.
- We were told that winter pressures the previous year had led to a full team of junior doctors being allocated to manage outlier patients. The average number of outliers in medicine (including specialities) at St Helier between January and June 2015 was 385. In cardiology the average was five, rheumatology three and geriatric medicine eight. A medical handover was held each morning to identify where patients had been assigned. Consultants in the medical directorate were allocated wards where they would cover outliers and we saw evidence that outliers were visited daily by the outlier team.

Competent staff

- Staff on a number of wards said they received regular appraisals, although fitting in supervision was more

difficult due to staffing levels. Data provided by the trust however showed that over the course of the last financial year the rate of appraisals in the medicine directorate was just 67%.

- Staff new to the hospital told us they receive a good induction. Some staff commented that this did not include bank and agency staff.
- The hospital had prepared an induction leaflet for bank and agency staff which outlined shift times, gave useful phone numbers and set out hospital specific care requirements relating to infection control and pressure area care.
- We observed a handover of patients on the acute medical unit, and also one between emergency department staff and ward staff. Both were good with clear instructions given.
- The hospital provided a specialist diabetic service. We found staff were unaware of the hospital's performance in the national diabetic audit. There was a lack of clarity about how diabetic link nurse roles were being developed and no knowledge of the imminent introduction of electronic prescribing and how this would relate to insulin prescriptions.
- We noted that the majority of nursing staff on one shift on the acute medical unit were junior, which could potentially mean the available skill mix was not as experienced as might have been expected. Nurse on other wards also commented on the skill mix and felt it prevented more senior staff from attending training as they could not be 'spared' from the ward.
- Staff spoke highly of the Patient first programme. They told us it was working well and had identified lots of initiatives in improving lives of patients. They were also complimentary of the virtual dementia course which enabled them to walk in the shoes of a person living with dementia.

Multidisciplinary working

- Within the medical directorate we identified a strong commitment to multidisciplinary team (MDT) working. Staff commented on good access to a full range of allied health professionals and team members described effective collaborative working practices. One member of staff commented 'despite the challenges we all face, the staff are really cohesive. Staff are patient focused'.
- Staff on the stroke ward spoke of positive MDT liaison. There was a stroke clinical nurse specialist who worked across both hospital sites. We were told by the consultant that every three months there was a MDT meeting to discuss joint education and clinical governance – although the ward therapists were not aware of this.
- The stroke ward had two allocated speech and language therapists, a dietician, a neuropsychologist and the supported early discharge team attended wards meetings. All patients on the ward received 45 minutes of physio/occupational therapy five times a week.
- We attended a whiteboard meeting on one of the wards. It was well attended by a variety of staff including therapists, palliative care nurses, clinical nurse specialists and doctors. It was effective, thorough and evidenced staff had a clear understanding of their patient's needs and a multi-disciplinary approach to their care.
- The hospital had an Older Persons Assessment and Liaison team (OPAL). We met with enthusiastic members of the team who demonstrated an in-depth knowledge of the needs of elderly patients. They were proactive in taking steps to ensure patients were placed on the correct ward, underwent a dementia assessment and had an appropriate level of support upon discharge.

Seven-day services

- Managers told us they were 'working towards' providing a seven day service, and some specialities had achieved this.
- New medical admissions were seen every day on one of the post-take ward rounds.
- A consultant did not routinely see and review patients at weekends in all specialties. For example, there was a consultant on duty up to 8pm every day on the acute medical unit, but no routine elderly care ward round at weekends.
- Access to therapy and social care services was available seven days a week. However, the service at weekends was limited and focused on assessments that enabled patients to be discharged. Specialist areas such as the respiratory ward had seven day a week access to therapists.
- Endoscopy services were delivered as part of the South West London upper GI bleed rota which was led by a specialty registrar and available 24/7. However, this was not compliant with NICE guidance which says it should be consultant led.

Medical care (including older people's care)

Access to information

- We were told by one ward manager that they were reliant on information about patient's care (such as needing extra help with feeding) being passed on verbally during handover. As this was not always fully documented in notes.
- Therapists told us they would like more access to electronic notes between organisations, as sometimes notes could not be accessed due to password protection.
- Staff felt working across organisation was a challenge. They found separate records between disciplines frustrating.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Junior doctors and matrons demonstrated a good knowledge of Deprivation of Liberty Safeguards (DoLS). Less senior nurses showed a basic understanding of DoLS and the Mental Capacity Act, and said they knew who to go to for advice if required. Some staff commented that training in this area was not provided. Staff were under the assumption that they needed to apply DoLS if a patient needed one to one care.
- Nursing staff were aware that formal best interests meetings may be required to establish a patients' capacity and determine their best interests in line with the Department of Health code of practice for implementing the MCA, however felt that this was very much the responsibility of the medical team although they did comment that the doctors sought and acted upon their opinions. We received feedback from relatives that they felt staff understanding of a best interest assessment was poor and had resulted in an unnecessary long hospital stay.
- Patients told us that staff told them about their treatment, explained what they were going to do and asked for consent.

Are medical care services caring?

Requires improvement

Patients spoke of care being delivered with kindness and of privacy and dignity being upheld. Feedback from relatives was not as positive with some expressing concern at the level of care – largely due, they felt, to staff shortages.

The Directorate had promoted the 'hello my name is' campaign and patients told us that staff introduced themselves and explained what they were doing.

Friends and Family results were overwhelmingly positive however the response rate was notably low. The average response rate at the hospital was 31.3%.

Compassionate care

- The majority of patients we spoke to told us staff treat them with respect and they were kind and caring. One patient told us they received 'superb care'. Another told us 'I feel safe and happy'. Feedback from relatives was not as positive. A number of them with elderly family members in hospital commented that understaffing led to patients not being helped with meals; being left in soiled clothing; not being mobilised; fluids not being monitored; patients not being given their hearing aids and that staff had a 'that's not my patient' attitude. They also complained of regular ward and sometimes site moves with no consultation. These comments were not specific to one ward, but related to a number including AMU, A5, A6, B6, C3 and C6.
- The Directorate had promoted the "hello my name is" campaign, which aimed to ensure every member of staff caring for patients took the time to introduce themselves to patients. Patients told us staff introduced themselves, explained what they were doing, and kept them informed.
- We observed that patients were treated with kindness and respect, and there was a culture of caring. On one ward we observed staff (including the ward manager, a nurse and an occupational therapist) taking the time to gently encourage a wandering patient back to his bed. Staff at all levels knew him by name, and they knew his wife was due to visit shortly and used his preference for

a favourite biscuit and cup of tea to settle him. However we also observed a member of staff move a zimmer frame out of reach of a who had dementia and was wanting to leave.

- Patients' privacy and dignity were maintained; for instance, we saw that care interventions were carried out behind closed doors or curtains, and staff asked permission before they entered. However we also received feedback at our public listening event that patient dignity was sometimes compromised by, for example, staff being too busy to help patients to the toilet so asking them to wear incontinence pads instead.
- We observed most patients had their call bells to hand and with few exceptions they told us that these were usually answered quickly. We noted one patient in a side ward could not reach their bell as it had been placed behind the bed. Relatives fed back to us that on one ward call bells were left out of reach.
- One patient stated that they often had to wait a long time for a bedpan. Another stated the nurses were so busy they had to wait 45 minutes for a commode.
- We noted on all the wards we visited that the Friends and Family Test response rates were exceptionally low, albeit the responses themselves were overwhelmingly positive. In June 2015 92% recommended the medicine directorate, whilst 4% did not. The response rate was only 14.1%. The average response rate at St Helier hospital was 31.3%. The best average response rate at St Helier hospital came from Beacon ward, with the worst from Mary Moore. Staff were unable to explain why the response rates were so low, and were not sure of ways to improve this. The senior management team acknowledge that this was an issue trust wide and was something they were trying to address.
- Data gathered through patient-led assessments of the care environment (PLACE) in 2015 showed over 97% of patients positively rated the wards for cleanliness; and over 67% for privacy.
- The trust was rated in the middle 60% for 17 indicators and within the bottom 20% for 20 of the indicators in the Cancer Patient Experience Survey 2013/14).

Understanding and involvement of patients and those close to them

- We received mixed feedback regarding the availability of doctors and their interaction with patients. One told us they saw a doctor, whereas another said they felt ignored.
- Several patients told us they were made to feel safe.
- We saw wards had access to magnetic symbols such as the 'forget me not' flower, which they could unobtrusively attached to the patients bed to indicate if a patient had dementia, or was hard of hearing for example. These were not being widely used however.
- Some relatives fed back to us that they had not been kept informed of discharge planning, and in once instance a patient was being discharged even though they did not have any clothes.

Emotional support

- We found that patients could access a range of specialist nurses, for example in palliative care, stroke and diabetes care, and that these staff offered appropriate support to patients and their families in relation to their psychological needs.
- We saw that staff took a holistic approach to their patients and in MDT meetings considered both their physical and psychological needs, seeking referral to the mental health team where appropriate.
- Feedback from the CQC public listening event held prior to the inspection included comments that staff did not seem to have the time to give good care, and there was a lack of clear communication.
- The hospital provided multi faith support however we received one complaint that there was a lack of support for Catholic patients. Chaplains had a list of leaders of local churches and faith communities if a patient wanted their own faith leader.

Are medical care services responsive?

Requires improvement

There was often a lack of medical beds which led to patients being placed as outliers on inappropriate wards.Discharge delays were common and the directorate was slow to respond to complaints.

We found that the medical directorate responded to the needs of local people in a number of ways. Dementia care was a priority, and ably supported by the OPAL team. We saw proactive work being carried out on the stroke ward. However we found that cross site working was disjointed, with specialist teams working to different practice models.

Medical care (including older people's care)

In all but neurology and dermatology, the medical directorate achieved the 18 week referral to treatment thresholds. The average length of stay at St Helier hospital was similar to the England average other than for non-elective geriatric medicine, however discharge delays were common.

The hospital had an escalation ward to enable it to meet the increased winter time demand. The ward was open at the time of this inspection.

Service planning and delivery to meet the needs of local people

- We saw that the trust was promoting supported discharge arrangements for stroke patients so they could continue their rehabilitation at home.
- We saw that cross site working was in some areas dysfunctional, and did not best meet the needs of the local people. For example, both Epsom and St Helier hospitals had a specialist diabetic team, and there was an additional diabetic team at the renal unit. There was no inter-site working to share best practice, and each site used a different practice model. The trust acknowledged this and had recently appointed a band eight nurse whose remit was to work across sites.
- The trust was also in the process of aligning service managers to specialities that were provided at both sites to enable cross site interaction to take place.
- We did not find there was a capacity issue which necessitated patients being transferred between hospital sites but there was often a lack of medical beds which led to patients being placed as outliers on inappropriate wards.
- We saw how the OPAL team provided wards with memory boxes and twiddle muffs for patients living with dementia. The OPAL team carried out an assessment of all elderly medical admissions within 48 hours of arrival. They liaised closely with district nurses, GPs and family members for example, when discharge was imminent. Following discharge, a member of the team would call the patient the day after they went home and again a week later.
- The trust had identified quality meetings needed to be more frequent and it had appointed additional clinical managers.
- A screening proforma had been introduced for staff to refer to when issuing a death certificate and the information gathered would be used to identify any clinical concerns/incidents within that clinical spell. Learning from this was escalated and fed into trust wide audits.

Access and flow

- The average length of patient stay across the trust was similar to the England average, but longer at St Helier for non-elective geriatric medicine.
- Across the trust the 18 week Referral to Treatment threshold was achieved for each pathway with the exception of neurology and dermatology.
- Staff told us that discharge delays were common and due to a variety of factors such as waiting for medicines to be dispensed; waiting for therapy assessments and waiting for placements in nursing or residential care. Complex discharges were sometimes delayed because, we were told, staff did not have the experience to deal with them. There had also been a reduction in the number of discharge coordinators, and staff felt this had had a notable negative impact. We noted on one ward that there were a large number of patients with section 2 and 5 community discharge orders in place.
- We received a number of complaints from patients and relatives with regard to the pharmacy and the 2-3 hour wait for medicines to be dispensed. Pharmacists felt some of the delays were due to last minute requests from doctors for medicines needed for a patients discharge.
- There were delays in producing discharge summaries. We spoke with a patient who had returned to the hospital a week after discharge because their GP had not received a summary. The trust had a target to provide an electronic discharge summary within 24 hours to 98% of patients. Trust data for April – June 2015 showed a success rate of between 74% and 78%.
- Medical handover arrangements ensured that medical patients in non-medical beds were reviewed in a timely way.

- The trust's bed occupancy had been in line with the national average since January 2015.
- Trust wide, within the medical directorate, 99.5% of patients were seen within six weeks for diagnostic tests.
- The medical directorate was meeting most of the national standards for cancer waiting times. Ninety five percent of appropriate two week wait cancer patients were seen within that time frame(national standard 93%) and 97.8% were treated within 31 days of a

decision to treat (national standard 96%).The trust fell below the national standard for the two month wait from urgent GP referral to treatment achieving 76.8% compared to the national standard of 85%.

- Data provided by the trust showed that in July 2015, 191 patients had been moved between wards after 10pm. This was an increase on the 179 who were moved after 10pm the previous month.
- Between August 2014 and July 2015 at St Helier hospital, 19% of patients were moved between wards once; 8% were moved twice, 2% were moved three times and 2% were moved four or more times during their admission. Patients told us they were not always informed they were being moved.
- We observed a handover on the acute medical unit. Thirty five patients had been admitted over the past 24 hour period. The ward was calm, efficient and the admission book clearly stated time each patient was referred to a ward, the time they were moved, potential breach times and discharge times.
- The hospital had a 22 bed escalation ward, ostensibly to be used to cope with winter time increased demand. The ward was open at the time of this inspection. Two of the patients were surgical outliers.

Meeting people's individual needs

- Within the medical directorate 94.4% of staff had attended equality and diversity training. This was just below the trust threshold of 95%.
- We saw that signs on elderly care wards had been replaced with dementia friendly signage and wards re-painted in 'dementia friendly' colours.
- People living with dementia were sometimes identified by a discrete 'forget me not' sign so all staff would be aware of their special needs. We saw that 'This is me' documents produced by the Alzheimer's Society were used to ensure staff had access to a patient's biographical data to inform the patient's care plan.
- We saw that bathrooms and lavatories were suitable for those with limited mobility. Supplies of mobility aids and lifting equipment such as hoists to enable staff to care for patients were available however therapists did comment that they may have to wait for a hoist to become available.
- Staff told us that interpreting services could be accessed; however, professional interpreters were not used as staff relied on colleagues who spoke another language. Staff told us they could provide leaflets in different languages if requested.
- Staff told us they were able to undergo training in dementia care, and spoke highly of the support the OPALs team gave in this regard.
- We noted the stroke ward had access to dedicated physiotherapists and speech and language therapists. This ward also provided a range of activities for patients and families. For example a noticeboard on the ward extended an invitation for people to attend a lunch group; education group; support group and/or a communication group.
- Some of the wards we visited were mixed gender. Whilst we did not observe any breaches of guidance on mixed-sex accommodation we did note that in some cases male patients had a long walk to the designated male toilets.
- The hospital had a number of clinical nurse specialists. Staff could seek advice from, for example, a tissue viability nurse and monthly tissue viability champions group meetings were held.
- Patients were generally positive about the quality of food provided.
- We observed that patients were served a choice of foods and that specialist diets were managed well. Patients were assessed by a dietician when screening suggested a risk of malnutrition or there were medical problems that compromised patients' nutrition.
- We noted that patients were helped to eat and drink and in most instances were left with a drink within reach. Wards had protected meals times during which visitors were only permitted to visit if they were helping a patient with their meal. All staff were expected to assist patients who needed it. Red trays were used to readily identify those who needed help. On one ward we saw the lids of water jugs were colour coded so that staff could tell at a glance when the water had been changed.
- Food that met people's special cultural and religious needs was available such as kosher, halal, Asian and Caribbean meals.

Medical care (including older people's care)

Learning from complaints and concerns

- In quarter one of 2015/16 the medical directorate had 75 complaints that were due a response. It only managed to respond to six, giving a response rate of just 8%.
- We reviewed the concerns that had been expressed by people who had contacted the Commission prior to this inspection. Most concerns related to low staffing levels but also included concerns relating to a lack of discharge planning, poor communication, poor palliative care, failure to assess mental capacity and decision making ability of patients (where relatives felt this was indicated), unavailable, broken and faulty equipment, a lack of consultant visits, general poor nursing care and unhygienic wards.
- We talked with one family who had a number of urgent concerns which they felt were not being addressed. We saw that the ward manager, when made aware of the full extent of the concerns, took immediate action which included arranging a formal meeting the next day.
- During our public listening event held prior to the inspection some people commented that they had either felt unable to complain or had received a poor/no response from the PALs team/senior nurses. Some relatives told us they were afraid to complain in case it impacted on patient care.

Are medical care services well-led?

Good

Governance arrangements in the medical directorate were adequate, and performance was monitored and managed. There was a positive culture within the hospital. Staff commented on very good multidisciplinary teamwork; collaborative care and line management support. They felt there had been improvement following the change in senior management, and spoke of a much clear vision and a proactive approach to problem solving.

Patients, relatives and family were able to feedback through the FFT but the uptake was low. The trust had introduced the 'Patient First' programme to improve communication and liaison with relatives and carers at ward level.

Staff felt able to raise concerns and give feedback. Most of their concerns related to low staffing levels which led to an increased workload and deterioration in the level of care they could provide. They felt this was most notable on the care of the elderly wards.

There were a number of innovative projects at the hospital, including the breakfast club on the stroke ward; the OPAL team and the SWOOP team.

Vision and strategy for this service

- The Trust had a five year clinical strategy, which included a SWOT analysis (a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in a project) and identified the medicine directorate strengths and weaknesses. Identified strengths included achieving dementia care targets; its 18 week referral to treatment performance and its stroke performance. Identified weaknesses included the lack of a cardiac catheter laboratory (resolved as a new laboratory opened not long after this inspection); not having an out of hours endoscopy service; below target statutory and mandatory training levels and an insufficient number of junior medical staff.
- Staff we spoke with were aware of the trust's vision and values and said the general goal of the hospital was to focus on care. Some commented that new leadership had resulted in a much clear vision and a proactive approach to problem solving.
- We found that ward areas had developed their own strategies, which were in line with those of the organisation. Staff spoke passionately about these visions and told us how they tried to make them part of their work.
- We noted that staff were engaged with the broader issues of the trust. For instance, they were aware of the lessons learned from a never event which had relevance across services.

Governance, risk management and quality measurement

- We found governance systems were in place. The medicine directorate's governance and risk committee met monthly. The July 2015 meeting had as agenda items reviews of complaints, infection control and staff training.

Medical care (including older people's care)

- We saw dashboards were maintained and that these provided a range of key management and quality metrics that could be benchmarked against agreed performance targets. For example, the rate of mandatory staff training in the medical directorate.
- Performance information was displayed in ward areas in the form of 'How we are doing' displays accessible to staff, patients and their families. Some ward managers displayed additional performance data. Staff we spoke with were aware of this data and took an interest in their team's performance.
- We saw that some areas, such as infection control, were assigned incidence thresholds. When these thresholds were reached, the ward entered a period of 'special measures' and enhanced monitoring of key metrics relating to the issue. In this way, medical care services intervened early when safety themes were emerging.
- The medical directorate maintained a risk register. This was not specific to individual issues but general concerns and listed the action needed to be taken to mitigate them.
- We saw in the minutes of the July 2015 (monthly) physicians meeting that a risk had been identified and an incident reported when a junior GP trainee had been given bleeps to cover two junior doctors and a senior trainee doctor. The meeting discussed the report and action taken which included having a backup senior trainee rota.
- A quarterly Medicine Directorate quality report was produced. The August 2015 report reviewed, for example, incidents by specialities (with the emergency department being the highest at St Helier); near misses – the most prevalent at St Helier relating to medication.

Leadership of service

- Senior management discussed with us where they were felt they were not as effective as they could be and outlined what they were doing to address this. For example they acknowledged that there was no cross site working in the diabetic specialism and had recently recruited a Band 8 nurse to work across both sites. Lack of cross site working was commented on by staff. For example physiotherapists said it was difficult to hand over patients to Epsom as they used a different documentation system and the level of service offered at each site differed, making it difficult to manage patient expectations.
- Ward based staff confirmed that the matrons were highly visible but that they would not recognise the chief nurse and they did not think that middle and senior managers visited ward areas. We noted however that the newly appointed chief nurse was taking steps to address this. For example the senior nurse uniform colour had been changed to red so that staff could easily identify them.
- Staff told us they felt supported by matrons. They described them as having an open door policy and easily approachable.
- Some staff commented that the hospital was going from strength to strength; that it was supportive and democratic.
- The majority of junior doctors reported they were supported by senior staff.

Culture within the service:

- We observed that staff spoke positively about their work, colleagues and the trust. Each person appreciated the contribution they made to the care of patients.
- We found that staff showed a keen interest in their work and that of others, and demonstrated a commitment to improving services.
- The average staff sickness rate within the medicine directorate was 8% amongst clinical staff and 5% amongst nursing staff. The trust's average sickness rate was 6%.
- Staff turnover in the directorate was 18% for clinical staff and 16% for nursing staff. The trust average was 14%.
- We found good morale amongst staff. Some had worked at the trust for a considerable length of time but did not feel that this inhibited either their motivation or vision.

Public engagement

- Patients, relatives and friends were able to comment and feedback on the care and service being provided through the Family and Friends test (FFT). The low response rates suggested that publicising the test was not seen as a priority for staff.
- The Directorate had introduced Patient First training to try to improve ward based communication and had developed a message book for ward teams to capture any issues or concerns raised by relatives or carers for patients. The concerns were then discussed at the daily board rounds and the relative or carer contacted with an explanation and to resolve concerns.
- The patient advice and liaison service (PALS) had received 413 enquiries relating to the medical

directorate for the first quarter of 2015, an increase on the previous quarter. The majority of enquiries were attributed to care and treatment enquiries; requests for information and advice and communication and information.

- We carried out a public engagement exercise at the hospital prior to the inspection. We received a number of positive comments about the level of care and the food. Concerns were expressed regarding staffing levels; the quality of cleaning on some wards; being moved wards late at night with no warning and poor pain relief.

Staff engagement

- Staff told us they felt able to raise concerns, and the hospital promoted an open environment. Some staff commented on the usefulness of monthly ward meetings. These were used to, for example, feedback on earning from incidents. Staff on wards where meetings were less frequent raised this as an issue with us.
- Junior doctors were complimentary of the care the hospital gave. They felt it was 'safe even when busy'.
- Staff talked of feeling valued, good team work, effective multidisciplinary cooperation and positive leadership. They were proud of the work they did. They felt the availability of supervision and appraisals met their needs however some commented on the difficulty attending training days because of staffing shortages.
- We saw some wards had implemented 'Safety Huddles' to handover important patient information to all staff on the ward. Some staff commented on the inconsistency in getting feedback on incidents however.
- Staff felt there was good communication and their direct managers were approachable and listened however there was also concern that issues which affected patient care - namely increased acuity and staffing shortages, were not being addressed, and this was causing frustration.
- Prior to the inspection we carried out a number of focus groups with staff of all grades. Positive comments were made included 'it's an empowering and innovative place to work' and that there had been a 'change in the culture since new chief nurse started, she was very visible and listened'. Staff liked the chief executive's weekly letter as it communicated information and they were asked for feedback which in turn the chief executive responded to.
- Some staff told us that career progression was limited and this effected morale. Conversely, others praised the opportunities to develop and undergo training for career advancement.
- The NHS staff survey carried out in 2014 indicated that the trust performed in line with other trusts in all but three areas. The areas achieving negative findings were the percentage of staff receiving well-structured appraisals; the percentage of staff working extra hours and the number of staff who believed the trust provided equal opportunities for career progression.

Innovation, improvement and sustainability

- The stroke ward held a number of initiatives such as communication group and a lunch group. Relatives could also attend these.
- The OPAL team had clearly had a positive impact in increasing the quality care of the elderly, particularly those living with dementia. They provided training to staff and were developing a delirium risk tool and a frailty tool. An 11 bed dementia unit was due to open towards the end of the year. The team also held bi-monthly meetings with local care homes to help improve staff training. Elderly patients being discharged were provided with a (larger) print discharge information document entitled 'Your Next Steps'. This listed useful contact numbers, advice re follow up appointments and medication; and what to do if, for example the home carer or district nurse did not turn up. Over the year to date, the trust had carried out dementia screening on 96% of (appropriate) patients.
- The hospital had set up a SWOOP team, made up of nurses, social workers and therapists, designed to expedite discharges without admission.
- Electronic patient monitoring was being introduced to assist staff to recognise and promptly respond to deteriorating patients.
- The "Perfect Handover" was being rolled out at St Helier.
- Ward managers discussed with us the areas they wanted to improve and the aims they had set for the next quarter.
- The discharge lounge provided a 'Winter Warmer' pack and 'Message in a Bottle' - initiatives designed to provide care and support for elderly patients who live alone.

Surgery

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

Information about the service

St Helier hospital provided emergency surgery and elective day surgery for those patients within the catchment area of Epsom and St Helier University Hospitals NHS Trust. There were 7,250 day cases, 4,625 emergency operations and 625 elective operations from and including January 2014 to December 2014 at the hospital. Ophthalmology made up 2,625 of the day cases.

The surgery teams sat within the surgery, critical care and anaesthetics directorate. The hospital had six operating theatres and an additional procedure room. There was a dedicated trauma orthopaedics theatre, a theatre for all other emergency, urgent cases and a theatre for planned morning and afternoon sessions that included pain clinics and dental. There were two theatres used for day surgery, one was exclusively for ophthalmic operations.

The hospital had four main surgical wards. A3 a 23-bed ward for patients predominantly with hip and spinal fractures, which took patients with a fractured neck of femur. B3 a 16-bed orthopaedic and general surgical ward. B5 a 31-bed general surgical ward. SAU the Surgical Assessment Unit also known as Frank Deas was a 22-bed general surgical ward. There were two day case units, B4 with 12 beds and the Eye Day Case Unit. Surgery services also provided a pre-operative patient assessment for patients undergoing elective day surgery.

During our inspections we talked with 34 patients and over 40 members of staff including administrators, domestic staff, healthcare assistants, nurses, student nurses, theatre staff, doctors in training, consultant surgeons and anaesthetists, senior nurses, managers and therapists. We visited clinical areas, observed care and looked at patient records. We reviewed national data and information provided by the trust and received information from focus groups where staff shared their views.

Surgery

Summary of findings

We have judged surgery services overall as inadequate. Low nurse staffing levels on some wards meant there was a risk to the quality of patient care. The shortage of staff had led to harm for some patients. There was no escalation plan to address staffing shortages as they arose. There was inconsistent feedback and learning from incidents and complaints. Processes to ensure people's safety were not robust or consistent across the service. Not all staff had received the training they required or had their annual appraisal which meant we could not be assured that staff were competent in their roles.

National audits that the trust took part in indicated that they adhered to best practice standards as well as or better than the England average, however there was a limited range of evidence for local audits.

The majority of patients told us staff were caring, the patient experience survey for April 2015 to April 2015 had an equal amount of positive and negative comments about the care patients had received on surgical wards.

The trust had fallen below the standard for the referral to treatment times (RTT). Bed management meetings did not discuss the patient's needs and staff told us that patients experienced moves to different wards at night.

Risks for the service had been identified in various governance meetings and from a series of incidents but significant issues identified were not addressed and action had not been taken. There lacked cohesiveness and a trust board understanding of how to address these issues in a timely manner.

Are surgery services safe?

Inadequate

Safety within the surgery services was rated as inadequate.

The shortage of staff had been highlighted as a high risk on the risk register for surgery. Staff reported they were unable to perform some aspects of care for patients due to a shortage of staff, this had led to harm for some patients. This had been identified by the trust;there was an action plan but not an escalation plan to address shortages as they arose.

There was a formal process for reporting incidents some staff were reluctant to report incidents and there was inconsistent feedback and learning from incidents across the service.

Processes for venous thromboembolism VTE assessments were not robust. Infection control audits were not consistent across the services, there had been non-compliance over a six month period on one ward just before our inspection.

Problems with equipment were identified by staff, there was no replacement programme, and the trust had identified a number of weaknesses in providing assurances that medical devices were maintained to the required standards.

Patient's records were often missing care plans, which advised nursing staff on how best to meet the needs of patients. The monitoring and response to patients observations was variable and a deterioration in a patient was not always identified and acted on appropriately

Staff had not all received all the mandatory and safeguarding training required to provide safe care to patients.

The second stage of the WHO Surgical Safety Checklist was not happening in all cases.

An investigation was being undertaken by the trust into six cardiac arrests that occurred on B5 ward within a five week period, some action points had been identified and responded to.

Surgery

Incidents

- The trust had not reported any 'Never Events' in surgical services from August 2014 to July 2015. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Thirteen serious incidents (SI's) requiring investigation took place between August 2014 and July 2015 of which eleven were pressure ulcers and two were falls. Nine of the eleven pressure ulcers had been acquired in the community and were not hospital acquired. In the incident reporting log for surgery we found themes in accidents; falls, pressure ulcers, staffing and equipment. The trust reported more no/low or moderate harm compared to other trusts. Some doctors told us that when they had reported incidents they had been downgraded. The trust's incident reporting policy set out their grading system and this correlated with the type and grade of incidents we saw reported.
- We saw two full investigations into two patients who had died from bone cement implantation syndrome following surgery, learning from this had resulted in new guidance and protocols.
- There were six cardiac arrests over a five week period in July and August 2015 on ward B5. An investigation was being undertaken by the trust, this included reviewing patient safety issues and incidents and the escalation and management of concerns from 1 April 2015 until 1 September 2015. We saw that action points had been identified by the trust and responded to. A final report was submitted after our inspection which identified that root causes linked to the cardiac arrests included a shortage of appropriately skilled and senior nursing staff; a ward culture which meant staff did not recognise the importance of escalating concerns in a timely way and a call bell system which was not fit or purpose (the call bell system was subsequently replaced in October 2015).
- Incidents were reported using an electronic system and staff we spoke with knew how to use the system. Nursing staff on the surgical wards told us they used this system to report incidents, some staff working in theatres did not use this system. Some staff across surgical services told us they were reluctant to use the electronic reporting system as they got little response to and actions from the incidents reported. We did see evidence of incidents reported both in theatres and on surgical wards.
- Staff in theatres received feedback from incidents at the weekly staff meeting. Matrons for the surgical wards told us they and ward managers attended monthly meetings where learning from incidents was shared. Minutes and email trials provided showed actions for ward managers but not learning from incidents. Ward managers gave varied ways of sharing information with some staff emailing, others doing this during handover and some was ad hoc. On the ophthalmic day ward we saw a document with incidents and actions for staff to read and sign once read. There was no consistent method of sharing learning from incidents. Medical staff told us they had to request feedback on incidents and there was often minimal or no action taken.
- Multi-professional surgical and anaesthetic mortality and morbidity meetings took place monthly. We saw minutes of these meetings, doctors told us they were presented by foundation year one and two doctors in training and lessons learnt from them.
- The duty of candour requires staff to be open and transparent with people about the care and treatment they receive. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred the principles aim to improve openness and transparency in the NHS. There had been a presentation about the duty of candour in September 2015 at the joint audit day for general surgery and anaesthetics which was attended by 122 staff. The trust told us that the presentation had been printed off and was displayed in staff rooms. Most staff were aware of the principles of duty of candour. One member of staff present during the trauma meeting gave an example of duty of candour for an incident with a letter of apology being written to a patient. A senior member of staff told us that if an incident was graded as moderate or above then a duty of candour investigation was instigated and a duty of candour lead nominated.

Safety thermometer

- The trust participated in the NHS Safety Thermometer scheme, used to collect local data on specific measures related to patient harm and 'harm free' care. The measures being the prevalence of pressure ulcers grade 2, 3 and 4, falls with harm, and new catheter acquired

urinary tract infection. Data was collected on a single day each month to indicate performance in key safety areas. This data was collected electronically and a report produced for each area.

- The trust's data was comparable to another trust of its size. The trust had seen an increase in the frequency of falls peaking in July 2015 to 10 per 100 patients surveyed, prior to this the rate had remained low since September 2014. Catheter acquired urinary tract infections had fluctuated in frequency but apart from a peak of three per 100 patients in March 2015 there had only been one or two each month. For pressure ulcers there had been a peak of nearly one per 100 patients in April 2015, otherwise the rate had remained low. Information on new patient harm was displayed on each surgical ward.
- The trust 'signed up' to the national safety campaign in June 2014 and was successful in a bid for falls prevention, management and reduction of associated risk. Two 'falls safe' nurses were recruited and ward managers were liaising with falls nurses on piloting new equipment. Staff on surgical wards told us that a falls specialist nurse had been recruited to work trust wide for 23 hours a week and 15 hours as a junior sister on one of the surgical wards B5 but not specifically as a falls nurse. A Cannard Falls Risk Assessment tool was in use on the surgical wards and documentation described the actions to be taken if a patient fell. We saw five monthly fall reports recording the falls occurring in each surgical ward across the trust including information on time and type of fall, fall repeaters and a statement that indicated where staffing was an issue. There was no analysis or evidence provided of how staffing might be an issue in relation to the falls recorded.
- On one ward B5 we were told that three patients had been referred to a doctor for a venous thromboembolism (VTE) assessment within 24 hours of admission. This was in line with National Institute for Clinical Excellence (NICE) guidelines and had been initiated by the VTE nurse. We did not see evidence of this in the records and the processes used. We found the three patients had missed this assessment. Medical staff also told us some patients across surgical wards did not receive VTE prophylaxis as required. We saw there had been eight missed VTE assessments recorded as incidents over the last year. One patient had developed a VTE during their hospital stay in October 2015. This meant that processes for VTE assessment were not robust and patients were at risk of developing a VTE.

Cleanliness, infection control and hygiene

- The trust scored similar or slightly worse when compared to the national average for the Patient led Assessment of the Care Environment (PLACE) survey of 2015. In the surgical wards the average score was 97%.
- We found the operating theatres and wards to be visibly clean during our inspection. Documentation showed that quarterly infection control and prevention audits were completed in the operating theatres and recovery areas and showed 95% compliance and we saw cleaning schedules.
- We observed that there were dedicated staff for cleaning ward areas. The surgical wards we visited were clean and all patients we spoke with were satisfied with the cleanliness. There were cleaning logs in place.
- Hand wash basins and alcohol hand sanitising gel were available at both ward and theatre entrances. Alcohol gel was available in patient bays.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE as appropriate. We observed some staff not complying with the infection prevention and control policy, being bare below the elbow and washing hands. On A3 ward we saw the door to the sluice area was propped open, the ward manager closed this. In the public cafeteria we observed theatre staff in theatre scrubs and clogs with a disposable gown worn over them. The gown was not wrapped around or tied up. This meant there was a risk of cross contamination between the operating theatres and public areas.
- Documentation provided by the trust showed four in patient surgical wards had quarterly infection control audits, we saw two audits completed in April/May and August/September 2015. These audited 14 standards including the management of Meticillin-Resistant Staphylococcus aureus (MRSA), the management of patients with diarrhoea, equipment cleanliness and documentation, care of peripheral cannula, care of urinary catheters, patient and staff hand hygiene. Actions were indicated and monitored for example by assessing staff hand hygiene technique with the ultra violet hand inspection cabinet.

- We were told that one ward B5 had not been meeting standards set by the trust for infection control and prevention measures,until the second day of our inspection. The last two quarterly infection control audits showed B5 ward needed to improve on 13 of the 14 standards set by the trust with an average score of 67%. This included improving the management of patients with MRSA, the management of patients with diarrhoea, the cleaning of equipment, the daily documentation and the need to improve handwashing. A3 ward in August 2015 scored 74% just below the compliance score of 75% and had identified the low use of the correct handwashing technique and the need to ensure equipment was cleaned appropriately.
- Staff on the ophthalmic day case unit gave differing accounts on infection control audits, from completing hand hygiene audits to no infection control audits for four years. We were not provided with documentation on infection control audits for this ward.
- For surgery in the trust, there had been two cases of MRSA from April 2015 to and including September 2015, this had been given a red rating on the surgery performance scorecard. One case of Clostridium Difficile and one of Meticillin –sensitive Staphylococcus Aureus were within the acceptable threshold on the surgery performance scorecard. All patients were screened for MRSA pre-operatively for elective cases and on admission for emergency cases. There was a system for regular screening of all patients and we saw evidence of MRSA screening in the records we reviewed.
- The Infection Prevention and Control Team undertook surgical site infection surveillance of selected procedures, which was coordinated by the Centre for Infections at Public Health England.

Environment and equipment

- Some of the bed spaces on the surgical wards had visible damage to the walls and some ward areas were in need of redecoration. Some areas, for example side rooms were missing privacy curtains and in the B4 ward lounge, window blinds were broken and missing. In the PLACE survey the average score for the condition, appearance and maintenance of the surgical wards was 87% comparable to the England average of 90%. Staff gave differing schedules for the changing of material curtains used on the wards and in theatre recovery areas from it being every three to every four months.
- In theatre B4 and ward B4 staff told us of problems with aging computers and screens that regularly did not work. There had been incidents when the x-ray computed tomography (CT) screen and the picture archiving and communication system (PACS) would not display images of patients which were required to enable medical practitioners to undertake surgical procedures. This had delayed patient care with subsequent patient's procedures being postponed. Staff told us they reported these incidents to managers and the IT services. From July to mid-November 2015 inclusive we saw three IT related incidents had been reported using the electronic system. Staff told us there was no routine programme to replace or refurbish IT equipment. Staff across the hospital in focus groups told us that IT was a barrier to working effectively due to old IT equipment and the lack of IT.
- Staff told us there was no replacement programme routinely in place for theatre equipment, capital bids were done once a year and when needed to replace or acquire new equipment.
- In theatres staff told us of varying turnaround times for instruments to be sterilised, some reported a fast tracking time of eight hours. Other staff spoke of delays in instruments being returned following sterilisation and decontamination, even if they had been fast tracked. There were also times when instruments returned were in a poor state of repair and needed replacing. Staff told us that when this happened it impacted on staff's time and slowed up the operating list. From July to mid-November 2015 we saw four incidents of inadequate or broken equipment having been reported using the electronic system.
- The medical equipment within surgical care was mainly managed by the trust's Electrical and Biomedical Engineering (EBME) department. Some specialist equipment, such as anaesthetic and theatre equipment was monitored by the theatre matron; we saw a manual system for checking equipment in place in theatres. The trust's Medical Devices Committee had identified a number of weaknesses in providing assurances that medical devices were maintained to the required standards. An action plan had been commenced in September 2015 to have department equipment coordinators in each department to review asset registers, categorise equipment into high, medium or low risk and to establish where devices were not

maintained by the EBME. This meant that the trust could not be assured that all medical equipment was maintained to the required standards and was safe to use.

- Annual maintenance and revalidation checks of the operating theatres' ventilation were carried out. We saw evidence of the latest report dated September 2015, which provided sufficient evidence to assure that a safe, clean, compliant environment for surgical procedures was provided within operating theatres in line with relevant regulations (Building Regulations 2000, England and Wales, approved document F1: Means of Ventilation and Heating and ventilation systems: Health Technical Memorandum. The report commented on remedial action required to a ventilation canopy.
- We saw resuscitation equipment available in all clinical areas with security tabs present on each. Systems were in place to check equipment we found this had been complied with on most wards. On one ward B5 checks had been missed on five occasions in October and on two occasions between 1 and 11 November 2015. During our inspection the oxygen and suction points were not checked and ready to use on B5 ward. In theatre B4 we found one intraocular lens out of date by one month, staff immediately removed this when we pointed it out to them.
- The surgical wards had adequate manual handling equipment. On ward A3 which mainly cared for patients with hip fractures there was a physiotherapy room with a hoist and specialist standing equipment.
- We saw that bedrails were used; we were provided with a bed rails assessment and policy on their use.

Medicines

- Medicines were stored safely and appropriately on surgery wards and theatres at St Helier hospital, including items which needed to be stored in refrigerated conditions. Temperature checks had been carried out on drug fridges and recorded daily except for in one anaesthetic room, where we saw inconsistencies in the recording of drug fridge temperature. For the first ten days of November 2015 we observed that the temperature was not recorded for four days.
- All the surgical wards had pharmacist input into the reconciliation of patients' medicines and the clinical screening of prescriptions. Pharmacists were involved in discharge planning, including the provision of compliance aids where these were needed.
- On discharge, patients were advised by nurses on the use of their medicines. The pharmacy team attached a checklist to all medicines to take out (TTOs) to help with this, which was signed and added to the patient notes.
- We saw medicines were given to patients by nursing staff in accordance with the prescription and that safety checks were carried out during the administration process. Patients had paper medication administration records, electronic prescribing was being rolled out across the trust. Medication prescriptions we saw were written clearly with the patient's allergy status. Nurses wore a red apron which identified them as administering medication during the medicines round and for them not to be distracted. Staff had access to up to date guidance on medicines and could access advice from a pharmacist.
- Medicines policies and resources were available on the trust intranet and members of staff were encouraged to access documents online. Medicines management was included within trust induction for nursing staff. Each nurse was also given a 'Clinical Competency Workbook' that they had to complete to record their progress. Nurses told us how useful they found this.
- We saw that medication errors were reported on the electronic reporting system. Staff on B5 told us that there had been two similar errors in medication administration by one staff member. There had been minimal changes put in place after the first incident, a similar incident occurred with the same staff member after this but no changes were implemented, this meant there was still a risk of a medication error occurring.

Records

- Most patient care was recorded in paper records; in addition electronic record systems were used in ophthalmology and for storing, and viewing x-ray and scan images. In the nursing records we reviewed, risk assessments in the bedside folder were not clearly organised into sections. For example, in the three records we looked at on one ward there were no care plans and no fluid charts. When we discussed this with a ward manager and practice educator they reported that care plans were not routinely completed and estimated that around five out of thirty patients would have a care plan. This was recognised by the staff as an area for improvement. Three medical staff told us fluid balance charts were not filled out. Records lacking a care plan and missing information meant that information on

which to identify, assess and communicate patient's individual needs were missing and meant staff would not be guided in how to best meet the needs of that patient.

- We spoke with patients about their pre-operative assessments and information they had received, this correlated with information recorded in the medical notes. The pre-operative assessment included written consent, medical history relevant to the procedure, a record of being given printed information about the procedure, and if any additional needs had been identified. The notes were legible and the pre assessment section was easily identifiable. Documentation for those having day case or short stay surgery followed the guidelines from the Association of Anaesthetists.
- Patient records were stored in locked record trolleys securely attached to the wall in close proximity and within sight of administrative staff and the nurses' station. During our announced inspection B5 ward had a records trolley with external padlocks for the three records sections, on several occasions' nurses were temporarily unable to locate the keys to these. This meant there was a delay in accessing records. We saw evidence that a new records trolley had been ordered. On the day of our unannounced inspection on 23 November 2015 there was a new locked notes trolley attached to the wall.

Safeguarding

- Most nurses and doctors we spoke to were able to explain their understanding of safeguarding and the principles behind safeguarding children and adults. They were clear about the escalation process.
- All clinical staff were required to complete level one adult safeguarding a 90 minute training session, senior staff such as ward managers were required to complete level two a one day training, level three training was over three days for senior staff who may carry out safeguarding adult investigations and instigate proceedings. The trust's target was 95% compliance, data was only available trust wide for non-medical staff working in surgical wards and theatres and indicated that 86% of staff completed this training. Medical and dental staff compliance for safeguarding adults training was 70%.
- Staff were required to complete the safeguarding children training, the level required depending on their role and contact with children. Some nurses in theatre working with children felt they should be attending level three safeguarding children training. The intercollegiate document on roles and competencies for health care staff in safeguarding children published by the Royal College of Paediatrics and Child Health does not include this staff group as requiring level three training. The trust's safeguarding children training target for compliance was 95%. Data provided for the three levels of safeguarding training for non-medical staff working in surgical wards and theatres across the trust showed an average of 87% compliance for level one, 80% for level two of 81%, and 95% for level three. Medical and dental staff compliance for safeguarding children was 63%.
- There was joint care between orthopaedic and care of the elderly doctors on ward A3, providing an 'orthogeriatric' service for post-operative patients with a fractured neck of femur. This model of care is seen as a good model of care by the British Geriatrics Society. Staff on A3 told us the safeguarding adult lead worked closely with the ward.

Mandatory training

- Nurses told us that mandatory training was booked by the ward managers for the surgical wards and a senior nurse manager in theatre. An electronic programme showed the training staff had completed with the date and showed when training was next due as well as highlighting any breaches. Staff could access their learning record on line. Staff in theatres told us they were encouraged to do e-learning as opposed to face-to-face training so that the department was not short staffed, but would prefer more face-to-face training. The 'bank partners' were responsible for ensuring all non-permanent staff received their statutory and mandatory training before they commenced work.
- The target set by the trust for mandatory training was 95%. Across the surgical wards and theatres in the trust this was not met, with the lowest figure being 59% for Information Governance and with 74% for conflict resolution.
- The mandatory training rates for medical and dental staff in surgery across the trust showed an average of 77% compliance with the lowest rate being equality and diversity training at 50%.

Surgery

Assessing and responding to patient risk

- The surgical inpatient wards had a hand held device to record observations at the patient's bedside, the device had the ability to calculate an early warning score (EWS) to prompt staff to take necessary action. Not all staff had access to this system, such as bank staff, student nurses and doctors. A senior nurse during our announced inspection told us that early warning scores needing a clinical response were not always acted on. Staff told us they would call the doctor if they were concerned about a patient but some staff we asked where unsure about when to put out an emergency call. This was corroborated during our unannounced inspection when we identified four patients who each had increasing early warning scores, but with no escalation taking place.
- In information provided by the trust following our inspections in relation to the investigation into B5 ward we saw that in five of the six cases, missing or inappropriate responses to early warning scores had been indicated.
- The trust reported that staff on B5 ward had in the two months, before our announced inspection, received training from a seconded practice educator to identify and respond to the acutely unwell patient. During our unannounced inspection on 23 November 2015 on B5 ward we were shown a hand held device, we asked about the early warning scores (EWS) for one patient. A criteria for clinical responses was provided to us but this had not been followed, we discussed this with the nurse responsible who told us she was aware of the scores. After further discussion the nurse called the patient's registrar and we observed the patient being seen by the matron. This meant there was a risk that those patients who were deteriorating would not be responded to appropriately.
- An audit from July 2015 by the trust of these observations being overdue within the week showed that two wards A3 and B3 had three to four weeks of over 15% overdue observations (from 16% to 19%). The Surgical Assessment Unit had one week of 20% being overdue. B5 ward had eight weeks of observations being overdue from 16% to 44% being late. Following our inspections the trust reported there had been an improvement on the number of breached observations both day and night on B5 ward.
- During our unannounced inspection we were told on another ward that an interim acute response team had been introduced trust wide the week before. We saw the standard operating procedure. This procedure had differing criteria to that showed to us on the other ward on the same day. This meant there was not one standard response in use and clinical referrals and responses could be variable.
- Doctors in foundation years one and two told us they were able to escalate any concerns about sick patients to the senior trainee doctor. The senior trainee could call critical care for advice but any formal critical care referral would be via consultant to consultant as per recommendations from the London Quality Standards. Doctors told us that patients admitted for vascular surgery would not have a named consultant within the trust, they would be under the care of another trust where vascular services were centralised and would be visited by a visiting consultant. We identified two such patients who had not been reviewed for two weeks and two months respectively; we escalated this to the trust leadership team immediately following the inspection.
- We saw that staff recorded the observations of patient safety parameters such as heart rate, respirations, blood pressure, temperature, and pain, these were hand written in the patient notes. Observations from the hand held device were available on a screen to those who had access and could be printed out for the paper records.
- Patients were assessed for actual and potential risks related to their health and well-being and we saw evidence of these in patient's bedside folders. On A3 ward where patients with a fractured neck of femur were admitted all patients had fall assessments on admission which was reviewed weekly or subsequent to any fall.

Use of the 'five steps to safer surgery' procedures

- Theatre staff 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) surgical safety checklist.
- Each patient in theatre had a paper WHO surgical safety checklist that the theatre and anaesthetic staff used and completed. There was a bespoke surgical safety checklist for cataract surgery as set out by the National Patient Safety Agency adapted from the WHO surgical safety checklist. We observed in two theatre sessions during the step three 'time out' that not all team members fully engaged in introducing themselves by name and role or even taking 'time out' to listen. Steps

one and four were followed fully but step five 'the debrief' did not always take place. In two other operations we observed full engagement in all of the five steps.

- An observational audit by the trust on one day in September 2015 highlighted that 'time out' was not happening in all cases and occurred in 85% of all cases. This audit occurred once a year with a plan to do observational audits twice a year and health records audit twice a year and further ad hoc according to the results. An audit of the WHO checklist in eye surgery for autumn 2014 showed 100% compliance. The trust's health records audit reporting in May 2015, although only a small sample showed 12% of those patients who had surgery had a checked and completed WHO checklist in their records. For those patients we observed having day case eye surgery we saw a completed surgical safety checklist for cataract surgery and a sticker with the bar code for the intraocular lens used. The 'time out' is a momentary pause before the procedure begins to confirm essential safety checks are undertaken and involves the team. The trust's audit and our observations showed this stage was being missed; WHO guidance states missing this could result in a procedure on the wrong person or site on the patient's body.

Nursing and theatre staffing

- Staffing in theatres was adequate and reviewed by the matron in theatre on a daily basis to ensure there was sufficient cover for the operating theatres. The rostering in theatre was based on national guidelines with two scrub nurses, one operating department practitioner and one theatre auxiliary in a theatre. We saw this in rosters produced and the operations we observed. Information from the trust for May to August 2015 showed between 23 and 35 shifts a shift a month were covered by either a bank or agency operating department practitioner. Information provided on staffing was trust wide for main theatre recovery; between April 2014 and March 2015 29% of staff working there were bank nurses. The matron in theatres told us bank staff at St Helier had previously worked in the department. We saw an orientation programme for new staff which included an induction checklist and competencies to be achieved in line with the national Knowledge and Skills Framework (KSF). The hospital provided a theatre for 24 hour emergency surgery. In addition, at night there was one band six theatre nurse resident on site and a second staff member on call with cover until 7.30am. On average there were six call outs each month.
- Daily morning meetings (huddles) in theatres were used to discuss the day's activity, issues from the previous day's performance and any possible issues for the day.
- The risk register for surgery highlighted a shortage of staff across surgical adult inpatient wards in the trust as a high risk that could lead to inadequate patient care. It was identified that this could happen as a result of work-related stress for staff and possible injury and high usage of bank and agency staff impacting on continuity of patient care. The controls reported by the trust was an overseas and local recruitment programme, requesting help with staffing from medical ward colleagues, pursuing retention programmes, sickness processes and the supply of bank staff.
- The report intothe six cardiacarrestsoccurring on B5 wardover a five week period in July and August 2015 that we received after our inspection identifieda shortage of appropriately skilled nurses and senior nurses as a contributing factor.
- Staffing figures were displayed on each ward, of planned and actual numbers of registered nurses and health care assistants on duty. The wards were not using proactive acuity tools to determine or adjust staffing levels. On three occasions staff told us that extra staff were on duty due to the inspection. Rosters on two wards showed there had been proportionately fewer unfilled shifts for the first two weeks of November and planned for the rest of the month than for the previous month. Two senior members of nursing staff on two separate wards when asked about staffing told us "it is not the numbers but the quality "
- The trust provided us with information on the number of unfilled registered nurse shifts for the surgical wards at St Helier. In June, July and August 2015 the number of unfilled registered nurse shifts varied from 29 to 76 shifts a month for each ward. B5 had the highest number of unfilled registered nurse shifts, 52 in June, 76 in July and 63 in August. On average four health care assistant shifts were unfilled in each ward over a month. On B5 we saw on average for September and October 2015 there were 43 unfilled registered nurse shifts and eight unfilled health case assistant shifts. This represented being short

of a registered nurse for more than one shift a day. We also saw in clinical governance meeting minutes from August 2015 that there were concerns about nursing staffing numbers and the nursing situation being unsafe.

- Staffing was included on the ward's scorecard but when we looked at rosters and the number of unfilled nursing and health care assistant shifts on wards there were many more than were indicated on the ward scorecard. The directorate's quality report of April to June 2015 indicated that the highest patient safety incidents were falls and under care and treatment the lack of VTE assessments was the highest theme, the fourth highest area of incidents was staffing. It stated that the number of incidents for staffing being reported were not reflecting the actual shortages being experienced on the wards.
- Senior nurses on the wards told us they were not able to authorise bank or agency staff and all requests had to go through the matron and this could cause delays. Information provided by the trust for nursing vacancies, turnover and sickness was for the surgery directorate across the trust and included critical care between April 2014 and March 2015. The vacancy rate was 19%, the turnover rate was 13% and sickness was 5%. Information on the use of bank nurses was provided on a ward or department level. On the surgical wards the average use of bank nurses between April 2014 until March 2015 was 39% for B5, 30% for A3 30%, 40% for SAU, 28% for B3 and18% for B4. After our unannounced inspection the trust provided information showing that B5 ward had been using almost no agency staff.
- Senior staff on three wards told us that unfilled shifts had an impact on the level of care they could provide and gave examples of not being able to reposition patients to prevent pressure ulcers. We saw in the electronic incident log that there were many incidents reporting insufficient staff to be able to undertake certain aspects of care and the impact this had on the patient. These incidents included being unable to give full care; reposition patients and give medications on time.
- The falls reports recorded the number, time and types of fall and if witnessed and a statement that indicated how many where staffing was an issue (very few) but gave no analysis or evidence of how this was determined. The quality report noted that a ward could have the agreed establishment for a given shift but the high acuity of patients could lead to staff becoming overstretched and the same when wards had a high level of confused patients. This had not been captured in incident reporting as a possible cause for falls.
- Five doctors told us that there were additional numbers of bank nursing staff at night and there was a significant difference between day and night care with reduced quality at night and weekends. Doctors told us that they had undertaken work usually undertaken by the nurse such as testing urine and completing fluid balance charts to ensure they were completed. Two doctors told us there were problems with nurse staffing on B5. Several patients told us there was a difference with the quality of care at night with less staff who were very busy and restricted in the care they could provide.
- In the surgical ward nursing handover we observed, the matron was present, some staff arrived late and did not receive the full handover from the night team. Risk assessments and patient's EWS were not discussed and information such as what the patient was admitted with was missed.

Surgical and medical staffing

- The trust had a comparable level of consultants, middle career, registrar and junior doctors to the England average. The general surgery rota was 1:8 for on calls. Information provided by the trust for locum use for April 2014 to March 2015 showed trauma and orthopaedics locum use at 24% and oral surgery at 15%. Documentation provided for our inspection showed that trauma and orthopaedic posts had been filled. During our inspection senior staff told us that there was very limited capacity for oral surgery.
- The London Quality Standards March 2015 identified that consultant work patterns met the demands for consultant delivered care, senior decision making and leadership on the acute surgical units across the extended day working, seven days per week. It identified rotas as maximising continuity of care for all patients in an acute surgical environment with a single consultant retaining responsibility for a single patient on the acute unit.
- There were twice daily ward rounds undertaken by the medical staff. From these the foundation year one trainee doctors told us they were responsible for producing individual patient plans and acting on them.
- Surgical treatment was consultant led. There was a consultant presence seven days a week and a

consultant on call at all times. Anaesthetic cover was available via a consultant on call and an on-site senior registrar was on site at night and a middle grade anaesthetist, with a consultant anaesthetist coming in for all emergencies in surgery. The anaesthetic department had one long term locum and a regular locum filling we saw they would be up to establishment in February 2016.

- We observed a medical handover which was attended by a medical consultant to advise doctors in training who were coming on duty. The meeting discussed any patients who had been unwell.
- The junior doctors we spoke with felt there were enough doctors to meet people's medical needs. Nurses told us they felt well supported by the medical teams. When we visited the hospital on both the announced and unannounced visits we observed doctors reviewing patients and liaising with nurses.

Major incident awareness and training

- There was a protocol in place for managing in patient emergency theatre bookings.
- There was a major incident plan due for review in October 2015 which set out key locations and reporting points. The surgical day case unit was designated as the overflow area. Staff were aware that there was a plan but not of their role within it. There was also a business continuity plan due for review in August 2015 for managing business disruptions. Senior staff told us there was a need for more developed business contingency plans and to undertake major incident exercises.

Are surgery services effective?

Good

Effectiveness within the surgery services was rated as good.

There was participation in relevant national audits, these indicated that surgical services adhered to best practice standards as well as or better than the England average. The relative risk of readmission to St Helier hospital following an operation was better than the England average for elective (planned) surgery but worse than England for some non-elective (emergency) surgery.The relative risk for trauma and orthopaedics was worse than expected. There was a limited range of evidence for local audits.

When people received care from a range of different staff and teams this was well coordinated with staff working collaboratively to meet the needs of patients. The pathwayfor patients with a fractured neck of femur (NOF) was in line with current evidence based guidance and standards.

On the surgical wards newly qualified staff were not on a preceptorship programme and staff did not receive regular supervision.There was not always access to information for staff, for agency staff who were unable to access information electronically and for staff when electronic information such as the picture archiving and communication system (PACS) would not display images.

During our announced inspection we found a consent form dated 2002 being used that referred to outdated legislation. We brought this to the attention of the adult protection specialist nurse who gave us an updated consent form; the chief executive and medical directors confirmed that the new consent form had since been implemented immediately following the inspection.

Evidence-based care and treatment

- The clinical governance manager for surgery, critical care and anaesthetics took National Institute for Health and Care Excellence (NICE) guidelines from the six to eight weekly trust wide audit team meetings to be reviewed at the surgery, critical care and anaesthetics monthly governance meeting. We saw examples of the agenda for the clinical governance meetings and these included sections on national guidance and audit, this meeting included the matrons. The clinical governance manager reported that minutes from the meetings were put on staff boards and that sometimes they would go to the wards and communicate these with staff. However sisters' meeting minutes we saw were inconsistently shared with ward staff and were focused on action points rather than evidence based information.
- On the surgical wards local audits of adherence with best practice provided were limited to those for infection control, monitoring of recording of patient observations, screening compliance for MRSA and monitoring falls.

- Across the trust there were audits for fungal infections, detection of antibodies, resistance to certain antibiotics, and of inappropriate virology test requests.
- We observed nurse led pre-operative assessments, and saw the guidelines they used including those for anaesthetist referral and blood ordering. The nurse went through the questionnaire, answered questions, gave clear instructions on actions such as fasting, explained pain relief, and completed tests. This followed guidelines from the NHS Institute for Innovation and Improvement and ensured the patient was well informed and prepared for surgery. On admission further assessment included a pregnancy test and a VTE risk assessment. On the incident log we saw that over a one year period five patients who had been operated on who had required a VTE assessment had been identified as not having had this assessment.
- The hospital met the expectation of providing an immediate life-saving operation when this was needed by having an operating theatre available with a back up theatre available at all times, with a theatre team, an anaesthetist and consultant surgeon available out of hours. The separation of elective and emergency surgery was recommended in the Royal College of Surgeons emergency surgery policy briefing 2014. It added that if elective and emergency are separated geographically as they are with St Helier hospital providing emergency surgery and Epsom providing elective surgery it is important that both have access to a sufficiently trained workforce and diagnostic and support services. Medical staff at St Helier told that us and information provided showed there was an appropriately trained medical workforce and diagnostic support.
- There was a clear pathway for patients with a fractured neck of femur (NOF), in line with nationally agreed standards with medical care overseen by an orthogeriatrician. Data from the National Hip Fracture Audit published in 2014 indicated that the trust performed better than the England average in eight of the measures and worse than average on two measures. For example 75% of patients were reviewed pre-operatively by a geriatrician, much better than the national figure of 52%. The percentage of patients having an operation within two days was much higher than average. The trust scored significantly worse than the national average for access to orthopaedic care within four hours (17% compared to 48%). We understood this was likely due to the demand for beds in the hospital. There were protocols for ward staff to follow for patients with fractures: obtaining pressure relieving mattress and putting in place a repositioning chart to help reduce the risk of skin pressure damage.Patients with a fractured neck of femur (NOF) were usually admitted to A3 ward.
- Patients requiring emergency surgery were assessed in the emergency department and admitted to any available bed. We saw a proposed model and pathways for patients requiring emergency general surgery but no agreed launch date.
- Data sets submitted to the National Bowel Audit (published in 2014) was complete in 73% for patients having major surgery. The audit showed that the trust performed better or about the same as the England average in its treatment of patients. All patients were discussed at a multi-disciplinary team meeting, nearly all had a CT scan and 96% were seen by a specialist nurse.
- The trust provided a summary of the first National Emergency Laparotomy Audit (NELA) report published in June 2015.The trust's NELA performance was in the top 10% of hospitals in England for clinical outcomes. This indicated that the trust followed best practice in areas such as the direct involvement of consultants in theatres, direct admission to critical care after emergency bowel surgery and had a lower average mortality rate. The trust had identified that it needed to improve the following, for patients to be reviewed by a consultant surgeon within 12 hours, for patients to be reviewed pre-operatively by both consultant surgeon and anaesthetist and for patients to have input from care of the elderly medicine in the post-operative period.
- NICE guidelines on the prevention of surgical site infections in theatres were followed.
- The trust did not have a stop smoking service but was able to refer patients to an external agency for this support.

Pain relief

- There was an acute pain nurse led service that included a consultant anaesthetist. This service advised nursing staff on pain relief and reviewed patients post-operatively. For those unable to take medication by mouth, pain relief also included patient controlled analgesia (PCA) and epidural infusion. Pain was

assessed using the Bolton Pain Assessment Scale which included observing the patient and identifying any behaviours that indicated pain. This scale could be included in the EWS assessment.
- Patients were regularly asked by ward staff whether their pain was being effectively managed. On A3 ward they had recently introduced a pre-printed prescription chart for pain relief which had improved timeliness for giving pain relief. Two patients we spoke with on B5 told us there could be delays in getting pain relief at night.

Nutrition and hydration

- We observed patients at pre assessment appointments for day case operations being given clear appropriate instructions for fasting. Patients were given drinks and snacks post-operatively in the day surgery units.
- The trust used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk of malnutrition. The tool (accredited screening tool) screens patients for risks of malnutrition but also obesity. Where patients were identified as at medium or high risk of malnutrition food intake was to be recorded, and the patient was to be encouraged and given assistance with meals. The meal hostess was also alerted on the menu card. Patients identified as at risk of dehydration also had fluid balance charts to monitor fluid intake and output. We were told that a new fluid balance system was being introduced using the electronic hand held device. We saw that written records of food and fluid intake was inconsistent.
- Staff told us and information provided stated surgical inpatient wards had protected mealtimes. This meant all non-urgent activities on the ward would stop and patients would be positioned safely and comfortably for their meal and staff would assist patients with their meals as necessary. During our unannounced visit we observed during a meal time on one ward activities carried on, six patients we saw requiring assistance with repositioning in order to eat comfortably had not been moved. We brought this to the attention of the staff; one patient was repositioned and ate well.
- We observed patients being offered drinks on wards and most patients were complimentary about the cooked meals. Food could be prepared at short notice and the same range of food was offered at the weekend. We saw that special dietary needs were catered for and there were choices of meals for patients from a variety of religious and cultural backgrounds.
- Some relatives of those patients moved from one area of the hospital, for example from the emergency department to a ward told us did not receive food or fluids for several hours. We saw one patient had not received nutrition for three days. A few patients told us of waiting for a long time for procedures and so going without food for the whole day.

Patient outcomes

- The trust contributed to relevant national audits, both these and local audits were presented at the audit team meeting. The national audits such as the NELA and the hip fracture audit showed the trust was performing better than the England average. Local audits for infection control, monitoring of recording of patient observations were showing poor compliance while there was varied compliance for the screening or MRSA. Monthly information on falls consisted of the number, type and time of fall and if a staffing issue but no detail as to what contributed to the falls. There had also been small scale trust wide audits on records, WHO compliance, and on use of MUST screening.
- The trust contributed data for the period of January to March 2015 for repair of neck of femur the trust was performing slightly better than the national average.
- The trust had enrolled in Anaesthesia Clinical Services Accreditation (ACSA) but had not yet completed the process. An inspection of the services was due in 2016.
- National data for December 2013 to November 2014 showed the relative risk of readmission to St Helier hospital following an operation was better than the England average for elective (planned) surgery but worse than England for some non-elective (emergency) surgery. The relative risk of readmission for general elective surgery was better than expected with 70 (compared to the expected figure of 100). The relative risk for trauma and orthopaedics was worse than expected 117 (compared to the expected figure of 100). The trust's surgery performance scorecard for September 2015 showed an emergency readmission rate of 4% for the year to date which was above its threshold of 3%.
- The length of stay (LOS) for surgical patients at St Helier between January and December 2014 was below the England average (better than) for those who had elective surgery and slightly higher for those who had emergency surgery (worse than). The trust's surgery performance scorecard showed 4.5% of their day cases

overstayed for the year to date, above their threshold of 4%. It is recognised that longer stays in hospital than necessary are inappropriate for the patient and are a barrier to other patients being admitted.

- The trust's surgery performance scorecard for September 2015 indicated there were no pressure ulcers grade 3 and over for the year to date. The scorecard reported that 95% of VTE assessments had been completed but when we looked at three patients records during our inspection for these they had not been completed and eight incidents of missing VTEs were logged during the last year. Systems shown to us did not appear robust in ensuring VTE assessments were completed.

Competent staff

- Information provided by the trust was for the whole surgery directorate, showed 82% of staff had an appraisal between April 2014 and March 2015. The NHS staff survey 2014 showed a negative finding for the percentage of staff having well-structured appraisals in last 12 months. Senior staff told us they needed to improve the completion rate. The report into cardiac arrests on B5 identified that very few staff had had their objective setting completed or mid year reviews. Theatre staff told us they found the appraisal process meaningful, they were flagged up when they were due.
- Induction for new permanent staff consisted of a three week induction programme and attendance at a monthly trust wide induction day. This included a local induction process with checklists.
- The trust provided an induction handbook for nursing staff on surgical wards and staff told us that the induction they received adequately prepared them. There were several nurses from overseas who were in their initial year after qualifying they told us they were well supported by colleagues on the ward. A senior member of staff confirmed that these newly qualified nurses were not on a preceptorship programme. Preceptorship is a recognised and recommended framework for supporting newly registered nurses.
- Following our inspections the trust informed us that a practice development nurse had been seconded to B5 ward initially full time in September 2015 and then reduced to two days a week to supervise and train staff. The action points from the investigation into the cardiac arrests on B5 identified more work was required regarding mentorship and preceptorship qualifications of the existing staff in order to support junior staff as well as students allocated to the area.
- Senior staff told us that the same agency and bank nurses were used where possible. Short- term locum/ bank staff were given brief induction information highlighting essential information and details about the trust from the 'bank partners'. Local induction checklists and staff handbooks were completed with the nurse in charge on their first day of work. Staff told us that many of the bank nurses were working extra hours on their permanent ward.
- Staff and patients told us that at night there were more agency nurses.
- A simulation training programme called Care, Recognition and Initial Stabilisation in Simulation had been recently introduced in managing the care of the deteriorating patient. The seconded practice development nurse on B5 ward was responsible for upskilling these staff in the management of the acutely unwell patient and in the usage of the simulation programme.
- Ward staff cared for patients who had undergone different types of surgery, in addition to medical patients for whom no bed was available on a medical ward. Ward staff told us they felt confident caring for other patients but that it was sometimes difficult to meet the needs of patients who required high levels of personal care. A trust investigation being undertaken on B5 ward for the period between the 1 April 2015 and 1 September 2015 included a review of staff competency in providing care that followed national guidelines and local policy.
- The national training survey of the trust by the General Medical Council (GMC) 2015 scored worse than expected in the induction and feedback that doctors in training received. Medical staff that we spoke with told us they felt well supported.
- Medical staff were evaluated for their competence as part of their revalidation. Although this group were not meeting the trust target of 95%. This was a recent initiative of the GMC, where all UK licensed doctors are required to demonstrate they are up to date and fit to practice. This is tested by doctors participating in a robust annual appraisal leading to revalidation by the

GMC. 85% of doctors within the surgery, critical care and anaesthetic directorate had received their annual appraisal up to June 2015, other staff had been deferred for example those who were on long term leave.

Multidisciplinary working

- On A3 ward where most patients with a fractured neck of femur were admitted, there was a physiotherapist present every weekday and a dedicated occupational therapist for the ward. A multidisciplinary team (MDT) meeting was held each morning and included the nurse in charge, a physiotherapist, an occupational therapist (OT), the ward clerk, and the discharge co-ordinator. They discussed the patients and the 10 day NOF pathway. There was a second MDT meeting twice a week with the orthogeriatrician, the nurse in charge, OT and dietician.
- Allied health professionals told us in a staff focus group that staff across the trust "work well across the disciplines, one thing we do really well".
- We observed multidisciplinary input in caring for patients from staff interacting with patients and staff on the wards. The patient records demonstrated input from therapists including dieticians, speech and language therapists, occupational therapists, pharmacists as well as the medical team.
- We observed close working between the theatres, anaesthetic, surgical and medical staff in the main three theatres and in the eye day case theatre.
- There were daily trauma meetings on weekdays attended by consultant surgeons, doctors in training, an orthogeriatrician and the trauma co-ordinator.
- There was a formal arrangement to access anaesthetic review of patients at pre-assessment, there was an anaesthetic referral rate of 15-20%.
- Nursing staff described good working relationships with the ward team, nurses were not always able to attend ward rounds but we observed doctors liaising with the ward manager on plans for ongoing medical care. All team members were aware of who had overall responsibility for each patient's care.

Seven-day services

- Pharmacy and radiology were available on weekdays from 9am until 5pm and then on call out of hours. There was only physiotherapy cover at the weekend for respiratory patients.
- St Helier took surgical emergency admissions with consultant surgeons attending all out of hours (OOH) theatre cases. Theatre cases after midnight were only for "life or limb" emergencies.

Access to information

- On surgical wards all authorised nursing staff and medical staff were able to access patient notes from a locked notes trolley to read for patient information and add relevant information. There were also risk assessments, and fluid charts in patient's bedside folders. Not all patient notes had nursing care plans which meant that processes to identify and communicate people's individual needs were missing and there was a risk that patients could receive inappropriate nursing care.
- Staff working in theatres told us the PACS sometimes would not display images of patients that were needed to undertake procedures and this could mean delays in treating patients.
- Permanent members of nursing staff had access to the electronic hand held device that recorded patient's observations and the trust's computers. Staff told us that agency staff would not have access to electronic information such as EWS and the intranet for policies. Minutes from senior nurses meetings had instructed that paper copies of policies were not to be used and they were to be accessed via the intranet. Medical staff had access to the trust's computers but not the electronic recording of patient observations This meant that these nurses were unable to access information on policies and both doctors and non-permanent nurses could not directly access current patient observations or EWS' scores.
- We saw that when patients moved between medical teams from admission and then to differing wards details on the computer sometimes remained unchanged and one medical member of staff spoke about having to track patients down.
- Staff with access to the computers were able to access test results electronically. Access to patients' diagnostic and screening results was good. Portable computers and fixed computers were available on the surgical wards for staff to use.
- A new trust intranet had been launched and some staff had difficulty finding policies and protocols on it. It was open and available to all authorised staff. Data within it

was locked so it could only be amended, deleted or changed by authorised staff. There were protocols, policies and guidance for clinical and other patient interventions and care.

- Patients told us they received copies of letters sent by their surgeon to their GPs. We saw in medical records that GPs were written to on the day of cataract surgery. These letters included a summary of the operation with the code of the intraocular lens implanted. Following our inspection the trust informed us that doctors checkedletters to patients before they were sent out.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us staff explained treatment and care and sought consent before proceeding. Patients having eye day surgery were given a large print booklet and copy of the consent form to read, we observed that patients had read and understood what they were signing. The ophthalmic consultant consented on the day of surgery and staff were able to answer patient's questions. All patients we spoke with said they had been given information about the benefits and risks of their surgery before they signed the consent form. We saw evidence of consent forms with risks recorded by the doctor.
- During our announced inspection we found a consent form dated 2002 being used that referred to outdated legislation. We brought this to the attention of the adult protection specialist nurse who gave us an updated consent form. We saw the policy with relevant legislation was available on the trust's intranet, we were told it had been there a week before. The trust provided us with an electronic copy of the policy. The patient appeared to not be competent to give informed consent, we brought this to the attention of the specialist registrar who, with the consultant agreed to accept the patient's sister's authority for consent to the operation as the patient was not retaining information.
- There was mandatory training for all staff in the Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS), it was also included in the trust's staff induction. Records showed that 87% of staff had received this training yet some staff we spoke with were unaware of the term DoLS. Staff told us they knew who to contact for advice.

Are surgery services caring?

Requires improvement

Caring required improvement in the surgery services.

Some patients said they had to wait long periods for assistance from nurses especially at night. On B5, there was not always enough staff to deliver adequate patient care. An internal investigation by trust on B5 included a review on behaviours and attitudes of nursing staff. We noted that on some occasions, nurses did not introduce themselves to patients.

However, the majority of patients told us staff were caring and the patient experience survey for April 2014 to April 2015 had an equal amount of positive and negative comments about the care patients had received on surgical wards.

Results for the Friends and Family test across the services during our inspection varied from 79% of patients on B5 ward recommending the trust to 99% of the patients who had undergone ophthalmic surgery.

Patients having eye day surgery were given time to ask questions about their procedure and address any anxieties or fears. The nurses understood the patient's potential to be anxious and made sure patients understood all aspects of the procedure.

Compassionate care

- On B5 ward, one patient told us there were "long waits for staff at night, not enough of them" while another patient on the same ward told us staff were "attentive and caring". We were told of two examples on B5 of two patients not receiving compassionate care. A trust investigation being undertaken on B5 ward for the period between the 1 April 2015 and 1 September 2015 included a review of the behaviour and attitude of the nursing team.
- We spoke with a new elderly patient whose admission was planned. He had arrived at the time requested by the hospital but had then been left for five hours before a bed was found. Once on the ward he had been left at the bedside with no information as to whether he should change into bed wear or even if he could have a cup of tea. This was obviously causing him some distress.

Surgery

- The majority of surgery patients we met told us staff were caring, some patients described staff as, “excellent, kind, helpful” and “fantastic, always help you out’. However, some patients told us that they had to wait longer for assistance as nurses were busy and that this was more so at night. Some patients told us there could be delays in getting pain relief at night. A few patients and relatives described the nurses as “run ragged” and getting side tracked with other demands.
- We observed mostly good attention from staff to patient dignity with staff knocking on doors before entering, and curtains being pulled around beds before treatment or private conversations took place. Some patients told us they were not orientated to the ward and shown where the bathroom and toilet was. We observed that not all nurses introduced themselves or colleagues to patients or asked if colleagues could be present. The cancer patient experience survey of 2013/14 ranked the trust in the bottom 20% for not all staff asking patients what name they preferred to be called by.
- Some patients and relatives told us that some of the staff’s language skills made communication harder. One senior member of nursing staff told us that there could be difficulties in staff communicating on the phone with relatives adequately. During our inspection we observed that some staff did not understand questions we asked such as the location of staffing information boards.
- June 2015 results for the Friend and Family test on surgical wards at St Helier hospital indicated 89% of patients would recommend the trust. The response rate for the trust was lower than the national level. During our announced and unannounced visits on the inpatient wards we saw results varying from 92% to 79% recommending the trust with low response rates below 30%. On the eye day case unit the Friend and Family test result indicated that 99% of patients would recommend the trust.
- The patient experience survey April 2014 to April 2015 had an equal amount of positive and negative comments about the care patients had received on surgical wards. Some commented on nurses being overstretched and eight responses out of 44 made negative comments including staff being rude, the trust had responded by talking to staff and organising communication training days.
- The cancer patient experience survey of 2013/14 ranked the trust in the bottom 20% of trusts in patients not always given enough privacy when being examined or treated and not always treated with respect and dignity by staff.
- The surgical wards scored an average of 67% in the PLACE survey for privacy compared to the England average of 86 in 2015, the trust average was 78%.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us that their treatment had been explained to them fully, for those having day surgery this had been during their outpatient’s appointment. Most patients and relatives told us they felt fully informed and involved with decisions when appropriate.
- Patients having eye day surgery were given time to ask questions about their procedure and address any anxieties or fears. The nurses understood the patient’s potential to be anxious and made sure patients understood all aspects of the procedure. A member of staff from the eye day ward accompanied the patient to theatre with the operating department assistant and remained with the patient until they went into the operating theatre. The member of staff reminded the patient of what was going to happen. Family members were able to remain in the dayroom to wait for their relative to return.
- Staff recognised when patients required additional support. For example a patient with a learning disability had extra support from staff and a health care passport (a pictorial communication tool identifying likes and dislikes and daily routines). The ward staff told us the adult safeguarding lead worked closely with the ward.

Emotional support

- Patient’s physical and psychological needs such as nutrition, hydration, personal hygiene and anxiety were not consistently assessed or recorded by nursing staff. There was an inconsistent use of care plans to indicate any particular needs that a patient had and how to address them.
- There was a drop in cancer information and support centre at St Helier hospital open Thursdays and Fridays offering information and emotional support.

- We were not made aware of any specific counselling or support services available to inpatients with regards to clinical care. Nurses told us that if any patient required extra support they would get the senior nurse to talk to the patients.

Are surgery services responsive?

Requires improvement

The responsiveness of surgery services required improvement.

The majority of surgical activity was day surgery. The trust had fallen below the standard for the referral to treatment times (RTT).The trust's bed occupancy rate for the last quarter of 2014/15 was 90%, comparable to the NHS average of 91%. It has been recognised that occupancy over 85% has an impact on the quality of care provided.

Bed management meetings did not discuss the patient's needs, the Surgical Assessment Unit (SAU) was not a dedicated surgical assessment unit and medical patients were often placed on surgical wards. Patients were moved to different wards at night.

In the trust only one patient had not been treated within 28 days of their cancelled operation between April 2013 and April 2015 and the trust performed better than the England average for the percentage of operations cancelled.

Service planning and delivery to meet the needs of local people

- The trust worked closely with commissioners and other NHS trusts in South West London (SWL) to plan and meet the needs of the local population. The trust was part of the SWL cancer network, with close contacts with the regional centres at other hospitals. Joint replacement surgery was performed by surgeons from the trust and three other trusts at SWLEOC (South West London Elective Orthopaedic Centre).
- There were links with Sutton's health and social care economy in developing integrated working on areas such as timely patient discharge.
- The local clinical commissioning group highlighted the positive work of the ward and pathway for those with a fractured neck of femur (NOF). These patients were mainly admitted to A3 ward, from day two post-operatively links were made with community bed based rehabilitation, with most patients being discharged from hospital ten days post-operatively. On A3 there was a potential for privacy, dignity issue with two toilets and only one on a corridor used by male and female patients. Female patients were required to walk or be wheeled past the male accommodation area to the female bed area.
- There were 7,250 day cases, 4,625 emergency operations and 625 elective operations between January 2014 and December 2014 at the hospital. Ophthalmology made up 2,625 of the day cases. There was an ophthalmology day ward and a separate day ward B4 for other day surgery. There had been occasions when the day case ward B4 had been used to accommodate patients overnight when the area was not designed for this purpose. Information provided by the trust following our inspection indicated that B4 day ward was used overnight from May to October 2015 for a total of 65 nights. This ranged from once in June to 17 nights in September and 22 nights in October. In September of the 57 patients admitted overnight 23 were general medical patients, 19 general surgical and the rest bar one from surgical specialities. In October of the 74 patients admitted, 32 were general medical patients, 22 general surgical, 15 from other surgical specialities withothers admitted including single oncology, haematology patients and two cardiology patients.
- Staff during the inspection and information provided by the trust following our inspection indicatedepisodes of extended recovery, where patients were kept in the recovery area after surgery for longer than clinically necessary, and that this was due to a lack of beds in B4 day ward. Between May and October 2015 the number and percentage of patients experiencing extended episodes varied, from none in June and July, to five in May, 16 in August (0.08%), 38 in September (0.15%), and in October 20 patients.Staff told us that some patients who were in the recovery area for longer than necessary were able to observe and hear care for those recovering from the effectsof anaesthesia. A doctor told us ofgynaecology patients being in recovery whilst male patients who had fully recovered from their anaesthesia waited to go to B4 day case ward. This meant that the privacy and dignity for those recoveringafter surgery could be compromised.

Surgery

Meeting people's individual needs

- The trust had developed easy read information for patients with a learning disability and a resource pack for ward staff. The patient and their family were asked to complete a health care passport, these were kept at the end of the patient's bed and referred to by all staff providing care and treatment. Patients with a learning disability were put first on the theatre list to avoid long waits.
- Staff attended dementia awareness training. A symbol of a blue flower was in use which indicated that a patient had dementia. On A3 ward patients with dementia were in a bay close to the nurses' station. Social dining with patients sitting at a table had been introduced on this ward in response to relatives' suggestions and relatives pre-ordered the meals. On other wards staff tried to position patients with dementia within sight of the nurses' station, sometimes this was not possible.
- There was no direct admission for patients with needs such as dementia who were often moved a more than once after their arrival at the emergency department. At a bed management meeting we observed there was no discussion about the needs of a patient; just their name and if there was an available bed on the surgical wards. Staff told us that the 22 bed Surgical Assessment Unit (SAU) was not a dedicated surgical assessment unit. During our announced visit there were nine medical patients on the ward and during our unannounced inspection there were five medical patients. Staff on the ward told us that patients were moved to different wards at night and senior staff told us "patients are being moved around a lot".
- The nurses in the pre assessment clinic had a set appointment time allocated to assessing patients. They had requested that there be some longer appointments for those patients with complex needs this had been rejected and some sessions over ran.
- Allied health professionals such as physiotherapists, speech therapists and nurses across the hospital told us there were issues with outside agencies affecting discharge for elderly patients, some staff felt that planning for discharge should be earlier. A nurse told us of one patient whose discharge from hospital had been delayed by 57 days.
- During our inspection we did not see any leaflets in other languages however a telephone interpreting service was available. Face to face interpreting and British Sign Language interpreters could be booked.
- At the nursing handover we observed staff were not alerted to the individual needs of patients such as needing to be supervised when moving around the ward. Patients told us that nursing staff would help them as they needed but that there were not regular checks or rounds to see if they had everything they needed.
- The discharge lounge in the day case ward B4 was small with seven reclining chairs fitted in. There was no place for doctors to have confidential conversations or to carry out final pre-discharge checks in privacy.
- Information provided by the trust after our inspection showed that all beds and equipment on the surgical wards met the needs of patients with bariatric requirements. Additional equipment could be accessed from the trust's equipment library.In the operating theatre there was an operating table to accommodate the needs of patients with bariatric requirements.
- A consultant told us there were no rooms to break bad news and that it was difficult to find a suitable place for this.

Access and flow

- NHS England data (April 2013- May 2015) for the referral to treatment time (RTT) indicated that the trust had fallen below the standard and been variable against the national average since June 2014. The RTT had risen above the national average since Apr'15 but was still below standard. By specialty, Trauma & Orthopaedics and Urology were not meeting the standards for RTT. The trust's performance scorecard for September 2015 year to date was 87% for the admitted pathways within 18 weeks close to its threshold of 90% and 90% for the non-admitted pathways within 18 weeks close to its threshold of 95%.
- The cancer 62 day target (those patients being treated within 62 days of GP urgent suspected cancer referral) was not meeting the trust's threshold of 85%. On the trust's performance scorecard in September 2015 for the year to date it was 63%. The percentage of patients waiting more than six weeks for diagnostic imaging was in line with the national average.

Surgery

- There was round the clock provision for emergency surgery, the hospital was a designated trauma centre but not a 'major' trauma centre.
- Daily theatre 'huddles' were attended by managers, leads from day surgery and theatres to discuss the previous day's list and any issues arising.
- There was one operating theatre dedicated for trauma and orthopaedic emergencies with the first two morning slots dedicated for those patients with a fractured neck of femur. There was a weekly scheduling meeting, lists were planned three weeks in advance.
- The information provided by the trust for May 2015 to July 2015 indicated the utilisation of the theatres at St Helier was on average 72%. When we spoke with staff, they told us that some theatre use by fertility services was not included within the utilisation rates. Senior staff told us that an external agency was assessing the utilisation of the theatres.
- In the trust only one patient has not been treated within 28 days of their cancelled operation between April 2013 and April 2015 and the trust performed better than the England average for the percentage of operations cancelled. In the trust's scorecard for September 2015 it was matching its threshold of 1% for cancelled operations for non-clinical reasons.
- Information from the trust showed that between April and October 2015 six operations had been cancelled because there was no critical care or high dependency bed available.
- Staff told us that faulty or missing equipment could delay the running of theatre.
- National data on delayed transfer of care for April 2013 to May 2015 indicated that 25% of the delays were a result of failure to complete an assessment (25% compared to a national average of 19%) and 24% were patient or family choice.
- During our announced and unannounced visits we found between two and nine medical patients on the surgical wards. Surgical wards were not ring fenced and senior staff told us that the trust was focused on the four hour wait in the Emergency department. A senior member of staff reported that surgery was "clinically led, but managerially facilitated bed management". In the trust presentation to the CQC the Chief Executive told us B4 the day case surgical ward had been an overflow medical ward the week before our inspection.
- The trust's bed occupancy rate for the last quarter of 2014/15 was 90%, comparable to the NHS average of 91%. It has been recognised that occupancy over 85% has an impact on the quality of care provided. A rate of 85% or below gives staff flexibility to admit people in emergencies, mentor new staff and undertake training.
- There were also times when there would be delays in patients being collected from the recovery area in theatres.

Learning from complaints and concerns

- The hospital provided a Patient Advice and Liaison Service (PALS) to deal with concerns and complaints. The PALS office was located on the ground floor next to the reception at the main entrance and open Monday to Friday 9.30am to 4.30pm.
- A new complaints policy had been introduced in July 2015, a manager told us there was work to improve the quality and timeliness of responses to complaints at the trust. For July to September 2015, 50 complaints had been recorded for surgery, senior staff told us there was a backlog in dealing with complaints. The policy set out the process and time lines for handling complaints, the compliance with this was 3-6%. If an incident graded at moderate or above was identified with a complaint a duty of candour investigation was instigated and a duty of candour lead nominated.
- A trust investigation being undertaken on B5 ward for the period between the 1 April 2015 and 1 September 2015 included a review of patient complaints including the nature and theme of the complaints. The report provided following our inspection showed the themes for complaints and fromPALS werepoor communication, poor attitude and lack of nursing care.
- Complaints were discussed in the departmental meetings, from minutes provided it was only in relation to administration. In the Surgery, Critical Care and Anaesthetic governance meeting from July 2015 complaints were discussed in terms of having a lot of overdue complaints and 'a lot of work required to get them in good shape'. From the August 2015 minutes complaints were discussed in terms of drafting letters and looking at how complaints were handled in other areas. There was no recorded discussion as to what the complaints were, how they were being addressed and if any actions had been taken to resolve them. The quality manager for the directorate told us they were not involved in the complaints process and we did not see evidence of learning from complaints.

Surgery

Are surgery services well-led?

Inadequate

The leadership of the surgery services was inadequate. There was no formal vision or strategy for surgery services. Managers were aware they had an unsafe ward and we were not convinced they were doing anything effective about it.

There was a good governance structure but the leadership, governance and culture did not always support the delivery of high quality person-centred care.

Risks for the service had been identified in various governance meetings and from a series of incidents on one ward.Significant issues had not been addressed and action had not been taken. Patients had experienced harm from these incidents. The trust was not open and did not express concern aboutthesignificant issues on this ward until we asked for more information.There lacked cohesiveness and a trust board understanding of how to address these issues in a timely manner. There was no escalation policy to address immediate concerns to ensure patient's safety. Incidents for reporting staffing shortages were under reported, there was no evidence of using a staffing acuity tool to respond to changing patient's needs.

Managerial rather than clinical decision making was used in determining bed management and equipment needs. There was no ring fenced ward for emergency general surgical patients and clear clinical pathways for these patients. There was low staff morale and a sense of frustration with reacting to differing needs and expectations. In wards, departments where staff had clear pathways such as A3 for those patients with a fractured neck of femur or in the ophthalmic day case unit or in theatres and where there was minimal staffing shortages there was a clarity and process which guided staff.

Vision and strategy for this service

- Surgery was part of the Surgery, Critical Care and Anaesthetics directorate. The Clinical Director had been in post for five years and spoke of a vision to develop planned care services but this had not been formalised or approved at board or directorate level. The trust had a five year plan launched in March 2015.
- In the trust's presentation to the CQC the chief executive spoke of the trust aiming to give "Great care to every patient, every day". For surgery the chief executive spoke of "needing to do better" in the following: theatre utilisation, improving the 18 week RTTs for trauma and orthopaedics and urology, improving the cancer 62 day target (those patients being treated within 62 days of GP urgent suspected cancer referral), wards B4 and B5 with B4 day case ward having been used as a medical 'overflow' ward the week before and surgical ambulatory pathways.
- Some staff told us that they had received information about the trust's five year plan and strategy in their April 2015 payslips.

Governance, risk management and quality measurement

- We saw minutes from governance meetings, a quality report, directorate management meetings (DMT, sisters' meetings and exception reports on falls. The governance and DMT meetings were attended by the clinical director, the general manager, the interim head of nursing, service managers and matrons and the quality manager. The directorate's quality report was presented to the trust's clinical quality assurance group and then to the board through the Patient Safety and Quality Committee. One of the duties of this committee was to make recommendations and seek assurances as to the robustness of the controls in place with particular focus on the key challenges identified of strengthening staffing in key areas. The quality report for April to June 2015 highlighted incidents and staffing issues in surgical wards in May, June and July these were not reported on or actioned in minutes we saw for the Patient Safety and Quality Committee meeting in July 2015.
- There was a performance scorecard for surgery and scorecards for individual wards. The ward scorecards included staffing issues, complaints, falls, pressure ulcers, and infection control and gave rag ratings. In the incident logs for staffing shortages, we saw that minimal action had been taken at the time by senior staff to address the shortage.
- In the governance meetings complaints was an agenda item, there did not appear to be learning from complaints, incidents and feedback from the patient experience survey. There were common themes in staffing and the ability to meet patients' needs.

Surgery

- On the wards we saw information displayed on the percentage of new patient harm for the previous month including pressure ulcers, VTEs, falls, MRSA, C Difficile. When we asked some senior staff on the ward for details about the patient harm experienced they were unable to do so.
- The information from the governance, DMT, and sisters meetings minutes highlighted some serious issues and safety concerns. In the August 2015 governance meetings in an agenda section for the matrons' risk reports ward B5 was described as unsafe, with concerns around, language skills of staff, eight new members of staff and the competencies of the newly qualified staff, vacancies and an increase in cardiac arrests. The trust did not indicate concern about this wardat the beginning of our announced inspection and the incidents that had occurred. When weasked the trust about the ward they described it as theirworry ward. The trust was not open about the significant issues until we asked further questions about B5 ward.
- We asked the trust for a report on the six cardiac arrests that occurred over a five week period in July and August 2015 on B5 ward. After our inspections we received a review of the patient case notes, a terms of reference for the investigation, an actions update and a final report. The final report showed there had beena ward move in September 2014 and an increase inbeds with an unsuccessful attempt to recruit to the vacant posts created. There had been over five Whole Time Equivalent (WTE) vacancies and this did not include annual leave, study and sick leave. The report also identified a culture that did not recognise the importance of escalating concerns.
- Staff views in the report cited being demotivated with the ward move, inadequate permanent ward staff and skill mix, and temporary staff not always being aware of procedures. They also reported that senior ward staff did not always deal with concerns, there had been very few staff meetings and no mentoring for new starters.
- The actions updatestated that there had been an escalation of concerns to the Directorate, Deputy and Chief Nurses. The final report indicated it would be sharedwith the chief nurse, the deputy chief nurse and the head of nursing.
- Clinical governance meetings included sharing national guidance and audit results. We were told that minutes from the meetings were put on staff boards. Minutes and action points that we saw from matron level down were inconsistently shared with ward staff and were focused on action points rather than evidence based information. There were no evidence of staff on the wards routinely discussing new clinical guidelines and effecting change from the ward level up.
- Staffing was included on the ward's scorecard but when we looked at rosters and the number of unfilled nursing and health care assistant shifts on wards there were many more than were indicated on the ward scorecard. The directorate's quality report of April to June 2015 indicated that the highest patient safety incidents were falls and under care and treatment the lack of VTE assessments was the highest theme, the fourth highest area of incidents was staffing. It stated that the number of incidents for staffing being reported were not reflecting the actual shortages being experienced on the wards.
- Some staff told us about problems with IT and other equipment that impacted on their ability to work safely. Documentation provided to us showed there was no replacement programme for equipment or IT ordering of equipment. Any instruments or equipment over a certain amount had to be put forward as a capital bid, this was then reviewed through the process of a risk assessment and scoring and was either then approved for capital bids money or declined.IT equipment had to be raised on an internal order which had to be risk assessed and approved by the general manager prior to being sent to the IT department for purchasing, The IT department held the register of requests and prioritised them across the trust. The chief executive told us that improvements in IT were included in the trust's five year plan.
- We observed and senior staff told us the bed management meeting was managerially rather than clinically led with the focus being to find a bed in order to move a patient from the emergency department rather than to meet their needs as a patient. In one incident logged we saw that one unwell patient was moved to allow another patient to be admitted to avoid a breech in the emergency department four hour wait standard. There was no ring fenced ward for trauma and emergency admissions.
- The trust had signed up to the national safety campaign launched by the Secretary of State for Health in June 2014 to drive safety improvements within healthcare. The ambition of the campaign being to halve avoidable harm in the NHS. In relation to surgery they were

successful in the bids for the escalation of the deteriorating patient and falls prevention, management and reduction of associated risks. This had resulted in a simulation training programme and two 'falls safe' nurses.

Leadership of service

- Staff told us that the chief executive was visible, and had visited some staff teams. Staff told us that some of them would not recognise their service manager and some senior staff told us they did not visit the departments on a regular basis.
- The general manager for surgery had been in post for 20 months, there was an interim head of nursing during our announced inspection, with a permanent head of nursing appointed. There had been continuity of management within theatres, there had been a recent change in matron and ward manager for ward B5. Information provided by the trust following our inspections in relation to B5 ward and the investigation being undertaken reported that an experienced band 7 ward manager and band 6 junior sister had been moved to manage and support the ward respectively.
- We compared the trust's job descriptions for staff working at a team manager level band 7 with those of other hospitals and found at this trust there was no strategic role or professional leadership within this role. There did not appear to be clear strategic leadership of the service. Some challenges had been identified for example in staffing and action had been taken to recruit staff, there were still though periods when wards were insufficiently staffed with no clear escalation process. Some information from results from audits such as monitoring the recording of patient's observations had indicated late recording. Following our inspections we were told that there had been an improvement on the number of late and breached observations.

Culture within the service

- Many staff told us they had worked at the hospital for a long time and felt a strong link with the hospital. There had been a period of uncertainty over the future of the hospital and staff told us that it had been a challenge to recruit staff due to this. Recruitment overseas had been successful with over twenty staff recruited from Europe.
- We found differences in how staff felt about the service they provided and the organisation they worked for. Some staff felt they were working well as a team and that they were able to consistently meet the needs of their patient. This varied within departments, some staff working in theatres found there were problems with equipment and the flow of patients, whilst other staff felt the theatres ran well. Staff on the surgical wards had varying experiences, staff in B4 day ward told us there had been improvements in the way the ward was used with patients admitted for day surgery being appropriately assessed for their suitability. Low morale in staff had been identified by the trust on B5.
- In theatres, A3 ward, and the ophthalmic day ward there were clear protocols for the patients who were to be treated there. B4 day ward was allocated for day case surgery and for the majority of the time was used as this and was able to meet the needs of its patients. SAU ward was not ring fenced for surgical admissions and at times found it hard to meet the additional needs of some patients.
- On B5 ward there were not clear protocols for the patients to be treated there, there had also been a high level of nursing vacancy, incidents recorded, non-infection control compliance and competency issues amongst recently employed staff members. Senior staff told us that B5 ward was their worry ward, governance meeting minutes and information in relation to the investigation on B5 evidenced the reasons for this. The hospital appeared focused on admitting patients to SAU and B5 wards but not taking into account the needs of the individual patients and the need for a responsive staffing acuity process.
- The staff NHS survey 2014 scored negatively for the percentage of staff believing that the trust provided equal opportunities for career progression or promotion and in the percentage of staff working extra hours.

Public and staff engagement

- We were told of the Patient First Programme by staff in focus groups, they told us that a lot of good ideas had come from nursing teams. Patients and staff could put forward suggestions on how to improve the patient experience, people could sign up for a monthly newsletter and were encouraged to give feedback about the trust. The trust planned for over half of its staff to have completed the patient first programme by March 2016. One of the suggestions from this programme that we were told about was the introduction of lanyards with job titles for patients to be able to identify staff. During our inspection we saw very few staff wearing these lanyards.

Surgery

- Staff told us that if they had concerns about any aspect of work they would report it first to their line manager. The trust's 'raising concerns at work' policy issued in February 2015 set out that a member of staff should initially discuss the concern with their immediate manager, who would consider it fully and then seek appropriate professional advice.

Innovation, improvement and sustainability

- The main focus of the leadership team was to maintain and stabilise services based on recruitment to reduce locum and agency staff. The trust's five objectives were to deliver safe, effective care, give patients a positive experience and responsive care, and improve the estate and to be financially sustainable. The fabric of the hospital was outdated and there were problems with the layout of the wards. We saw that there had been recent redecoration.
- The separation of acute and elective surgery between the two hospitals was seen positively by the trust.
- The national audits such as the NELA and the hip fracture audit showed the trust was performing better than the England average
- Staff told us there were good opportunities for development and progression through the hospital and we saw that staff received awards in acknowledgement for the work they do.
- Information collected by the trust such as in audits, incidents reporting and complaints was not always analysed and addressed promptly and used to improve care.

Critical care

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

Information about the service

The critical care unit at St Helier Hospital consists of one Intensive Care Unit (ICU) of six beds, providing level 3 care and one High Dependency Unit (HDU) of five beds, providing level 2 care. There was the potential to open a seventh ICU bed and a sixth HDU bed, although these beds were currently unfunded. The unit is part of the South London critical care network, which includes several other NHS trusts across the south of England. It mostly admits emergency patients as well as patients referred to the tertiary specialist renal service on site and takes all level 3 patients from Epsom General Hospital. The critical care unit admits patients from the emergency department and post-operatively from theatres, but a proportion are also admitted via the hospital wards, when becoming unwell.

We visited the critical care unit over the course of two announced inspection days and one afternoon of unannounced inspection on the 25th November 2015. During our inspection, we spoke with 18 members of staff including doctors, nurses, allied health professionals and ancillary staff. We spoke with the divisional leadership team within critical care at the trust. We also spoke with four patients and two relatives. We checked eight patient records and 12 pieces of equipment.

Summary of findings

We rated the critical care unit as 'requires improvement' overall. Although staff were reporting incidents, there was no system in place to ensure that all staff were learning from incidents. We identified gaps in record keeping and found that intravenous (IV) fluids were not being stored securely. The unit was small and cramped and staff told us this made it difficult to have all the equipment required around the patient bedspace.

There was a lack of agreed guidelines specific to the critical care unit and multidisciplinary working was not well embedded. The unit had a larger number of delayed discharges and out of hours discharges compared to similar units and staff in other parts of the hospital reported delays in accessing critical care.

Patients were not always given the opportunity to be involved in their care. There was a poor response to patient feedback surveys and the unit did not offer a follow up clinic for patients post discharge.

The leadership team had struggled to achieve good team dynamics because of behavioural issues from certain staff members and had not been successful in their attempts to manage this. The service had been unable to agree a strategy and an external advisor had been appointed by the trust to assist the critical care workforce in achieving this. The culture on the unit was very hierarchical and challenges were not always welcome.

Critical care

The unit had good outcomes for patient when compared to similar units and staffing was in line with national guidelines, although agency nurses were used frequently. Staff, including agency, received a good induction and competency based assessment prior to caring for patients independently. Doctors in training received good teaching and support from consultants and patients we spoke with spoke highly of the staff and the care they received on the unit.

Are critical care services safe?

Requires improvement

We found aspects of medicine management such as the storage of IV fluids in an unsecured area concerning. Although these were removed to a more secure area during the visit. We also identified some gaps in record keeping such as safety checks and delirium screening not always being completed. Staffing on the unit was in line with national guidelines although agency nurses filled a high proportion of nursing shifts. Staff were aware of the process to report incidentsbut near misses and delayed discharges were not always reported as incidentsand there was no system in place to ensure learning from incidents was cascaded to all staff groups.

The unit was clean and staff mostly adhered to good infection prevention and control practice during our visit despite the clinical area being small and cramped.However infection prevention and control audits showed compliance with hand hygiene was not always achieved and staff were unaware of precautions required to protect patients during building repairs, which was ongoing on one of the days of our announced inspection. The record for providing harm free care was good and staff on the critical care unit were mostly up to date with their mandatory training.

Incidents

- The trust did not report any never events in critical care in the last year (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented).
- There were three Serious Incidents (SIs) reported for the period of August 2014 to July 2015, two of which were grade three or four pressure ulcers acquired prior to admission to the unit. The other SI related to an unexpected death and we saw that the incident was fully investigated using the serious incident framework and an action plan was developed as a result. This incident related to delays in identifying and escalating a deteriorating patient on the ward and a Managing Acutely Ill Patient (MAiP) policy had been approved but was yet to be implemented, although consultant review on the ward had improved as a result.

Critical care

- Incidents were reported using an electronic system and all staff we spoke with during the inspection told us they knew how to report an incident and they received individual feedback from the matron or lead nurse. Incidents were discussed at a weekly meeting attended by the consultant, matron and lead nurse. We saw evidence of these discussions in the meeting minutes we reviewed. It wasunclear how learning from these incidents was cascaded down to the rest of the nursing team as the critical care unit did not hold regular staff meetings. Some nurses we spoke with told us they received emails from the matron or lead nurse but often were too busy to read emails. Nursing staff were unable to tell us of the last incident on the unit they had received feedback about.
- 139 other incidents were reported for critical care at the St Helier site.The three main categories for the incidents reported were pressure ulcers, medical devices injuries, and medical equipment being faulty or unavailable. Senior staff acknowledged that there might be under-reporting of near misses and delayed discharges, as these had been reported in other data but very few were reported as incidents. Staff felt delayed discharges were common and reporting did not result in any change.
- The critical care team held monthly mortality and morbidity meetings and these meetings were shared with different specialties on a regular basis. We saw minutes of joint meetings with haematology, renal and anaesthetic teams, demonstrating the willingness to enhance the care of patients on the critical unit through improved collaborative working between teams.
- The clinical lead for critical care had recently introduced a multidisciplinary team meeting with Allied Health Professionals(AHPs). We saw evidence that a never event that had happened in another department was discussed by the nutrition team and the learning from the investigation was shared with the group. Only one meeting had taken place at the time of our inspection.

Duty of Candour

- More junior staff we spoke with had limited knowledge on the duty of candour but we saw in a serious investigation report that the duty of candour was followed and a designated person met with the relatives of the patient involved and kept them informed throughout the process.

Safety thermometer

- The critical care unit participated in the NHS Safety Thermometer scheme used to collect local data on specific measures related to patient harm and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas. This data was collected electronically and a report produced for each area.
- The information on harm free care was clearly displayed at the entrance of each unit along with the expected and actual staffing levels for that day. On the days of our announced inspection, we observed the critical care unit had the required number of nursing staff on duty.
- For the period of November 2014 to October 2015, the unit was providing harm free care for eight of these months and the type of harm reported in the other months were mainly pressure ulcers, with only one catheter acquired infection and one patient fall.
- The critical care unit had reported 35 pressure ulcers (admitted with and acquired) as incidents. The lead nurse informed us the trust reported skin damage caused by oxygen masks or an endotracheal tube(a tube inserted in the windpipe and connected to a ventilator to aid breathing) as medical devices injury, of which there had been 10 reported for the last year. Pressure ulcer risk assessments were completed for all patients. The unit had access to specialist advice from the tissue viability nurse, and basic pressure relieving equipment was available. More specialist pressure relieving equipment for use in complex cases was loaned through an external company and staff reported the delivery of this equipment could sometimes take a few days. The lead nurse informed us she had recently put in a bid to purchase some more advanced pressure relieving equipment for the unit to ensure prompt availability, but was yet to hear the outcome of this.
- The critical care unit had reported one case of acquired Clostridium difficile in the last year and we saw evidence of an investigation by the Infection Prevention and Control (IPC)team as well as more regular IPC audits on the unit as a result.
- Records we reviewed demonstrated that all patients had undergone a venous thromboembolism (VTE)assessment on admission and were receiving the appropriate VTE prophylaxis treatment. The safety thermometer data also showed a 100% assessment rate for VTE for the last year.

Critical care

Cleanliness, infection control and hygiene

- There were dedicated staff for cleaning the critical care unit and they were supplied with and used nationally recognised colour- coded cleaning equipment. This enabled them to follow best practice with respect to minimising cross-contamination. Cleaning staff understood cleaning frequency and standards and said they felt part of the ward team. Additional deep cleaning of the units was carried out by a separate team and the ward staff were unaware of how often a deep clean happened, although we observed staff carrying out deep cleans on both days of our announced visit.
- The units we visited were clean and all the patients we spoke with were satisfied with the cleanliness. Other areas within the critical care unit, such as the relatives waiting area, quiet room and nursing stations, were clean and tidy. We observed bed space curtains were labelled with the date they were last changed.
- We looked at the equipment used on the units, including commodes and bedpans, and found them to be clean. Labels indicated they had been cleaned, except for the commode in the High Dependency Unit. There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required.
- Alcohol hand gels were readily available at the entrances to the critical care unit and at each bedside. We observed staff and visitors decontaminating their hands when entering and leaving the unit.
- Staff adhered to IPC precautions throughout our inspection such as cleaning hands when entering and exiting the unit and bed spaces, and wearing personal protective equipment when caring for patients. Side rooms also had signs displaying that there was a presence of infection but the doors remained open.
- The IPC audit for the last quarter showed that the Intensive Care Unit(ICU) had an overall compliance of 80% against the 10 elements being audited with management of patients with diarrhoea scoring 17% and staff undertaking hand hygiene scoring 70%. The HDU achieved overall compliance of 71%, equipment cleanliness at 60% and peripheral cannula audit achieving 56%.
- Intensive Care National Audit and Research Centre(ICNARC) data for the unit showed no concerns in relation to hospital-acquired infections, such as MRSA or C. difficile and performance in these areas was similar to comparable units.
- There was no formal policy for the use of side rooms. Patients were discussed three times a day and side rooms were allocated on a clinical need basis, following discussion with the microbiology team.
- We observed staff using heated wet wipes rather than soap and water to wash patients. This was on the advice of the IPC team as the tap water had tested positive for pseudomonas previously. Although the water was regularly tested for pseudomonas, staff told us this would be ongoing due to the age of the building and pipework. The senior staff informed us that all staff were also expected to use alcohol gel after hand washing for the same reason, however junior doctors we spoke with were unaware of this and hence not complying.

Environment and equipment

- The ICU had three side rooms and the HDU had one, which were neither negative nor positive pressure rooms. Negative and positive air pressure rooms are either to prevent patients from acquiring an infection, as they are immunosuppressed or to stop a patient's own infection from spreading.
- The environment in the main bays on both ICU and HDU was small and cramped and meant the service was not following Intensive Care Society standards regarding space between beds. Staff told us private conversations could not happen at the bedspace and it was sometimes difficult to have all the equipment required for procedures around the bed due to the cramped space. The fabric of the building was dated although, we found no element of the environment immediately unsafe during our inspection.
- There was a general lack of storage space on the unit and in HDU; a 3 bedded area designed for use as escalation beds as part of the trust's major incident plan, was currently being used as a storage space. Nursing staff reported that this area had been identified as being cluttered on a recent Trust Development Authority (TDA) visit. We observed the area to have patient's bedside chairs, spare mattresses and a bed as well as manual handling equipment. Although the area was used to store a large number of equipment, staff had attempted to declutter the space as much as possible following previous feedback.
- We saw resuscitation equipment readily available on the units, with security tabs present on each. Systems were

in place to check equipment daily to ensure it was ready for use. We saw from records that staff complied with these systems. Difficult airway and emergency tracheostomyequipment was available on the unit.

- Staff reported previous issues with flooding on the HDU and during our announced inspection, we observed ongoing repairs to a water leak in the ceiling. The repairs were being carried out in close proximity to clinical equipment and patient's bedspaces and plaster dust was visible around the area, even after the workers had left the unit. There had been no barriers set up to isolate patients and the risks to patients on the unit at the time, some with a tracheostomy in situ, had not been considered. We highlighted this to the senior nurses.
- Staff reported most equipment was old but they had a good relationship with the electro-medical engineering (EME) department and equipment repairs were carried out without any delay. The trust did not currently have an equipment replacement programme and senior staff told us capital bids to purchase new equipment had been turned down for several years running.
- All the equipment we inspected had the necessary portable appliance testing and had been serviced in the last year, except for one feeding pump in use on the ICU. The pump had been due a service in August 2015 and when we pointed this out to the staff, they took immediate action to remove the pump from use.

Medicines

- The critical care unit had a designated pharmacist who visited the unit on weekdays and an on-call pharmacist provided cover at weekends. The pharmacist was responsible for compiling patients' drug histories and recording allergies. This allowed the pharmacist to check for inappropriate drug interactions and risks.
- All drug storage cupboards were securely locked and regular audits were completed regarding the accuracy of controlled drug documentation and medicines management. In a controlled drug (CD) audit carried out in October 2015, it was noted that the CD keys were not kept separate from other keys and this had been rectified by the time of our visit. The audit also noted that entries in the CD book were not clear with no crossing out or obliterations in both ITU and HDU and errors in the CD book in HDU were not dated and signed by two members of staff. This was not in line with the trust policy.
- The medicines refrigerator was within the appropriate temperature range. There was a fridge temperature checking record, which showed fridge temperatures were checked daily on HDU but there was inconsistencies and omissions in the ITU checking records. We also observed the fridge temperature recorded as being out of range for 3 days in a row, with actions recorded each day as medicine quarantine and pharmacy informed, before any action was taken. Staff could not explain why it had taken three days for actions to be taken.
- On HDU, we observed Intravenous(IV) fluids were stored in a room with a keypad lock but the door was wedged open during our visit. Due to the lack of storage on the unit, we were shown a large stock of fluids for the critical care unit stored in a corridor accessible to the public. This left the fluid open to tampering but the risk had not been included on the risk register. We highlighted this issue to the senior nurses and we observed on our unannounced visit that the fluids had been moved to a storage space at the entrance of the HDU.
- We observed four sets of medicine administration records and found that almost all were completed accurately and according to national guidance. The only omission we observed was stop dates for antibiotics were not recorded. Staff told us antibiotic prescriptions were reviewed on the daily ward round, with input from the microbiology team; we observed this in practice during the unannounced inspection.
- A medicine administration test was part of the induction process for all new starters on critical care and staff were not allowed to administer medication until they have completed the test. All staff also needed to attend the IV training course and agency staff were asked to provide evidence of their training.
- Senior nursing staff told us that they could not isolate the piped medical gases to each bedspace currently, so if there were a problem with medical gases, the whole unit would be affected. We noted this had been on the risk register for the last four years and plans to mitigate the risk included having large oxygen cylinders available but these were not currently stored on the unit due to lack of storage. We were told the funding had now been agreed but they had been unable to decant to another area to allow for the work to take place.

Critical care

Records

- The critical care unit used paper-based records. Each patient on the unit had a booklet containing the nursing risk assessments such as pressure ulcers and nutrition. The proforma used for nursing care plans was comprehensive but in the records we reviewed, these proformas were not always being completed fully. Significant omissions observed were wound assessments not being completed for two post-operative surgical patients and inconsistent recording of safety checks at night. We saw evidence of documentation audits, carried out by the senior staff in June, August and November 2015, had an 89 to 92% completion rate. We did not see any actions taken because of these audits and did not see evidence of discussion around documentation in meeting minutes we reviewed.
- The medical team carried out ward rounds three or four times a day. In all the records we reviewed, the evening ward round was not documented.
- We saw evidence of clear and comprehensive discharge summaries completed for patients leaving the unit, although none of these was signed. The nursing staff also used a transfer/discharge summary with details of all important information to handover to the receiving ward staff. This was signed by the transferring and receiving nurse to maintain consistent communication when transferring patients out of the critical care unit.
- The critical care unit had developed a family communication sheet and we saw evidence of these in the records we reviewed, stating clearly all discussions that had happened with family members of patients on the unit.
- 98.6% of nursing staff and 80.7% of medical staff had completed the information governance training. This data relates to staff at both the St Helier and Epsom sites.

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 give an example of the last safeguarding referral made on the unit and more junior staff reported they would seek advice from more senior staff if unsure. Staff told us an incident report was completed when a safeguarding referral was made and we saw evidence of this when reviewing the incidents data on the unit.
- 94% of medical staff and 100% nursing staff had completed the safeguarding adult training and safeguarding children Level 1 and 2 had been completed by 81.9% of medical staff and 90% of nursing staff. This is the figures for staff at both the St Helier and Epsom sites as the trust did not collect site specific data.

Mandatory training

- Critical care nursing staff achieved the trust target of 90% for all mandatory training modules, except for VTE risk assessment where only 78.6% of staff had attended training. 100 % of nursing staff had attended training for infection control, conflict resolution and equality and diversity.
- Medical staff achieved the target of 90% for conflict resolution, equality, and diversity and infection control but were close to achieving the target for other modules except for VTE risk assessment, where only 19.3% had attended training.
- Staff we spoke with told us they were up to date with their training and were booked onto training by the practice development nurse. They were also allocated time to complete e-learning.

Assessing and responding to patient risk

- Ward based staff were currently using a clinical software system which allows staff to use handheld devices to record inpatient observations (such as pulse, blood pressure and temperature) at the bedside. The system uses the data inputted to calculate an early warning score using the National early Warning System (NEWS) as a measure of risk for each patient. Staff would then escalate to the medical team for the patient in the event of any deterioration.
- Admission to critical unit was on a consultant-to-consultant basis and doctors attending the junior doctors focus group told us this could lead to delays in accessing critical care as it often meant making numerous phone calls before a deteriorating patient would be seen by the critical care team. During our unannounced inspection, the lead nurse told us there was now a doctor available to review all patients referred to critical care (which was not in place during our announced visit).

Critical care

- A committee, led by an intensivist, had been put in place in February 2104 to develop a policy and pathway for Managing Acutely Ill Patients (MAiP). This was in response to a number of concerns expressed about the operational pathways for escalating and managing acutely ill patients in the trust and the requirement to meet guidelines. The new MAiP policy was agreed by the Trust Executive Committee in March 2015 and each department was asked to submit an implementation plan by October 2015. In documents we reviewed, we noted that critical carehad yet to submit an implementation plan at the time of our inspection.
- The committee was also in the process of exploring different models for an Acute Response Team (ART) to provide a dedicated and trained team able to respond to acutely unwell patient. This team was not yet in place at the time of our announced inspection and plans were still in their infancy. However we were informed ART was operational a few days after our announced inspection so we attempted to contact the team during our unannounced inspection. We were however told by the person answering the bleep that she was at the Epsom site and no ART was available at St Helier.
- A nurse we spoke with on the ward did not know when to refer to ART and we saw evidence of patients with an elevated NEWS score that had not been escalated. This was despite posters being displayed to inform staff of ART.
- 24 and 48 hours review of patients discharged from critical care was currently undertaken by the critical care doctors but there was a proposal for this to be carried out by ART in the future.
- A simulation suite opened early in 2015, and provides specific multi-disciplinary training for teams managing the acutely deteriorating patient.

Nursing staffing

- The unit was overseen by a lead nurse and a matron, who both worked cross-site with Epsom General Hospital. The day-to-day running of the unit was the responsibility of the supernumerary shift leader.
- Nursing staff received an overview of all critical care patients from the shift coordinator at the start of their shift and then a thorough bedside handover once they had been allocated a patient. An acuity tool was used to determine staffing levels on HDU.
- The total WTE nursing establishment for the critical care unit was 55.2 and the unit currently had nine vacancies. It had been difficult for the unit to recruit and retain band 6 nurses and the establishment was therefore changed to recruit additional band 7 nurses. The senior nurses told us that recent local and overseas recruitment had been successful and more permanent staff had been recruited onto the unit.
- There was a high use of agency staff but the service was meeting the intensive care society standards of 1:1 care for Level three patients and 1:2 care for Level two patients. Staff reported agency usage of up to 50% on certain shifts and we observed this when looking at nursing rotas on the ward. Best practice guidance suggests no more than 20% agency staff usage per shift. The overall agency use for the critical care unit for the period of April 2014 to March 2015 was 24% compared to the trust average of 14.3%.
- Agency staff underwent a thorough induction to the unit and senior nurses told us that they tried to use the same agency staff whenever possible to maintain the continuity of care and avoid repeated inductions to the unit, which can be time consuming for the shift leader.
- New nurses were initially supernumerary while becoming orientated to the department. They were allocated a mentor and received support from the Practice Development Nurse (PDN). Staff who had started recently gave us positive feedback about the induction process.

Medical staffing

- Consultant cover on the critical care unit was provided by six intensivists. They each provided 24 hours cover to the critical care unit for one week in six, working as an anaesthetist for the other five weeks. During the week on intensive care, the consultant provided cover during the daytime Monday to Friday and for the whole weekend. Monday to Friday night time on call was allocated to the other consultants not covering the unit that week. The consultants all felt an additional two consultants was required due to the current onerous rota. Discussions had been had around this matter, although no firm business case had been developed as yet.
- The consultants on the unit were supported by a team of registrars, clinical fellow and junior doctors. We saw copies of the junior doctor rota and staff we spoke with told us cover was adequate.
- There was a doctor allocated solely to the critical care unit at night, although this person was not always

airway trained. The anaesthetist registrar on call was available to provide advanced airway management to the unit at night. Staff told us the on call consultant anaesthetist would always come in if there were a case in theatre, so that the registrar would always be available in an emergency.

- Medical handovers took place morning and evening and staff told us consultant led bedside ward rounds took place three times a day. The microbiologist and pharmacist joined the midday ward round and recently other AHP staff have been encouraged to attend by the clinical lead.

Major incident awareness and training

- All staff received fire safety training as part of their mandatory training programme; however, none of the staff we spoke with had practiced an evacuation procedure on the unit.
- There was an up to date major incident plan for the trust with a specific action card for the critical care unit and staff we spoke with were aware of this. There was also a three bedded area in the HDU identified for use as extra beds in the event of a major incident. However this area was a cluttered storage area and there were no spare ventilators onsite. Staff told us the spare ventilators would have to be borrowed from the Epsom general hospital site, so it was unclear how quickly these escalation beds could be opened up in the event of a major incident.

Are critical care services effective?

Requires improvement

There was a lack of agreed critical care specific policies and procedures based upon current guidance although staff were able to access national guidelines. We observed consent was not recorded on the tracheostomy checklist and staff we spoke with had various views of when a Deprivation of Liberty Safeguard (DOLS) application was required. There was good access to seven-day services and the unit had input from a multidisciplinary team, although access to occupational therapy was limited. The multidisciplinary approach to patient care was not embedded in the unit although some progress had been made recently.

Patient outcomes, such as mortality and unplanned re-admissions, were in line with or better than other similar units. Pain was regularly assessed and patients told us they received pain relief quickly when needed.

Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Medical staff received regular training as well as support from consultants.

Evidence-based care and treatment

- There was a lack of agreed guidelines for the critical care unit, based on National Institute for Health and Care Excellence (NICE), Royal College guidelines and Intensive Care Society recommendations. This was due to the consultants not being able to reach an agreement on specific guidelines to be used on the unit. Resources to help guide practice were available but many of these were not dated or version controlled, which meant staff might be using out of date information. The practice development team acknowledged the guidelines needed updating. The trust intranet contained all the national and Royal Colleges guidelines as well as other trust wide guidelines such as managing sepsis, which were relevant to patient on critical care. Staff we spoke with knew how to access this information.

· The critical care unit had achieved compliance of over 97% with the central venous catheter care bundle for the period of January to July 2015 and scored over 97% for the Ventilator Acquired Pneumonia (VAP) care bundle for the same period.

- The critical care unit underwent a peer review, published in March 2015, to look at compliance with the London Quality Standards, and was found to be compliant in all 26 standards.
- The critical care unit 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.
- The nursing care plans were detailed and contained evidence-based risk assessment tools and checks for easy reference.
- All patients received daily physiotherapy as required by the National Institute for Health and Care Excellence (NICE) guidance and intensive care society standards. All patients were screened within 24 hours, although from the records we reviewed, it was not clear if their

rehabilitation needs were identified at the time. Rehabilitation progress was not currently measured using a validated outcome measure although the physiotherapists told us they were planning on using the evidence-based Chelsea Critical Care Physical Assessment Tool (CPAx), so patient progress could be monitored.

Pain relief

- Pain relief was managed primarily by consultants on critical care. Staff had access to the hospital based acute pain service on referral and staff told us they were very responsive although they were not needed often.
- Staff used a standardised scoring tool to assess patients' pain. Patients told us they were regularly asked if they had pain and were given medicines quickly if requested.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed by the nursing staff using the Malnutrition Universal Screening Tool (MUST). In most patient records, we observed the MUST assessment had been completed and documented.
- Patients receiving parenteral feeding were reviewed by a team consisting of dietician, pharmacist, chemical pathologist, and gastroenterologist on a daily basis during weekdays. Other patients were started on nutrition according to a standard protocol but could be referred to the dietician when concerns about nutrition were identified; for example because of a raised MUST score.
- A recent nutrition audit looking at 48 patient records showed that there was an average of two days delay in starting feedon the critical care unit. The audit showed that only 27% of patient were fed on day one and 24% were fed after being on the unit for three days. There was no action plan following this audit and staff were unable to tell us of any changes that had happened as a result.

Patient outcomes

- The ICNARC Standardised Mortality Ratio shows a trend of good outcomes on critical care. Mortality rates were within the expected range when adjusted for case-mix in comparison with data submitted by similar units. The rate of post critical care hospital deaths was better in comparison with other units.
- Over 91% of patients were admitted to critical care following emergency bowel surgery and this included 99% of high-risk patients.The National Emergency Laparotomy Audit showed a lower mortality rate of 8% in the trust compared to 11% nationally.
- The mean length of stay on the unit for the period of January to March 2015 was 5.7 days, which was in line with similar units.
- Unplanned re-admissions to critical care within 48 hours from unit discharge and after 48 hours were better when compared to similar units for the period of January to June 2015.
- The unit had a higher rate of non-clinical transfers in as all level three patients were transferred over from the Epsom General Hospital site. The rate of non-clinical transfers out of the unit was low.
- Patients discharged 'out of hours' between 10pm and 7am are associated with worse outcomes and ICNARC data demonstrated a higher number of patients were discharged to the wards out of hours than in other similar units.
- The majority of patients returned to their pre-admission residence and previous level of independence on discharge from hospital.

Competent staff

Nursing

- The critical care unit had two designated part-time practice development nurses, who made up less than one WTE, responsible for overseeing the professional development and learning of nurses working on the St Helier and Epsom site, as well as supporting student nurses on placement. A student nurse we spoke with felt she had received excellent support and information and we observed the feedback from the universities to be excellent.
- All new starters worked as supernumerary members of staff for a designated period, during which they had to have specific competencies signed off by a senior nurse or practice development nurse before being able to care for critical care patients independently. Bedside training was available from the mentor or practice development nurse during that period.
- The Faculty of Intensive Care Medicine 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. 77.5% on nurses on the unit had completed this training.

Critical care

- Senior staff told us the tool used for allocating nursing staff to shifts took into account who had additional intensive care qualifications, to ensure a suitable skill mix for each shift.
- Agency staff had a robust induction on the unit, which included a clear outline of their duties, equipment competency checks and recording evidence of their IV training.
- 91.7% of nursing staffhad received an appraisal in the last year and all staff we spoke with told us they regularly received appraisals. Senior staff described a four-year development programme for band 6 nurses as part of their recruitment and retention plan.

Medical

- Junior medical staff were staff grade doctors as well as doctors on rotation to the unit as part of their on-going training scheme. Staff we spoke with told us their induction to the unit was thorough and trainee often chose to work on the unit due to the level of support and teaching they received.
- Junior staff received some formal teaching as well as bedside teaching daily, during ward rounds. They also had the opportunity to lead on training sessions such as journal clubs and audit feedback.

Multidisciplinary working

- Although the intensive care consultant remained the named clinician for all patients on the critical care unit, there was regular input from the medical and surgical consultants. This was more established with the renal team, whereby renal staff often worked on the unit to provide dialysis for patients under their care.
- A team of four physiotherapists and one therapy assistant provided cover to the critical care unit and the surgical wards. Patients on the unit were prioritised and seen daily. However the level of staffing meant that the physiotherapists relied on nursing staff to implement some of the rehabilitation plans, especially in the afternoon. In one set of records we reviewed, we saw that one patient did not sit out of bed for four days in the afternoon, as per their rehabilitation plan, with lack of staff stated as the reason on two of these days.
- The Allied Health Professionals (AHPs) told us multidisciplinary team (MDT)working with the nursing staff was well established but remained to be embedded with the medical staff. The AHP services were previously provided by a neighbouring trust but a month before one inspection, these services had transferred to the trust. AHPs we spoke with felt this would help strengthen future working relationships.
- AHPs were encouraged to attend the midday ward round but there was no multidisciplinary board round set up on the unit. The physiotherapist obtained a handover from the shift coordinator every morning. Staff told us MDT meetings were not routinely held although this might be considered for long term or complex patients.
- There was no formal guidelines for referral to AHPs,therefore involvement of some staff such as Speech and Language Therapists (SALT) depended on the consultant of the week. Staff told us some consultants were more receptive to input and recommendations from AHPs than others.
- Ventilator weaning (when patients' reliability on breathing machines is reducing and they are able to do more breathing on their own) programmes were currently consultant led although there had been recent discussion by the clinical lead to develop a MDT weaning protocol.
- Physiotherapy staff told us they underwent a competency based training prior to working on critical care and being on call. All on call physiotherapist also had yearly training updates in caring for critically ill patients. We requested evidence of this competency training but did not receive it.

Seven-day services

- The unit had a consultant present from 8am to 8:30pm every day and on call overnight, with a response time of 30 minutes. There were trainees available 24 hours each day and they were supported overnight by an anaesthetic registrar, with advanced airway training.
- Portable X-ray was available on the unit and patients had to be accompanied to the radiology department for other scans. Medical staff told us there was no problem with accessing imaging services out of hours or at weekends.
- Emergency respiratory physiotherapy cover was available overnight and at weekends, on a bleep referral basis. A pharmacist was available to support critical care at weekend, although they also had responsibilities in other areas of the trust.

Critical care

Access to information

- When patients were admitted via A&E or the wards, a verbal handover was provided to the medical and nursing staff as well as written information in the patient records.
- On discharge from critical care, a comprehensive medical discharge summary was written and verbal Hanover to the receiving team was provided. The nursing staff also had a separate nursing handover sheet for the nurse on the receiving ward, which had to be signed by both nurses following the verbal handover.
- Physiotherapists did not complete a written handover as they often continued to care for the patient when transferred to the ward. For patient they did not follow, a verbal handover was given to the ward physiotherapist.
- Staff obtained most of their in-house information via the intranet site, although some staff reported that only have two computer terminals on critical care made it harder to access the intranet during busy periods. There were some folders on the unit with some trust policies, although some of these were not the most up to date version.

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

- Staff on the unit received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards(DOLS) and this training was also part of the trust induction for all new starters.
- All levels of relevant staff were able to tell us how they would obtain consent and when consent could not be obtained, such as if the patient was unconscious; staff told us care was provided in the patients' best interests. A recent checklist had been introduced for tracheostomy insertion but we noticed that consent was not one of the checks on this form.
- We observed a ward round where surgery was planned for an intubated and sedated patient, however there had been no documentation on capacity, best interest meeting or discussion with the family.We brought this to the attention of the medical team and were assured these discussions were due to take place. This was also raised with the medical director at the time of the inspection.
- Senior nursing staff told us that DOLSs application were not routinely completed for patients who were being sedated but they would complete an application for use of mittens or other physical restraints. The senior nursing team told us they were awaiting new guidelines from the Intensive Care Society regarding DOLS application. We saw evidence of a completed DOLS application for use of mittens in one of the records we reviewed. This was for a level two patient, where mittens were being used to stop accidental removal of lines.

Are critical care services caring?

Requires improvement

Patients on the critical care unit were not always involved in their care as we observed a ward round where no attempt was made by the team to engagepatients who were well enoughin the discussion. One patient also told us ' they only tell me what's happening if I ask.' There was a communication sheet to record discussion with family members but this was not consistently filled in in the records we reviewed. Although staff told us they filled out patient diaries, none of the patients during our announced and unannounced visits had had a diary started. We observed kind and compassionate interactions between staff and patients and patients told us they were happy with the care received. The unit received only two responses for the Friends and Family Test in the last six months.

Compassionate care

- We observed a ward round on the unit where the team reviewedthe seven patients but did not attempt to interact with any of the patients or engage them in their care.
- We observed most staff interacting with patients and their visitors in a respectful and considerate manner, such as asking how they were feeling. Patients we spoke with told us' the nurses are fantastic' and 'they are always kind'.
- We observed one episode of care where a nurse went to take blood from a patient but there was little interaction with the patient and no explanation was offered as to why the blood was being taken.
- Patients told us their privacy and dignity was maintained at all times and we observed staff pulling curtains around patient areas before completing care tasks.
- Patients on HDU had their call bells within reach and those who were able to drink had water on their table.

Critical care

- We observed a therapy session, where a patient was being mobilised with a frame for the first time and the therapists motivated and reassured the patient in a kind and sensitive manner throughout the session
- In the last six months, only two patients had completed the Friends and Family test on the critical care unit and they both said they would recommend the unit. The critical care unit did not have a system in place to collect local patient feedback and senior staff acknowledged this was an area they had identified for improvement.

Understanding and involvement of patients and those close to them

- We observed a ward round on the unit where the team went round and had a discussion at each bedside but did not attempt to interact with the patients or engage them in their care.
- There was a communication sheet for the unit, where all discussions with family members was documented and we saw evidence of this sheet being completed in three out of the seven records we reviewed.
- A patient told us 'they only tell me what is happening if I ask'.This patient had been told by a surgeon that she would be moving to a ward at 8am but when we spoke to them at 11am she had not been given any further information about her transfer to the ward.
- The senior nurses informed us that patient diaries had been started by the practice development nurse but were unable to give us further information that they were being usedon a daily basis. We did not observe patient diaries about the bed space and requested to see evidence of this but were not provided with a diary for any patient on the unit at the time of our inspection. During our unannounced inspection, we again requested to see a completed patient dairy but none of the 12 patients on the unit had had a diary started.

Emotional support

- We observed staff providing emotional support to relatives of a palliative care patient on one of the days of our announced inspection. Doctors spoke to the relative in a separate quiet room and answered their questions. However, the palliative care team was not contacted and were therefore unable to offer additional specialist support to the patient and the family members.
- Emotional support could also be provided by the multi-faith spiritual service within the hospital 24 hours per day and representatives from various faiths could be accessed.
- Feedback from patients and relatives was positive and they told us staff had been reassuring and comforting. One relative told us how staff had been very accommodating about visiting hours, 'they are very flexible and let me visit whenever I can as they know I have other caring responsibilities.'
- The senior nurses had discussed sending bereavement cards to relatives of all patients who die in critical care but this had not been implemented at the time of our inspection.
- The patient bedspace did not contain personal items like pictures or cards and staff we spoke to said they did not specifically ask relatives to bring these in. Staff we spoke with were not aware of external organisations that could provide support and were therefore unable to signpost patient and relatives to these organisations.

Are critical care services responsive?

Requires improvement

Discharges out of critical care were regularly delayed due to lack of a lack of available beds in the rest of the hospital and this had a knock-on effect of creating further access difficulties for other patients. An increasing number of patients were transferred from critical care out of hours. The unit was not recording the number of mixed sex breaches, although delayed discharges led to male and female patients being cared for together in an open ward. Bed spaces on the critical care unit were close together, making it difficult for staff to have all the necessary equipment required to care and rehabilitate patients.

Visiting hours flexible and staff made an effort to accommodate requests from patient's relatives.

Facilities for visitors were limited to a small waiting room with facilities for making drinksor a specified toilet. Visitors were not able to stay overnight.

Staff had access to communication aids and translators when needed, giving patients the opportunity to make

decision about their care, and day to day tasks. Patient passports were used for patients with a learning disability and staff had access to the trust's safeguarding team and were aware of when a referral was required.

Service planning and delivery to meet the needs of local people

- ICNARC data showed that the majority of admissions to the critical care unit were unplanned admissions, although the unit also admitted patients following elective surgery. The unit receivedpatientsfrom the emergency department, theatre and the wards as well as all level 3 patients from Epsom General Hospital. Senior staff told us this made service planning difficult, as patient flow was unpredictable.
- Thecritical care unit had slightly more level two patients for the period of January to March 2015. Although the ITU and HDUunit were separate due to the configuration of the building, staff told us the beds on each unit could be used flexibly to care for level 2 and level 3 patients, although very rarely would they have a level 3 patients on the HDU side.
- When patients were well enough to be weaned from ventilation, there was consultant led weaning plan in place and access to the regional home ventilation and weaning unit, if required.
- The critical careconsultantsworked closely with the renal team to accommodate the needs of this specific group of patients on the unit. We saw evidence of the renal team reviewing patients and providing dialysis on the critical careunit.
- The environment on the unitit was not responsive to the needs of patients. Because the beds were too close together, it was particularly difficult to arrange all the equipment around them so that it did not get in the way of staff treating patients, especially if they were on dialysis. This made rehabilitation particularly difficult at times if it needed to be done out of the bed.
- There was an overall lack of storage space, which meant some equipment was being kept in the designated escalation bed space, and this area was noticed to be full, meaning staff had to step over or move items to access certain equipment.

Meeting people's individual needs

- A mixed sex breach occurs when level one or zero patients are placed on an open ward area with a member of the opposite sex. Mixed sex breaches should occur infrequently on critical care units, as patients are stepped down to a ward once they reach level one dependency. The unit was currently not recording mixed sex breachesbut due to the high number of delayed discharges from the unit. Staff told us that mixed sex breaches were happening regularly on the HDU. The HDU patients had access to bathroom facilities, but as there was only one, it was used for both male and female patients, although staff would always accompany patients to the bathroom.
- There was access to interpreting services; although staff felt that it took a long time to get an interpreter so often would use other members of staff in the trust to interpret, especially if they needed to communicate important information to the patients or relatives urgently.
- Various information leaflets were available on the unit, although they were all in English, but staff told us these could be provided in large print or in other languages if required.
- Staff were able to describe various formats of communicating with patients who could not speak, such as pen and paper, picture charts and using closed questions.
- A learning disability nurse was available on referral and those patients that had a learning disability had appropriate care and plans in place such as hospital passports as well as a review by the learning disability nurse, when appropriate.
- It was not clear how patients living with dementia were identified and we did not see evidence of specific documentation.We also noted there was no routine screening for delirium in place and staff we spoke to were not able to tell us if a particular patient had been screened for delirium, although the records mentioned the patient being agitated overnight.
- The unit was able to refer patients to a psychiatrist and we saw evidence of a comprehensive assessment in one of the records we reviewed.
- The critical care unit did not currently offer a follow up clinic where patients could reflect upon their critical care experience and discuss anything they were unclear about. This was not in line with NICE guidelines CG83 'Rehabilitation after critical care in adults.
- A number of posters and leaflets were displayed in both the relative's room and the corridor, which gave patients information on the unit such as visiting times, pictures

and names of the lead clinicians as well as details of how to raise a concern and the PALS service. There was also picture board with all relevant staff situated at the entrance of the ITU and HDU unit.

- The unit operated flexible visiting hours, with two visitors allowed at any one time but asked relatives to refrain from visiting before 1100 and during the rest period of 1230 to 1430. We spoke to relatives who told us they had always been able to visit at a time that suited them.
- There was a small relatives' room, which was clean and airy, and an additional quiet room which was used by staff to have private conversations and to break bad news to relatives. The quiet room had drink making facilities but we noticed that relatives were not able to access this room without a member of staff as it was kept locked.
- There were no facilities for relatives to stay overnight and they were encouraged to return home but were able to ring the unit for updates any the day. Staff told us they would direct relatives to a local hotel if needed.

Access and flow

- Staff told us there were difficulties discharging patients from the critical care unit due to a lack of bed availability in the rest of the hospital. The critical care quality analysis data for Januaryto July 2015 showed that there beenan average of 29 delayed discharges per month. ICNARC data also showed a trend for the unit to be worse for delayed discharges compared to other units. This could lead to access difficulties for patients requiring a critical care bed.
- A Commissioning for Quality and Innovation (CQUIN) target for 2015/16 was in place to reduce the amount of delayed discharges for emergency laparotomies and senior staff told us bed meetings were held twice daily. Staff felt the bed management team would always prioritise the transfer of patients from the unit, especially when they had a patient waiting to be admitted to critical care. Often the unfunded beds would be opened up to accommodate new admissions. However, the draft critical care strategy states inability to admit patients within the four hour timeframe as a weakness for the unit.
- An increasing number of patients were discharged from the unit between 10pm and 7am and the unit reported 33 out of hours discharges between January and July 2015. ICNARC data showed the critical care unit was worse than similar unit for out of hours discharges, although staff we spoke with told us they would only move a patient out of hours when they needed to admit an emergency patient. Discharges from critical care out of hours is against national patient safety guidance and the core standards.
- The consultant intensivists told us access to critical care unit was on a consultant-to-consultant referral basis. They felt this was important to ensure that the consultant in charge of the patient care had been fully informed of the deterioration in the patient and had the opportunity to discuss ceiling of care. Other staff we spoke with felt this could sometimes delay access to critical care, especially in the absence of a critical care outreach service. The unit was not recording data on delays in admission to critical care, so were unable to ascertain if this was a problem.
- The bed occupancy for level three patients ranged between 61% and 76% for the period of Dec 2014 to May 2015 and between 62 to 84% for level 2 patients for the same period.
- Patients within the hospital were assessed by the critical care team prior to admission and were able to support ward-based staff to care for patients requiring escalation prior to being transferred. In the last 12 months here had been three patients ventilated in recovery whilst awaiting a critical care bed. Data provided by the trust showed 10 patients had their surgery cancelled due to unavailability of critical beds to care for these patients post-operatively in 2015.
- Non-clinical transfers out of the unit were low, with only one patient transferred to the Epsom site in 2015.

Learning from complaints and concerns

- Information provided by the unit showed there had been one formal complaint that included the critical care unit in the last year, although this complaint was not specific to the care received on the unit. We saw evidence that this complaint was fully investigated and a response provided within the trust's agreed timeline. Most concerns raised by relatives were dealt with informally on the unit by nursing staff.
- Some relatives told us they were aware of how to make a complaint and could reference posters advertising PALS in the corridor. They felt they could also discuss any problems with staff on the unit.

Critical care

Are critical care services well-led?

Requires improvement

The critical care team were not united in their vision and strategy for their service and hence an external advisor had been appointed to assist in developing a strategy. Staff we spoke with felt the advisor engaged and sought the opinion of all staff groups but were unsure of the impact this would make as the report was yet to be shared.

There were interpersonal problems between staff and some staff expressed the view that the leadership of the service was 'stale' and this was hindering the progress of the unit.The culture on the critical care unit was very hierarchical and challenge was not always welcomed; some staff perceived the behaviours of certain individual as bullying. The trust took the decision to commission an external review into bullying and harassment after our announced visit and on the unannounced inspections, staff told us this was perceived as a step in the right direction to tackle the longstanding issues.

The trust board also appointed a new leadership team, consisting of senior clinicians from a neighbouring trust, within days of our announced inspection. We had the opportunity to meet some members of the new leadership team during our unannounced visit and they were undertaking of review with some changes already being implemented.

Governance arrangements were in place, although staff felt critical care was overshadowed by the bigger services in the directorate. A risk register was maintained, but it did not reflect all the risks we identified during our inspections. Risk registers were reviewed as part of the directorate governance meetings but it was unclear how actions were followed up as some risks had been on the register for up to four years.

Vision and strategy for this service

- The critical care draft strategy was not aligned to the trust's five-year plan. The trust's five-year strategy for critical care serviceswas an integrated approach for managing the most acutely unwell patients at the St Helier site. This would allow for a single intensivist rota at the St Helier site with only an anaesthetic rota for the Epsom site. However, staff we spoke with and the critical care draft strategy stated the vision is still to provide critical care facilities through dedicated intensivists and the lack of intensivist review at the Epsom site was a concern. The plan, as per the draft strategy, is to employ two further intensivists to provide daytime input at the Epsom site.
- A critical care strategy was still in a draft format and was awaiting approval from the Trust Executive Committee.We were told by the directorate team for critical care that it had been difficult for the team to agree a strategy due to interpersonal challenges amongst the critical care workforce. The vision and strategy for the service was not shared by all members of the critical care team and this had been acknowledged at the directorate and board level. An external advisor had been appointed to provide the critical care team with some assistance in agreeing a strategy and provide the board with a report highlighting the areas of concerns to be addressed.
- The strategy and vision for critical care services had been discussed in regular trust meetings such as 'Safe and Effective Hospital Care Steering Group' and 'Managing Acutely Ill Patients in Hospital' since 2014, but was yet to agreed.
- Staff we spoke with were unclear on the future direction of the service, although a few commented they felt the unit had not progressed in the last five years, as ideas for service improvement such as introducing a critical care outreach service, had been blocked by certain senior staff. However all staff we spoke with said their vision was to provide high quality, safe, evidence-based, compassionate care to critically ill patients within the trust and they were striving to do so despite the challenges they faced due to the environment and lack of cohesion in the team.

Governance, risk management and quality measurement

- The critical care service was governed under the surgery, anaesthetic and critical care directorate. Senior staff told us there were too many services in this directorate and critical care was not well represented. We were shown a discussion paper on the proposal to strengthen clinical and operational leadership and create a clinical director for anaesthetics and critical care. Other clinical staff we spoke with were not aware of this proposal.

Critical care

- The unit was engaged with governance activity within the hospital and had representation at a range of relevant meetings across the trust, notably the Safe and Effective Hospital Care programme (established in the trust to take forward recommendations from a variety of sources; Francis and Keogh reviews, London Quality Standards (LQS), NCEPOD and NICE guidelines) and the Managing Acutely ill patient Task group which aimed to establish pathways to deliver quality safe and effective care to all acutely unwell patients admitted to the trust
- There was a monthly risk and governance meeting where incidents, staffing and recruitment as well as any other performance issues were discussed for each of the surgical areas, critical care and theatres. The clinical director also provided feedback from the trust executive committee. We noted these meeting were not attended by intensivists and the lead nurse or matron for critical care provided an update for the service. It was unclear how information and feedback from these governance meetings were disseminated to the rest of the staff and staff we spoke with did not receive feedback from these meeting.
- The unit maintained a risk register, including concerns and assessments of potential risks on the unit. We saw evidence these risks were reviewed and mitigating plans were in place but it was unclear how actions were taken as some of the risks had been on the register since 2012.The mitigating plans for the risk relating to failure of piped medical gases stated the unit would have large oxygen cylinders to be used in the event of failure. However staff told us there were unable to store the cylinders on the unit due to the lack of storage so this risk was being mitigated.
- The risk register did not reflect all the risks identified on the inspection, i.e. out of hours discharges, delayed discharges, potential delays in admitting patients within four hours, increased infection control risks due to the environment and lack of storage space leading to fluids being stored in open corridor.
- A monthly quality scorecard was produced but critical care was reported in the surgical directorate and staff felt that issues in critical care were being overshadowed by the larger surgical services as the score cards did not provide a breakdown specific to critical care. It was therefore unclear how quality measurement for the critical care unit was being undertaken and understood at senior management level or how managers had full oversight of the concerns affecting front line staff and patient safety and experience.

Leadership of service

- The critical care unit was led by the lead intensivist, who worked closely with the lead nurse and matron. The nursing leads also covered the Epsom site and staff we spoke with told us they were very approachable and supportive although they were not clear about the difference between these roles. Some staff felt the nursing leadership could be more proactive and there was a sense the leadership was 'tired' due to the constant resistance to change.
- Some consultants told us the leadership of the service felt 'stale' and they felt the clinical lead should be a rotational post so other people could bring forward new ideas. Although all staff said their colleagues were excellent clinicians, they recognised there were challenges in achieving good team dynamics and the unit was being held back by this. The trust appointed a new leadership team following our announced inspections, who were senior clinicians from a neighbouring trust. Staff we spoke with during our unannounced visit were positive about this change and were optimistic 'things would improve.' The new leadership team told us, during the unannounced visit, that they were undertaking a review of the service and some changes were already being implemented. they were due to an action plan to the board within 6 weeks.
- Staff told us the leadership were fully aware of certain clinicians whose behaviours were not conducive to teamwork but this seemed to be accepted rather than challenged, hence most staff felt it was futile to highlight these issues as 'it has been going on for a long time and nothing gets done about it.'
- Staff stated the senior management team was not visible and did not understand front line issues.

Culture within the service

- Staff were proud of their work and were driven to provide the best care for their patients despite some of the challenges they faced. They felt able to raise concerns to the senior nurses and felt listened to although they did not always get feedback on the actions taken because of the concerns they raised.

Critical care

- Staff told us the culture on the unit was still very hierarchical and challenges were not always welcomed. Some nurses told us how they were not always able to refer patients with tracheostomies toSALT,as certain consultants would question this.
- The behaviours of certain consultants were perceived as low level bullying by some staff we spoke with, both on the critical care unit and in other areas of the trust. Staff told us these consultants were not open to discussions and more junior staff felt unable to raise issues about patient care with these individuals. Staff also attributed the lack of innovative practice and service improvement initiative to the resistance to change displayed by some consultants.
- Some AHPs told us the clinical lead had worked hard to implement a MDT approach on the unit recently but some consultants were yet to embrace their input into certain aspects of patient care such as weaning plans and they were seen as didactic when voicing their professional opinions.

Public engagement

- Relatives and patients could complete feedback forms but the response rate for these were consistently low as there had been only two responses in the last six months. The unit did not have a follow up clinic, which limited further feedback from patients following discharge.
- We were also told about a patient survey that had been carried out and but none of the staff we asked were able to tell us when this was completed. Wewere given a copy of the results but this was not dated.

Staff engagement

- Some junior staff told us they did not feel engaged in decision making process in the unit and they were told of decisions taken and changes made by the senior nursing team rather than involved.
- There had been recent meetings with an external advisor to facilitate the critical care team to work collaboratively and agree on a strategic plan for the service. This has been well received by some staff we spoke with stating ‘something had to be done to listen to the views of everyone involved'. However, the report from the external advisor and the trust’s response had not been shared with staff at the time of our inspection and staff were unaware if these discussions would make a difference.
- Staff were aware of the trust five Year plan and the Chief Executive was well known but the executive team and senior staff not based on the unit were not very visible.

Maternity and gynaecology

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

Information about the service

St Helier Hospital maternity department serves the south west London Boroughs of Sutton and Merton and provides all services relating to pregnancy, including an assisted conception unit. The hospital has a walk-in maternity assessment unit open from 8.30am to 4.30pm (weekdays only) for women over 20 weeks pregnant. The antenatal ward has 16 beds, including four single rooms, as well as an emergency delivery room. The consultant led delivery suite has two dedicated obstetric theatres, three recovery beds and seven delivery rooms. An eighth room (Poppy room),is used for women in cases of bereavement. The postnatal ward has 22 beds in six bedded bays, including five single rooms and is used for transitional care for newborn babies. A midwife led birth centre is adjacent to the labour ward, with three birthing rooms and a post-natal room.

This is a small maternity unit in terms of the number of births; about 2875 women are expected to deliver their babies in 2015/16.

All women come to the hospital for their booking appointment, for scans and sometimes for blood tests. Most women's antenatal care is provided by community midwives in their local area, based in GP surgeries and children's centres. Some medical led (consultant and midwife) antenatal clinics are held at the hospital for women with specific health conditions such as diabetes, mental health problems and obesity.

The hospital has a recently refurbished assisted conception unit which will soon undertake embryo transfer which previously was done at another trust. Fertility clinics are run.

The gynaecology service provides inpatient and outpatient services. A walk-in and by appointment early pregnancy assessment unit is open on weekday mornings.

The gynaecology clinic has 2 colposcopy rooms and two ultrasound rooms. A joint cancer clinic with another trust, and 2 of the two week rule clinics are run in this area, as well as an emergency gynaecology clinic, a recurrent miscarriage clinic and fertility clinic. An ambulatory gynaecology centre offers urodynamics and outpatient procedures. The ward, M2, has 17 beds, 11 of which are funded for Gynaecology. Gynaecology surgery is carried out in the main theatres and patients who need admission stay on ward M2 . Day surgery patients use ward B4.

Medical and surgical terminations for severe maternal illness and major fetal abnormalities are offered. Women will stay on the gynaecology ward or labour ward according to gestation.

During our inspection we visited all clinical areas, observed care and looked at patient records. We talked to over 47 staff including administrators, domestic staff, healthcare assistants, midwives, nurses, doctors in training and consultants. We spoke with 14 women and reviewed patient records as well as other documentation. We received comments from patients and families attending

our listening events, from staff focus groups and from people who contacted us to tell us about their experiences. We reviewed national data and information provided by the trust.

Summary of findings

We judged maternity as requiring improvement. Poor deployment of staff combined with inadequate numbers of midwives meant there was a risk to women's care. Processes for addressing staffing shortages were not well planned and did not take account of skill mix. We were aware that the hospital had processes for addressing staff shortages but these were not all in place at the time of inspection.

There was inconsistent cascade of learning from incidents and complaints and the service was slow to implement change.

The trust took part in national audits using trust wide and not hospital-specific data. The use of merged data from both maternity units was unhelpful because of the differences between the two units in terms of size, culture, activity, staffing and demographics. Site specific maternity dashboards were produced but were not actively used and the dashboards we saw on display were trust wide. St Helier Hospital performed better on normal birth because it had a well-established birth centre, and had fewer instrumental births, but the hospital had higher caesarean section rates and numbers of mothers smoking during pregnancy.

St Helier Hospital carried out a narrow range of audits and did not collect data on all nationally recommended indicators. Some data was misleadingly reported, such as midwife to birth ratio which was reported on the basis of establishment rather than actual numbers of midwives to care for women.

The majority of patients told us staff were caring. Bereaved women were sensitively supported.

Flow through the maternity wards was poorly organised, and women were not always in the most appropriate wards. Little work had been done to find out what women wanted in their antenatal and postnatal care, and to design the service around their needs. There was no dedicated telephone line or triage for women in labour.

Maternity and gynaecology

Not all high level risks were reflected on the risk register and action to manage risks was slow. There was little evidence of challenge in governance meetings. The culture was hierarchical and did not involve staff in developing the service.

There was a lack of strong leadership or vision. The communication route from ward to board was not effective. There was a lack of good quality data on many aspects of performance, and audits were not used to drive improvement or monitor change.

The gynaecology service had weaknesses in incident reporting, and a high level of agency staffing leading to poor completion of patient observations and a past record of poor hygiene. Referral to treatment times were not always met.

Are maternity and gynaecology services safe?

Requires improvement

We did not see enough midwives on the maternity wards to provide a consistently safe service. Paradoxically, we were told the ratio of midwives to births excluding maternity leave, vacancies and managers was 1:29 in July 2015.This was, on the face of it, better than many London hospitals. However, later information showed the vacancy rate was over 16% and turnover 12%. Shifts were not fully filled on our inspection and the labour ward coordinator was not supernumerary and therefore unable to support some inexperienced staff. Together, these factors affected record keeping on the labour ward, regular equipment checks, 1:1 care of women in labour and the flow of women between the wards. Midwifery staffing levels, which midwives told us had been low for many months, had only been added to the risk register the month before our inspection in November.

The hospital exceeded the national guidelines for consultant presence, although it was below the London standard which recommended 24/7 consultant presence on labour wards regardless of size. Births were static or possibly declining to judge from bookings this year.

The processes for investigating serious incidents were timely in terms of completion, but the action plans were not sufficiently time-bound and system improvement was slow. There was a formal process for reporting incidents but we were not assured all incidents were being reported, particularly in gynaecology.

Incidents

- It is mandatory for NHS trusts to monitor and report all patient safety incidents. Trust wide, between April and September 2015, there had been 17 Grade 3 incidents in maternity and three serious incidents (SIs) requiring investigation and one in gynaecology. Maternity SIs were reviewed by the maternity board and those causing harm, by the trust's SI Panel. We looked at the root cause analysis (RCA) reports of the two most serious maternity incidents in the past 18 months. Even the most serious SI investigations did not involve a professional external to the trust. Instead, a clinician from the trust's other maternity unit was involved.

- There were round table meetings to review incidents. The investigation of incidents we reviewed contained action plans, but lacked dates for completion and we did not see evidence that actions were monitored effectively. We were subsequently told that incidents were monitored on the SI tracker but this was not show to us during the inspection.
- Follow up after incidents were closed was sometimes slow. For example, after a serious incident in September 2014, there was a recommendation that an early labour lounge should be opened. This was one of only three recommendations from this SI investigation. The recommended unit had still not been opened by November 2015. Staff blamed time and funding. We did not see that a business case had been made for this. Effective follow up of SI investigations is a critical part of corporate and clinical governance.
- After a serious incident, staff told us those involved were debriefed. Trainee doctors said consultants were very supportive at such times. However consultants did not involve trainees in panels on SI investigations. Such experience would help trainee doctors in their development and appraisals, and in their Advanced Skills Training Modules. Doctors in training said they did not hear about incidents in the trust's maternity unit at Epsom. Both these were missed learning opportunities.
- Midwives said they reported incidents on the electronic system. Incident reports were combined for both sites and the format did not lend itself to easy analysis. We had requested all data by site but this was not provided. Breakdown of incidents and analysis by unit would have been valuable to compare performance between units. Staff told us they did not always have feedback on incidents.
- Based on our own analysis 832 incidents had been reported in Women's Services at St Helier Hospital between September 2014 and August 2015. The trust later said that 977 of the 1629 incident in that period were attributable to the St Helier site. Almost all the incidents were clinical incidents. Staffing issues constituted 69 of the incidents, although other incidents due to staffing were categorised as delay to treatment, so categorisation was not standardised. Managers told us the top incident themes were perineal tears and blood loss, CTG interpretation, communication, and escalation. We were not confident all incidents were reported because we did not see any incidents recorded in this period in relation to items on the current risk register, such as beds being moved from maternity wards.
- We noted that a perinatal mortality meeting had highlighted the need to report blood loss of 1500ml and above as an incident. This implied staff were not routinely reporting this serious occurrence.
- Mortality and morbidity issues were discussed at monthly perinatal meetings covering both maternity units. We reviewed meeting notes from June to October2015. There was low representation from obstetric consultants and no trainee doctors from the Epsom unit at some meetings. Follow up actions were not assigned to individuals in these meetings so there was limited scope for these meetings to reduce risk in the service or help staff learn and improve.
- The risk midwife held risk meetings weekly with consultant/neonatal consultant representation. Many midwives and doctors we spoke with said they were rarely able to attend. Trainee doctors we spoke with said they were unclear how risk information was disseminated.
- The gynaecology matron oversaw incident reporting in her area. There had been 32 gynaecology incidents affecting patients (across both sites) between January and end March 2015 which was an increase on the previous year, but seemed a low number of incidents. Two had been serious incidents, one requiring investigation and two moderate harm incidents.
- In genito-urinary medicine, the risk register itself recorded patients may be harmed as a result of under-reporting of near misses, incidents and concerns. Only nine incidents had been reported between January and March 2015.The risk register did not show mitigating actions.

Duty of candour

- The duty of candour requires staff to be open and honest with women and their families about the care and treatment they receive. Organisations have a duty to provide patients with information and support when a reportable incident has occurred or may have occurred. We saw a training presentation from September 2015 in folders on wards. There was no column to evidence duty of candour action on the Root Cause Analysis tracker. This would have helped managers oversee action taken.

- Not all staff we spoke with were aware of the implications of the duty of candour. This was a concern because the duty had applied to NHS trusts since November 2014. In October 2015, the maternity division had produced a duty of candour sticker to put in women's notes when an incident was reported, which was presumably a prompt for follow up. This had not yet been audited to assess its effectiveness.
- We saw records of an example of duty of candour in action relating to a SI in gynaecology. A duty of candour lead had been appointed to liaise between the patient and the hospital. A phone call was made to the patient at the start of the investigation and this was followed up by a formal letter which highlighted the investigation process and the sharing of investigation findings with the patient when the investigation was completed.

Maternity Safety thermometer

- The national maternity safety thermometer allows maternity teams to take a temperature check on harm in their unit. The trust aggregated data across the two maternity units so it was not a useful tool for individual units. However, the data over time was revealing in showing the variability of trust results in relation to the national average. This could have been useful for comparing the two units. Midwives and doctors were not aware of this tool and we saw no trend data on display in the hospital.
- Both the maternity and gynaecology wards displayed the number of staff, planned and actual, on duty that day. There was no overview of the previous week or month, so the information was of limited use to staff or patients as a indicator of service performance. On our unannounced visits, there was a shortfall of staff in the birth centre and antenatal ward.
- All the wards displayed information about falls and infections.

Cleanliness, infection control and hygiene

- The maternity wards were clean during our inspection. Cleaning schedules were on display and cleaners understood cleaning frequency and standards. However records showed scores for infection prevention and control had been lower at two audit points earlier in the year. In February and May the overall infection control compliance had been 78% and the wards had been subject to weekly checks until they improved. This suggested high standards may not be fully embedded. The percentage of staff attending infection prevention and control training were 79% in gynaecology and 88% in maternity.
- We observed most staff washing their hands or using gel between attending to women. There was ready access to personal protective equipment and we saw this used.
- There had been no recent incidence of MRSA or Clostridium Difficile.
- Sharps bins were correctly assembled and dated, clean linen was stored correctly and equipment used by patients such as blood pressure cuffs were clean in both maternity and gynaecology areas. On the gynaecology ward, there were single rooms that could be used for isolation.
- The gynaecology ward, sluice and bathrooms were clean when we inspected. However, records showed overall IPC compliance had only been 68% in July 2015. At that time five out of eight observed hand hygiene opportunities had been missed and equipment was not cleaned effectively. There was a risk that high standards of IPC were not embedded.

Environment and equipment

- Midwives in the focus groups reported they did not always have sufficient equipment on the wards for the safe monitoring of women and babies. They reported there were sometimes shortages of epidural top-ups and dynamaps. There was not always a dynamap in the recovery bays.
- Community midwives mentioned havinginsufficient weighing scales and connectors for blood pressure cuffs. They had no hand held IT equipment and had to come to the hospital to complete computer records.
- Staff told us, and we observed, that computers were slow. New computers had been supplied in the antenatal clinics, but not on wards. Only one computer on the labour ward could be used to input data to the maternity computer system, so a manual register of births was maintained in a birth book. This duplicated data recording.
- The birth centre was well equipped with birthing pools, relaxing lighting, birthing balls and stools. Delivery rooms were clinical and not conducive to normalising birth.
- Staff did not check resuscitation equipment in the labour ward daily. No check was recorded for 12 days in October and the first ten days of November. Six blood

culture bottles were out of date and we removed these (dated May 2015) and advised the midwife in charge. The pre-eclampsia box contained drugs, intra-venous fluids and blood bottles that were in date.

- The labour ward had two types of buzzers: one for emergencies such as a Grade 1 caesarean and the other for urgency, for example if a second midwife was needed. A screen showed the room where emergency call had been activated which was helpful to staff in emergencies.
- Staff were supposed to check the paediatric resuscitaires twice daily but we noted a number of missing entries in the log book over the past two months. An audit in October 2015 had indicated 74% compliance butwe did not see evidence of improved performance during our inspection.
- The defibrillator was fully charged and serviced. The CTG equipment on labour ward was clean, checked and working, and there was evidence that PAT tests had been done.
- In the antenatal clinics the examination couches were old fashioned. Midwives had to pump them up with a pedal. This was a potential health and safety concern for midwives operating these.

Medicines

- Staff were aware of medicine management policies which were included in the trust induction for nursing staff. Medicines on wards were stored in locked cupboards. The controlled drugs cupboard and the logbook were correctly completed and drugs were clearly labelled.
- Allergies were documented on the women's noteswe looked at during inspection. However, we saw from an audit in September 2015 that records had not been signed and dated about half of all cases sampled and clear legible notification of notable medical history was missing in 59% of cases.
- The unit had become latex free in June 2015 to avoid any risk to women who might be unaware of a latex allergy.
- A medicines management audit in September 2015 in maternity had shown room for improvement in areas such as assessments for the risk of blood clots (VTE), records relating to IV fluids, legibility of prescriptions and names, indication for use, documentation of drug discontinuation, correct checking procedure and the time the drug should be administered.
- We saw from a newsletter there had been a high number of incidents of wrong blood in tube (WBIT) earlier in the year (blood of one patient labelled with the name of another patient). This error could lead to catastrophic outcomes if a woman needed a transfusion. Various approaches had been tried but not reduced errors. The incident reports showed two WBIT at St Helier Hospital and one at Epsom Hospital. We wondered whether some near misses had not been reported. Since this had been made a disciplinary offence in 1 September 2015 there had been no further errors
- The trust did not have a ratified guideline covering the writing up and administration by midwives of a pre-set list of medications, in line with NMC standards for Midwives Exemptions 2010. This was on the risk register and from June 2015, midwives had started a training programme in prescribing. Midwives would not be permitted to prescribe until all had received training.

Records

- All women attending antenatal clinics carried their own pregnancy-related care notes and brought them when they came to hospital for the birth. Women's hospital records (pink notes)were electronically tagged and staff said they could usually be tracked easily. The 'pink' notes for all booked women who were 37 weeks pregnant were stored, locked, on the labour ward so they were available to staff when women attended.
- We looked at eight sets of notes in maternity, including notes written by community midwives. They had been completed with the relevant clinical information. The chronology was contemporaneous and the entries were clear and signed.On postnatal ward notes, there was evidence of regular review by medical staff, and records were clear and legible.We noted however that one woman's notes recorded her emergency caesarean section was delayed by nearly two hours due to labour ward activity.
- We looked at three sets of gynaecology inpatient notes which were well laid out and signed and dated in line with guidelines.There was evidence of discharge planning. However, one set we reviewed recorded "antibiotics given"without recording dose or type.

Safeguarding

- Managers and staff showed an understanding of what was important to promote women's safety and to protect unborn and newborn babies. There was an

interim lead for safeguarding. Staff knew her name and that of the trust's safeguarding lead. Social circumstances were assessed at the first antenatal appointment. Safeguarding alerts were held on the maternity system and women who missed appointments were followed up.

- Women were asked about domestic violence. We saw an example of a speedy reaction to a woman presenting very late in pregnancy about whom there were concerns. This involved an alert to social services and bringing in an interpreter.
- There was a clinic for women with mental health issues or substance abuse.
- All permanent staff providing direct care to pregnant women should have face to face level 3 safeguarding training. Training in Women's and Children's Directorate on Safeguarding Children was 93% at November 2015. Training on safeguarding adults was 80%. The trust target was 90%. Midwives' Level 3 Child Protection update was incorporated into mandatory training to ensure it was accessed by all midwives.

Security in maternity wards

- The main doors to the maternity and gynaecology building were open 24/7.Access to the clinical areas was through a buzzer system at each ward entrance. There was also a door bell on the labour ward entrance because the midwives had difficulty hearing the buzzer at night when they were caring for labouring women in the delivery rooms.
- A ward clerk was only available between 9am and 2.30pm Monday to Friday. When a clerk was present, they were able to greet women, check them in, and answer the telephone. At other times there was a less systematic response. One evening we saw a family member open the ward door so a woman in labour could enter the delivery suite. This was a potential security risk as well as being a less than welcoming experience to a woman in labour. Tailgating was possible because the electronic doors closed slowly. Staff admitted CQC inspectors on an unannounced visit without checking their credentials.
- We noted there had been incidents when babies had not been labelled with patient identifiable tags.
- On a weekday afternoon, the doors to the antenatal and postnatal ward were seen to be wide open for at least 20 minutes.

Mandatory training

- Core statutory and mandatory training in this trust included IPC, Resuscitation, Manual handling, equality and diversity, health and safety, child protection, safeguarding adults, fire prevention and conflict resolution. The target set by the trust for mandatory training was 90%. The central record showed performance in the Women's and Children's Directorate at 88% in maternity and 73% in gynaecology. Of concern was lower rates of training in assessing women's risk of blood clots (VTE): 77% in maternity and only 34% in gynaecology. Data was reported separately for gynaecology and maternity, but not by grade, staff group or site, so it was not easy to identify where the gaps lay. The trust later told us that all doctors and midwives had mandatory training in VTE at induction, and that the training of bank staff was recorded.
- Midwives had five mandatory training days a year. Staff could access online training from home.
- Annual CTG training was mandatory for midwives and doctors. Staff were required to retake CTG training if they scored below 80% in the competency paper. Training records showed that bank staff were trained. There was no consultant lead for CTG. This was a concern given the acknowledged weaknesses in CTG interpretation skills.
- There was mandatory multi-professional skills and drills training to rehearse response to obstetric emergencies including simulation. Trainee doctors said it was sometimes difficult to attend skills and drills, even though it was mandatory, as there was no protected time for this. There were some unannounced drills.
- There was a plan to cascade training on STAN monitoring (ST segment analysis) by midwives that had undertaken training at a tertiary centre. This is a type of CTG that uses computer analysis of the baby's heart rate and heart muscle which has the potential to reduce obstetric interventions in high risk cases. We noted the decision to invest in this technology would still depend on reliable interpretation of CTGs so the reliance on technology was not a complete solution to improving safety. New STAN machines would not be available until February 2016.
- The practice development midwives kept local spreadsheets of midwives training and reported midwives were up to date with mandatory training.
- Staff had different perceptions of whether training time was protected on the off duty rota. Midwives said they

were advised to bring their uniform to training in case the unit was short staffed on the day. We witnessed a discussion at handover about pulling midwives from training because of short staffing.

Assessing and responding to patient risk

- Maternity staff said they had been trained in the use of the modified obstetric early warning scoring to recognise women who were becoming more unwell. This was in response to incidents where deterioration had not been recognised quickly enough. We looked at women's records on the wards and saw charts had been correctly completed.
- Some key policies designed to promote safety were not being followed in practice. The trust Induction of Labour policy said 'planned inductions are to be limited strictly to three per day' and that women with SROM (spontaneous rupture of membranes) should take priority over the planned inductions. Records showed this limit had been exceeded 11 times in the last three months, and on five occasions, five women had been induced. Staff could not explain why inductions were not spread more evenly or why capacity and staffing on the labour ward was not taken into account when considering whether to induce a woman.
- During our inspection we observed the labour ward coordinator at morning handover telling staff they were expecting five women who were being induced. However at that point the labour ward was full and the postnatal ward had only one bed. There were not enough staff to manage five more women in labour. The trust policy was to induce no more than three women. On visiting the antenatal ward we found there were nine women at different stages of induction of labour. Staff told us the 'official' list of women to be induced (a list taped to the wall in the office), was regularly increased. Figures subsequently sent by the trust were not consistent with what we observed on the day, and what midwives on the labour ward and antenatal ward told us. The coordinator should have the authority to influence activity on the antenatal ward when the labour and postnatal wards did not have the staffing or the beds to accept more women. . A recent audit showed too many inductions was one of the reasons women did not receive 1:1 care in labour.
- There were two well-equipped obstetric theatres. Planned caesareans were carried out twice a week in one theatre. We observed a briefing for an emergency caesarean section and saw evidence of safe practice including the Modified Maternity WHO checklist, checking of the anaesthetic equipment and checking the name band for the woman and the baby, and a check of maternal allergies.
- We did not observe theatre practice for gynaecology patients but the surgical inspection team reported that in the main theatres not all team members engaged with the process and the debrief did not always take place. An observational audit in theatres in September 2015 showed 'time out' only occurred in 85% of cases.
- There were protocols to deal with obstetric emergencies. We were told the risk of inadequate management of pathological cardiotocography (CTG) had been reduced through training, although this remained on the risk register. Managers said not all midwives were confident in interpretation. "Fresh eyes", a structured review of electronic fetal monitoring by someone other than the midwife providing the care, carried out hourly, did not seem to be working in practice and was not always recorded. Staff had not audited this before our inspection although after the inspection the maternity unit submitted a 'snapshot' audit from December 2015 showing only 67% of CTGs were interpreted in line with NICE guidance and only 17% used 'fresh eyes' hourly which was concerning.
- There was a process for checking VTE assessments had been done to ensure the hospital was funded for this. An orange sticker in the paper birth register indicated an assessment had been done. We were told VTE assessments were done on admission to labour ward and on transfer to the postnatal area in all cases, and that compliance was 98%.
- Records showed low levels of recording of vital signs observations of women on the gynaecology ward between June and August, particularly during the day time. 23% of observations had not been recorded in June, 10% in August.

Midwifery staffing

- The midwifery establishment was shown on the maternity dashboard was 1:27. The actual rate was currently 1:29, taking account of maternity and sickness. This had reduced from 1:31 in April 2015. The projections for 2014/15 indicated around 2875 births at this site - numbers were static or slightly declining. However, there appeared to be insufficient midwives to support activity levels, suggesting poor deployment.

- Staff told us they did not always get breaks and the newly qualified staff we spoke with told us they were not always supernumerary during their orientation programme. However, midwifery staffing levels had not been discussed at maternity board meetings during the year. In October 2015, the Women's and Children's Risk meeting minutes had recommended midwifery staffing should be on the risk register as 'high'. It was only added that month, despite staff shortages being regularly reported on the incident reporting system during the past year.
- Over 11000 hours had been covered by bank and agency staff between April 2014 and June 2015, with an even split. Had this been displayed on the dashboard, the staffing risks might have been identified earlier. The vacancy rate on this site was over 16%. 18% of maternity ward staff had been bank staff in the year from April 2014.
- There would be 22 additional WTE staff by January2016. The trust had allowed some over-recruitment to cover maternity leave and sickness. We saw 16 new midwives,10 of whom would work at St Helier, on a three week maternity orientation which included working in each clinical area.
- During our inspection we were sufficiently concerned about staffing levels in relation to activity and patient flow that we raised this with the executive team.
- There was a consultant midwife for normality and a lead midwife for clinical governance, who worked across sites. There were vacant posts for the postnatal pathway and for community and audit. The was a clinical practice facilitator for this site.
- The Band 7 labour ward coordinator was not always supernumerary. An experienced supernumerary ward coordinator was recommended best practice to oversee safety on the labour wards, to support and clinical staff and manage workload and activity. The definition of supernumerary at this trust was unusual. A coordinator was deemed to be supernumerary as long as they only gave 1:1 care in labour for up to two hours during their shift. This definition was out of line with London Quality Standards and recommendations of the Kings Fund for Safety in Maternity Services which said coordinators should not have any co-existing responsibilities.
- On our unannounced inspection, we observed the labour ward coordinator taking a clerical role and answering the telephone rather than supporting the other midwives in the ward. A ward clerk or maternity assistant could do this. The trust standard was for 90% of coordinators to be supernumerary. In August2015,78% was achieved. An audit in August2015of the loss of supernumerary status was attributed to staff shortages, midwives acting as scrub nurses, when labouring women required 1:1 care, when the postnatal ward was busy and when many woman had their labour induced. The purpose of an audit should be to improve practice but there was no action plan to improve the deployment of staff.
- The unit did not use the recommended NPSA intrapartum scorecard to record staffing, skill mix and activity. They used a shift coordinator handover sheet recording activity every six hours. A recent audit had shown this was not fully completed for about 30% of activity periods This meant there was no clear record of activity. Nurses were not used in the recovery/high dependency unit.
- The policy was that midwives scrubbed for emergency caesarean sections on the labour ward. This took at least two midwives away from caring for women in labour, one to scrub for the surgery and another to care for the baby. As the rate of casearean sections was high this was an almost constant pressure on staffing. A scrub nurse was only employed for elective caesareans.
- Midwives on the antenatal and postnatal wards said they were regularly asked to attend the labour ward to assist with the workload, leaving their clinical areas short of staff. Community midwives were also asked to attend the labour ward when they were on-call for home births due to staffing shortages in the hospital.
- There was a full time Supervisor of Midwives. Records showed each supervisor had been responsible for 15 midwives until August 2015 when the ratio had increased to 1:17, worse than the national standard of 1:15. This change was not shown on the dashboard which recorded a ratio of 1:14 throughout the year. This ratio was not corroborated by any other documentation we saw.
- The antenatal team were not meeting targets for screening compliance. Managers saidthis was because some women did not book in time. Booking by 13 weeks averaged 86% which was lower than the national target of 90%.The shortfall in screening targets was either due to staff shortage or insufficient screening clinics. We did not see any plan to ensure women were screened on time.

- The service planned a reconfiguration of midwives from January 2016. This plan was not well understood, it had not been co-developed with the community midwives and was causing some unrest among community midwives who felt their role was not valued.
- The skill mix was poorly developed. Midwives would have benefited from more support than was available from midwifery assistants and administrative staff to allow midwifery time and expertise to be focused on care for women. A labour ward clerk was only employed between 9am and 2.30pm, Monday to Friday. At all other times, midwives carried out clerical work that could have been done by others. There was also only four hours administrative support for screening to cover four consultant FMU scan sessions a week.

Obstetric staffing

- There were 27 obstetric and gynaecology doctors at St Helier. Most worked only at this site.
- The Royal College of Obstetricians and Gynaecologists recommends 98 hours a week of consultant cover for a labour ward with between 4000 and 5000 births. This unit provided 98 hours consultant presence for under 3000 births, but cover was not evenly spread across the week. On Mondays and Fridays, consultants were resident on-call, and were on site until 10pm on Tuesday to Thursday. RCOG guidelines for consultant labour ward cover should not include gynaecology cover or other areas of labour ward, but given the birth rate at St Helier this was considered acceptable at this unit. There was 24 hours obstetric consultant on-call. The same consultant covered both days of the weekend. Doctors reported the intention was to provide the full 168 hours consultant presence on the labour ward in line with London Quality Standards. The London Standards did not differentiate between the size of units in terms of number of births.
- The structure of consultant cover was three four hour session each day. This limited the continuity and consistency of care for women who could potentially see three or more different consultants while in labour. There were no plans to change this.
- A consultant was assigned to each hospital antenatal clinic alongside a midwife. Consultants considered this a good model for doctors training, and believed women benefited from having a consultant interested in a specific area of medicine and a detailed pathway. There were two consultants with a special interest in fetal medicine, three consultants for reproductive medicine, two consultants for maternal medicine and two for oncology.
- On our inspection there was only one consultant anaesthetist on the labour ward, even though there were two theatres, and elective caesareans were taking place in one of them. The hospital did not record the hours of consultant anaesthetist cover on their dashboard. We were told a senior registrar was available for emergency caesareans, supported by an operating department practitioner.
- Trainee doctors reported good induction to the trust and to the obstetrics and gynaecology service.
- Locum use across both maternity units in obstetrics and gynaecology was 8%, below the trust average for locum use. The trust did not give us a breakdown by site. There was locum cover on the postnatal ward because the consultant was on maternity leave.

Gynaecology staffing

- There had been considerable use of bank and agency nurses during the year. The vacancy rate had reduced to 8% by the time of our inspection. Turnover was 13% with a sickness rate of 5.3%.This was on the risk register but there were not dated actions to show how the risk was being mitigated. Records showed day nursing shifts were only filled between 85and 92% in August 2015.The shortfall of staffing was seen during our inspection. Patients told us there was a difference in the quality of care at night and at weekends.
- Most consultants, and all trainee doctors worked across maternity and gynaecology. There was limited continuity of care for gynaecology patients, as for women on labour wards, because there was a different consultant and registrar every day.
- A clinical nurse specialist in urology was supported by a midwife. Ambulatory gynaecology care was a growing area, and was run by a nurse practitioner.
- There was a sub-specialism in urogynaecology with two consultants at St Helier, but no specialist nurse. Since the suspension of urogynaecology at a neighbouring trust, the pressure on this service had increased.

Major incident awareness and training

- The Staffing Levels and Escalation Plan' dated October 2015 provided no indication of the skill mix required to sustain the maternity service when there were capacity issues.

Maternity and gynaecology

- The maternity unit had closed three times in two years. Twice in July 2014 because of a lift out of order or undergoing maintenance and on 29 May 2015 because there was no on-call anaesthetist. On those occasions, women were diverted to the other maternity unit at Epsom General Hospital.
- Staff said they would follow trust policy in the event of a major incident. They were aware there was a plan on the intranet. There was no obvious information on wards about major incident plans and staff did not know what their roles would be in an incident and had not been involved in any incident exercises.

Are maternity and gynaecology services effective?

Requires improvement

Although we saw policies had very recently been updated in line with best practice standards, we saw practice that was not always contemporary nor evidence based. Many staff were not familiar with recent protocol changes.

The service had a maternity dashboard to monitor its performance but some key indicators were not included and few staff beyond managers were aware of it. Instrumental and caesarean rates were higher than national rates which increased the cost to the service and also the risks to women and babies. Although performance was in many cases out of line with local and national performance, we were not shown any strategic plan to tackle these discrepancies.

Staff worked well together when workloads were high and the requirements of women with complex needs or social needs were met. Although staff had been trained in the SBAR (Situation, Background, Assessment, Recommendation) tool to report information to other professionals. We did not see staff using this valuable tool in handovers.

Evidence-based care and treatment

- Most protocols and processes had been very recently updated using national guidelines from the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG). The guidelines were up to date, clear, and available on the intranet and had some multidisciplinary input in their development. We noted a limited range of staff were involved in revising guidelines. Junior doctors had only been involved in 12 of the 115 revisions. Staff did not feel ownership of the changes or understand them and information about changes were inconsistently shared with staff. For example, we asked two midwifery managers about guidelines for induction of labour and received conflicting answers.
- Antenatal care followed Quality Standards 22 about risk assessments. Data on numbers of women booking their first antenatal appointment by 10 weeks was collected, although not reported on the maternity dashboard. Quality Standard 32 was followed in documented decisions about caesarean sections and Quality Standard 37 on postnatal care.
- The unit did not follow the guidelines in Safer Childbirth: minimum standards for the organisation and delivery of care in labour February 2015 and NICE guidance 'Safe midwifery staffing for maternity settings' February 2015. These recommended all women in established labour should have 1:1 care. Such care was proven to lead to improved outcomes and reduced interventions in labour. The trust's current target was for only 95% of women to have 1:1 care in active labour and they met this, on average, since April 2015. The target the previous year had been 90%. Managers were not able to explain why the trust did not aim to provide 100% of women with 1:1 care in labour. The maternity dashboard showed 1:1 care was not provided in all cases and this was confirmed by midwives we spoke to.
- Trust wide data for 2014 had been supplied to RCOG for its second report on Patterns of Maternity Care in English NHS Hospitals, The commentary on the trust's results indicated they were outliers in instrumental deliveries and episiotomy procedures for both vaginal delivery and instrumental procedures.
- All eligible babies had their temperature recorded at birth, achieving the National Neonatal Audit Programme (NNAP) standard. All parents of babies admitted to the neonatal unit had a recorded consultation with a consultant within 24 hours of admission. 98% of relevant babies received retinopathy of prematurity screening; 53% of babies were receiving only mother's milk on discharge and 31% had a combination of mother's milk and formula. These were good results.
- The unit followed the National Screening Programme and details were documented in women's care notes. All

women were given the National Screening Programme booklet. Nuchal screening was carried out(scan & blood tests) and the risks were calculated and women advised of findings. The laboratory services were said to be good. The Northgate failsafe system for blood spot tests for six inherited diseases in babies was used but no data was shown on the dashboard to indicate whether results were received in 17 days.

- Data was also provided to UNICEF Baby Friendly Programme and to the Maternal, Newborn and Infant Clinical Outcomes Review Programme (MBRACE-UK).
- The unit had just begun to participate in the Perinatal Institute's Growth Assessment Programme (GAP) for reducing stillbirths through improved detection of fetal growth restriction.
- The unit supplied data to the regional South West London Maternity Network (SWLMN), although we saw little evidence that the unit was an active participant or used the opportunities provided to learn from good practice elsewhere. Trust wide data was contributed which, as previously mentioned was not meaningful when the two units were so different. In two priority areas for the SWLMN: outpatient induction and fetal fibronectin screening, no data was yet collected at St Helier. The network was driving forward continuity of care through antenatal, labour and postnatal care by a named midwife or buddy. The unit was far from achieving this despite the fact that continuity of care during pregnancy and after birth is proven to lead to consistent advice and better take up of health interventions.
- In the Quality Standard in 2014, the trust had erroneously reported it was standard practice for women to be cared for by a named midwife throughout pregnancy. From talking to women and midwives, we found this was not the case.
- The range of registered local audits was very limited. A number of the trust maternity policies and guidelines required a range of supporting audits, for example the induction policy. The required audits were neither registered in the annual plan nor carried out.
- Assisted conception results were reported quarterly to clinical commissioning groups and the Human Fertilisation and Embryology Association which licenses clinics.
- In gynaecology, we saw protocols for early pregnancy loss, ectopic pregnancy hyperemesis, manual vacuum aspiration, medical management of miscarriage and pregnancy of unknown location and some of these were audited. However, some priority audits from the previous year had not been finished. Recently registered audits were audit of care of women with late still births, termination of pregnancy, word catheter placement for Bartholin's cyst /abscess and maternity readmissions. We saw completed audits of urogynaecology and MDT involvement.
- Audit results were discussed in a bi-monthly Women's Health clinical audit meeting and covered maternity and gynaecology on both sites. A few audits were only carried out on one site which was a missed opportunity for comparison. Clinical duties were rescheduled to enable staff to attend audit half days.
- The service for termination of pregnancy for foetal abnormality offered appropriate multi-professional input and scanning. Almost all terminations were medical.

Pain relief

- Women's options for pain relief included epidural analgesia and other pain relief such as nitrous oxide (gas and air) and pethidine. The birth centre had pools in each birth room for pain relief. The maternity dashboard did not show the epidural rate but we were told most women having pain relief had epidurals. For operative anaesthesia most women had spinal anaesthetics.
- An audit from January to September 2015 showed 94% of woman were happy with labour analgesia, 99% with operative pain relief and 97%with post-operative pain relief.
- On the gynaecology ward, patients were regularly asked by ward staff about whether their pain relief was adequate.

Nutrition and hydration

- The unit had the UNICEF Baby Friendly Initiative Level 3 accreditation for supporting new mothers with the feeding of newborns (an international initiative to encourage breast feeding. The hospital's breast feeding initiation was 88% and averaged 73% 10 days after delivery. The unit were below their target of 90% and 100% for these two measures. Midwives thought this might be because of low staffing on the postnatal ward.
- The gynaecology ward used the Malnutrition Universal Screening Tool (MUST) for patients who were at risk of malnutrition. Those at risk of dehydration also had fluid balance charts to monitor fluid intake and output.

- Mealtimes were protected. Most patients considered the food acceptable, although some women on the postnatal ward thought not enough food was provided.

Patient outcomes

- The unit did not collect data or generate statistics on some of the standard maternity outcomes as recommended by the Royal College of Obstetricians and Gynaecologists (Good Practice No 7. 2008). For example, the maternity dashboard used to display unit performance was not used to monitor staff sickness, use of agency staff or vacancies. The trust wide dashboard was included in papers for the maternity board each month, but with a time lag in data presented. For example, the dashboard for March 2015 was presented to the June 2015 meeting. Data was not actively used to manage current and future performance.
- The maternity dashboard was not used to focus on improving performance and some data was outside trust thresholds month after month with no evidence of action being taken. For example, we noted 7.5% of women did not attend appointments, and 15% in any month cancelled their appointments. This was red flagged on the dashboard but the reasons for this and possible solutions were not being investigated.
- The CQC's intelligence monitoring did not reveal evidence of risk in any of the maternity outlier indicators but this may have been because the data from each hospital was merged to provide a trust figure. Doctors had noted the St Helier unit was an outlier on Dr Foster for the proportion of women readmitted to hospital after giving birth: 5.9% of women were re-admitted. National rates for readmission are between 0.5 and 2.4%. 39 of the 135 re-admissions in the previous year were coded as sepsis and 20 as post-partum haemorrhage. Although some recommendations had been made, the number of re-admissions was not falling. There were 65 women readmitted between April and August 2015. Maternal re-admissions were not on the risk register. Re-admissions of babies born at term were 3.4%. The hospital did not offer a helpline to GPs that might have enabled some women to stay at home.
- Women's spontaneous delivery rate averaged 58% from April to September 2015. This was about the national average. 20% of all births took place in the birth centre which was good. On average nine women a month were transferred from the birth centre to the labour ward. The home birth rate was below the trust target, at about 1.2% on average in 2015.
- The planned caesarean rate was 9%, better than the England average of 13%. However the overall caesarean rate had averaged 27.7% since April 2014, which was high compared to the national figure of 22% and flagged red on the St Helier maternity dashboard. When questioned, one member of staff told us if a CTG trace was non-reassuring, the default position was a caesarean section. We did not see any systematic review to assess whether the high rate of caesareans was justified on grounds of the health of women and babies or a comparison with the lower caesarean sections rates at Epsom General Hospital. The proportion of induced labours resulting in caesarean section (trust wide) was also worse than the national average: 16.8% compared to 12.6%. We were not given data specific to the unit on this indicator even though we had asked for all data to be split by unit.
- We saw evidence that 50% of category 2 caesareans were breaching 60 minutes in March 2015. These delays were not recorded on the dashboard, so we could not assess the frequency of this, and we did not see breaches reported as incidents. However, we noted meetings as recently as August 2015 recorded the struggle to keep caesarean sections under 30%, which caused us to question the reliability of the figures staff were recording..
- Induction of labour had been 'red' on the maternity dashboard for six months with no evident action to reduce it to the trust's own target of 21%.
- Several clinical indicators were worse than both the trust's own thresholds and national averages. Instrumental delivery rates averaged 11.3% in the year to date compared to an England rate of 7.6%. The episiotomy rates for vaginal delivery were 40% (national rate 36%) and 82% for instrumental deliveries (national rate 72%).27% of women had their labour induced compared to a local average of 22%.Induction is not the most efficient, comfortable way for a woman to go into labour, although it is clinically indicated in some cases. The trust policy referred to carrying out an annual audit of a variety of aspects of induction of labour which we requested, but it was not provided. After the inspection we were given some limited data on inductions but without an analysis.

Maternity and gynaecology

- The number of consultant hours on the delivery suite had risen from 60 to 98 from July 2015 and we were told it would further increase to 132 hours by the following year 2016 in line with commissioners requests. We noted this would be expensive for a unit this size. Although consultants told us additional consultants should reduce the number of failed instrumental deliveries and caesarean sections, this was yet to be proven.
- Most women were assessed for the risk of venous thromboembolism (VTE):96%.This meant 4% of women were not benefiting from this important assessment of the risk of blood clots.
- The unit had more women with postpartum haemorrhage than might be expected, and averaged 4% for severe post-partum haemorrhage (over 1500ml) but under 3% for massive PPH (over 2000 ml).
- Unexpected admissions of babies to neonatal care averaged 10 a month. The unit did not set a target for this.
- There had been six stillbirths since April 2015. This was within the normal range of about five per 1000 births in England and Wales. The average number of neonatal deaths at the trust (the period from seven to 28 days after birth) was 0.8/1000 births (national figure 2.1/ 1000). The Centre for Maternal and Child Enquiries (CMACE), showed the mortality rate of new-borns and the number of stillbirths were below the national average at this hospital.
- Women were encouraged to have a normal birth for a second child after a caesarean birth first time. We were told 80% were consenting to VBAC although the numbers to date were small as the programme was new. Managers told us women's choice was respected although some midwives thought there was pressure on women to agree to VBAC.
- An enhanced recovery programme for women having a planned caesarean section had begun in February 2015. This encouraged early mobilisation, eating and drinking. It enabled women to go home the next day if they were ready. The number of women benefiting from this was low. We were told this was partly because there were not enough community midwives to visit women next day.
- Outpatient induction of labour could aid capacity management. However in this unit, most induction took place on the antenatal ward. An audit had been carried out which indicated that outpatient induction, commonly used in other hospitals, was potentially extendable across the trust, but numbers had not been large enough to reach a definitive view. Staff were taking a conservative approach to this.
- We reviewed the continence surgery complications which were low – the mesh exposure rate was 2.3% and there was one return to theatre for tape division, which had led to complete recovery.

Competent staff

- Data on appraisals showed 77% completion for nurses in gynaecology (trust wide data)and 77% for midwives. The trust were not able to break this down by site although we had requested a breakdown. Some midwives reported appraisals were formulaic rather than personalised. Midwives said their individual development did not seem to be a priority of management.
- Induction for new permanent staff was a three week orientation programme and attendance at a monthly trust wide induction day. Staff told us the induction was helpful.
- Some midwives were trained to undertake the new-born and infant physical examination (NIPE) where support was available from paediatricians when required.
- We were told about a proposal to rotate midwives through the birth centre to maintain competencies. However, we found this rotation would only be for new staff. Band 6 staff would do limited rotation and Band 7 staff were excluded from this.
- Trainee doctors told us they were generally well supported. They received a weekly educational newsletter from a consultant with teaching activities for the week. The national training survey of the trust by the General Medical Council showed the unit scored less well than expected in the induction and feedback that junior doctors received. We noted there were few opportunities for trainees to carry out audits or attend or chair meetings. Trainees had protected time for training one morning a week.

Multidisciplinary working

- Midwives and doctors had separate handovers on the wards. A midwife did not necessarily attend the medical handover. An electronic handover board on the labour ward showed women on the labour ward. It did not

show information about women on the antenatal ward, so information about women being induced was reported less formally. The plan of care for each woman was not discussed at the main handover.
- Doctors' handovers were multidisciplinary and we were told usually included anaesthetists. On the unannounced inspection the anaesthetist arrived after the handover and had not been told there were any problems on labour ward. A specialist advisor on the CQC inspection team directed this doctor to the delivery room where there was concern about a woman.
- We saw effective working during an emergency caesarean between obstetrician, anaesthetist and paediatrician.
- We observed good multidisciplinary management of a woman with mental health problems in maternity, involving the mental health team. The consultant was present in theatre for the caesarean section to reassure the woman and mental health professionals were available.
- We saw from minutes of meetings that there was a degree of uncertainty about whether the local tertiary maternity unit would take all relevant complex cases. There was no service level agreement with the external service. The hospital was not equipped to deliver babies for women with some complex conditions such as cardiac problems or women whose scans indicated morbidly adherent placentas and who were more likely to suffer severe bleeding after birth.
- Transitional care was available on the post natal ward. Transitional care is recommended practice and is provided on the postnatal ward so babies who need treatment such as antibiotic medication can stay with their mothers. We saw effective working with the paediatric nurse practitioner.
- In gynaecology, there was a weekly MDT for colposcopy and monthly MDT with other local hospitals involving uro-gynaecologists, urologists, clinical nurse specialists, physiotherapists , trainees and continence advisors. The combined services at St Helier and Epsom had contributed 37 cases to discussion March 2014 – April 2015. Staff considered there was very good multidisciplinary working and that the service was outward-looking
- In the gynaecology service we were told the communication to GPs was not always timely and there was a backlog of typing.

Seven-day services

- On Saturdays and Sundays, a consultant did a ward round on both the maternity wards and the gynaecology ward and was on site for six hours each day. Other medical cover was a registrar and junior doctor. The trainee doctors said medical cover was stretched thin at weekends and it would be safer to have an extra doctor. They suggested there might be a business case for increasing staffing if this was linked to opening the EPAU and MAU at weekends as was common in other hospitals, and extending the hours which would also benefit women..
- No gynaecology clinics took place at the weekend.
- Weekend scanning could be undertaken by the on-call consultant if required.
- Pharmacy and radiology were available on weekdays from 9am until 5pm and then on call, out-of-hours.

Access to information

- All guidelines and protocols were on the intranet which had recently been re-launched. There were not many computers on wards and staff said some computers did not work properly. Agency staff were not able to access the IT system.
- Most patient notes were in paper form and available to ward staff. Some clinic staff reported not always having patient notes for appointments..
- Staff with access to computers could view women's test results electronically.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women were given choices over the treatment for miscarriage: expectant management, surgical management or evacuation under general anaesthetic. For ectopic pregnancies, women also had choices of medical or surgical treatment, where appropriate.
- At the time of the inspection there were no women who did not have capacity consent to their procedure. We saw consent was recorded in women's notes in both gynaecology and maternity wards. However, one member of staff expressed concerns those women did not always have time to give considered consent. We saw correspondence from a patient complaining about lack of clarity in the consent process, but no evidence that this had led to a review.
- Training in the Mental Capacity Act and Deprivation of Liberty Safeguards was part of the trust induction programme.

- When consenting to termination of pregnancy, the disposal of pregnancy remains was discussed with women and they had choices about the method.

Are maternity and gynaecology services caring?

Good

In maternity care was given with kindness and compassion, and emotional support was good, particularly in times of bereavement.Partners were only able to stay in the hospital after the birth if they were needed to support their partner because of a difficult situation.

Two patients on the gynaecology ward told us weekend nurses were less caring than those during the week.

The Friends and Family test for September 2015 had only two respondents for antenatal care. For care on the ward there was a 27% response rate and for the postnatal ward the response rate was 12%. Althougha high proportion of women were 'likely to recommend' the service, the results were not statistically reliable,

Compassionate care

- We saw staff were welcoming to patients in the antenatal and labour wards, particularly in the birth centre. Two mothers we spoke to on the postnatal ward said their antenatal and inpatient experience had been generally good and they had birth options and pain relief. However they had no named midwife. One mother, with a medical condition which meant her antenatal clinics had been at the hospital, had seen a different doctor and midwife at every visit.
- Women found the staff lanyard's showing the staff member's role to be helpful in understanding who the different staff were.
- On the gynaecology ward, two patients reported variable care day and night, and inadequate staffing at weekends.
- We observed mostly good attention from staff to privacy and dignity. However on the antenatal ward, staff numbers limited the care given to women, especially when several women were being induced. We saw one woman in early labour and in pain, on the antenatal ward in a bay with other women.
- September 2015 results for the Friends and Family test indicated100 %would recommend the hospital but the response rate was lower than the national level.
- Responses on the day case unit were favourable, although we could not identify gynaecology patients separately. On the gynaecology ward, October results from the Friends and Family Test showed 98% of women would recommend care, although two women we spoke with felt care at weekends was rushed and not always sympathetic.

Understanding and involvement of patients and those close to them

- Women we spoke with said they had been involved in decisions about their choice of birth location and the benefits and risks of each. They felt staff supported their decisions.
- Women we spoke with said they had been given a range of information and they were clear about their birth plans and explanations of treatment. Women said they were given a choice of where to give birth, and this was recorded in notes. Most said doctors and midwives had given clear explanations at antenatal appointments and answered their questions reassuringly. One woman mentioned that the different midwives she had seen had given inconsistent advice.
- Staff recognised when women required additional support, for example women with a learning disability or mental health issues.
- Women were advised of their options when there was a significant fetal abnormality. . Terminations before 20 weeks were carried out on the gynaecology ward and after 20 weeks on the labour ward. Most terminations were prior to 20 weeks gestation. Post mortems were carried out by another trust.
- The results of the CQC National Maternity Survey 2015 found the trust scored close to the national average on inpatient measures. The only area reporting better results was that midwives recommended women should arrange a postnatal check-up with their GP. They scored less well on partners being able to stay after birth because there were only a limited number of recliners for partners to use overnight.

Emotional support

- Women using the maternity services could access support for specific health issues such as diabetes or mental health needs.

Maternity and gynaecology

- Managers had reviewed their processes for women who had lost a baby. A bereavement midwife was responsible for speaking with women who had been bereaved during or after childbirth or had a late miscarriage or termination for medical reasons. There were sensitive mementos for parents and on-going postnatal support in some cases. Women were assessed for anxiety and depression and counselling services were available.
- Individual cremations were held with the parents invited, including for late terminations. Burials and blessing could be arranged through the chaplain.
- There was an effective emergency gynaecology service. Terminations of pregnancy and miscarriages were handled sensitively and many women had a choice of procedure.
- Nurses helped women cope emotionally with their care on the gynaecology ward. Feedback from patients was generally positive.

Are maternity and gynaecology services responsive?

Requires improvement

The maternity services required improvement in their responsiveness to women and their families. Services appeared to be designed more around staff needs than around women. The gynaecology services had fallen below the standard for referral to treatment times.

Complaints were not always dealt with in a timely way and the style of replies was often formulaic. Even the reports on complaints to the risk committee were based on data two months prior to the meeting

Service planning and delivery to meet the needs of women

- In July, the trust had replaced generic antenatal clinics by nine condition-based clinics for high risk women, driven by the intervention required. The clinics were held in the hospital and led by a doctor and midwife. It was not clear how closely the clinic types matched the clinical needs of the local population as the same range of clinics was offered at Epsom General Hospital which served a different demographic. One of the stated objectives was to improve continuity of care, but some women said the split of clinics required some to attend more than one antenatal clinic due to lack of co-ordination. We were told there was a plan to audit these clinics after six months but obstetricians had not registered this on the annual audit programme.
- Interpreters had been used on 303 occasions in the maternity service between January and October 2015. The hospital did not audit the range of languages or whether all women who required interpreting facilities benefited from this. We saw there was an antenatal class in Polish.
- Some women who lived in the catchment area of the hospital chose to give birth at other local hospitals. They had postnatal care from St Helier midwives. The service had carried out an audit to see how they could market their maternity service more effectively, but we did not see plans to involve local women is suggesting improvements. Women had a choice of home birth, birth in a midwife led unit adjacent to the hospital obstetric unit and birth in an obstetric unit, in line with NICE guidelines.
- There was pressure on beds on the postnatal ward, because of slow discharge processes. Although midwives carried out some newborn examinations waiting for discharge processes caused frustration to families. The average postpartum length of stay was longer than some neighbouring hospitals.
- The Maternity Liaison Service Committee (MLSC) was to be re-launched as it had not been active in involving mothers in the way the service operated, and did not seek to reach out to harder to reach local mothers. It was well supported by supervisors of midwives. There was little user involvement in developing the service to improve women's inpatient experience.
- A walk-in early pregnancy unit ran on weekday mornings for women in the very early stages of pregnancy who had concerns about their baby. It was staffed by one midwife and a maternity assistant, with medical input as required. The clinic was very busy, and in very cramped space, with one cubicle, and one room where women could be given bad news. A positive feature was the use of an EPAU Assessment Sheet designed to save mothers repeating the same distressing information at each appointment in the unit. On the other hand, there was no drinking water in this unit, or in the nearby gynaecology waiting room. Women who needed scans on a full bladder had to go to the antenatal clinic to get a glass of water. This was insensitive.

- The room designated for women who were bereaved was on the labour ward. It was not a dedicated room and was clinical in appearance with a hospital bed and no sympathetic design features.
- Weekly breastfeeding clinics were held at local children's centres.
- The fetal medicine unit provided all services in house except for rare conditions where the women benefit by invasive procedures being undertaken in a tertiary unit (fetal transfusion and lasers for twin to twin syndrome where babies were at risk because they shared the same placenta)). Fewer than 1% of the women referred to fetal medicine were transferred to other centres for their care.
- The discharge lounge for day case gynaecology patients was very small. There was no place for doctors to have private conversations or carry out final preoperative checks in privacy
- There was a modest range of leaflets on display in antenatal waiting areas, including on caesarean section and antenatal classes. Most women we spoke with who were receiving maternity or gynaecology services said midwives and doctors had given them clear verbal explanations as well as giving them written information. There was no information on the website to supplement information women may have been given at appointments.

Access

- All referrals for antenatal care were received in the antenatal clinic. Most referrals were from GPs, but there was a self-referral form on the trust website which women could print and bring to the hospital. There was no online self-referral option.
- A high proportion of women cancelled appointments - on average 15%. This was 'red' on the dashboard for every month, but no work had been undertaken to understand why women cancelled or to offer appointments at times that might suit them better.
- Performance data at December 2015 showed 75% of women booked(attended their first appointment in their pregnancy) before the completed 13th week of pregnancy. Early booking is important for the early identification of risk and appropriate care planning. All women had to come to the hospital for their first (booking) appointment, and then later for scans. There was no one-stop shop clinic. After the initial appointment, women with low risk pregnancies would then attend clinics in GP surgeries or children's centres and higher risk women would be referred to condition specific antenatal clinics at the hospital. No data was reported on women accessing antenatal care at 10 weeks compared to those accessing it by the end of 13 weeks.
- Continuity of care required improvement and the unit had recognised this, but plans to improve continuity would not have an impact for some months. An internal survey December 2014 to March 2015 showed 65% women had seen the same team of midwives, although no women we spoke to had seen a named midwife regularly. Although seeing the same team of midwives was an improvement on the previous year when only 13% of women had seen the same team, the NICE quality standard is a named midwife should be responsible for providing and coordinating all or most of a woman's antenatal and postnatal care. Women we spoke with said they had not seen the same midwife most of the time.
- Admission processes when women thought they were in labour were unsatisfactory. Women were not offered a dedicated telephone line for triage. A woman in labour ringing the ward might speak to a different midwife each time, and the phone might not always be answered. There was no dedicated triage midwife, contrary to NICE guideline CG190. Women coming in to the hospital in early labour were seen in a delivery room on the labour ward. As there was no early labour lounge some women would be sent home which was not a good experience for anxious women.
- Between April and November2015,634 women had been admitted to the labour ward and not delivered during that admission. This was not best use of delivery rooms. There was a large antenatal ward, underused during our visit. Information about bed occupancy was not split between the antenatal ward and the postnatal ward, which midwives said was generally full. Data showing 47% average occupancy was not useful for service planning. Labour ward occupancy was higher but as previously mentioned there were women on the labour ward who ought properly to have been on either antenatal or postnatal wards.
- The Maternity Assessment Unit (MAU) was open limited weekday hours and not at weekends at all. However, even when the MAU was open midwives did not provide triage. Many other hospitals used the MAU for triage.

- Partners were encouraged to visit but overnight facilities were only available in the event of a stillbirth, neonatal death or other special circumstance. There were few reclining chairs for partners staying overnight.
- Some midwives told us women followed the staffing pathway rather than a midwife following the woman's journey.
- The supervisors had recently started a debriefing service in local clinics for women who wanted to review their birth experience.

Flow through the maternity wards

- On inspection we raised concerns about flow across the maternity wards impacted on women's pathways. This led to uncoordinated care during times of peak activity. The service strategy dated September 2015 did not to take the opportunity to address the patient flow issues identified.
- Women who were undergoing induction of labour were cared for on the antenatal ward. If there were no beds available on the labour ward when women went into labour, they laboured on the antenatal ward where there were not enough staff to provide1:1 care. Midwives told us births on the antenatal ward happened regularly. There had been three deliveries in the previous week (November). One of these women had had a previous postpartum haemorrhage and another a previous shoulder dystocia. Such high risk mothers should have been on the labour ward for their safety. The antenatal ward with 16 beds should have two midwives and a healthcare assistant, but there was often only one midwife. This was acceptable when the number of women on the wards were low.
- Records showed two or three births on the antenatal ward every month between April and October 2015.As a result of this Room 11 had been set up as a delivery room.
- Too many women were cared for on the labour ward inappropriately. On an evening inspection we found as many women not in labour on the labour ward as there were labouring women. Three women were in labour in the ward and two in the birth centre. Three postnatal women were on the ward, one was two days post-birth and stable, one woman was four hours post-birth and the third had given birth shortly before we arrived. There were also two antenatal women on the ward even though the large antenatal ward was not full. There was no clinical indication for at least three of these women to be on the labour ward at that time and the beds should have been made available for women coming into the hospital in labour. When another woman was about to arrive in labour, the coordinator felt the unit was too busy to take her, and made arrangements for the woman to go to Epsom Hospital. We heard later that the decision to direct the woman to Epsom was overturned, and she was admitted to St Helier. There were six midwives, a consultant, a registrar and a trainee doctor on duty during that time. The occupancy levels of the maternity wards were relatively low so it was not clear why flow was poor, and in particular why any woman should give birth on the antenatal ward.
- There was no 24/7 telephone line managed by a midwife to respond to queries from women. During most of the day and night when there was no ward clerk, the labour ward telephone was often unanswered. We observed nine calls in a one hour period. The telephone was only answered four times. Community midwives reported that, when they rang the labour ward about attendance at a home birth(as they were required to do as part of the Lone Worker Policy), the telephone on the labour ward was usually unanswered.
- There was no triage to keep women out of the labour ward until the appropriate time nor an early labour lounge where women who did not yet need to be admitted could spend time rather than being sent home. We were informed by the clinical management team that the Directorate had been considering the establishment of a maternity triage, which exists in the majority of maternity units, for over eight years.
- Midwives told us discharge from the postnatal ward was often delayed by waiting for baby checks and medicines. Women regularly discharged themselves to avoid waiting. This was particularly the case at weekends when there were fewer paediatricians available.
- 250 couples a year were seen for assisted conception. Treatment was either NHS funded or self-funded. The intent is to become a centre of excellence by being the only IVF unit (NHS) that provides a comprehensive tertiary fertility service in south west London.
- In gynaecology, performance against the 18 week referral to treatment times between April and October 2014 was 94.2%. We saw from meeting minutes that

some consultants insisted on doing procedures on particular patients. This had the potential to delay treatment times because staff were not acting as a team and cross covering lists.

- There were 392 inpatient procedures a year and 77 day case procedures in gynaecology. There was an acute gynaecology unit and an emergency gynaecology service. Bed occupancy in the gynaecology ward was 80-90%. As this was part of a larger ward there was sometimes scope to flex the number of gynaecology beds. Some women had to be admitted as inpatients for gynaecology procedures and hyperemesis (severe nausea in pregnancy) as there was no 23 hour day unit.
- There was a separate room on the gynaecology ward where women having termination of pregnancy up to 19 weeks could be accommodated. A respect notice on the door indicated that the patient's privacy be respected.
- Women having day gynaecology procedures were accommodated in the day surgery ward B4. Two consultants told us about female gynaecology patients in recovery while male patients who had fully recovered from anaesthesia opposite. Ideally, the service would like a discrete day surgery unit as B4 was also used as an escalation ward.
- An audit had revealed nine breaches of the two week rule for women who might have cancer at St Helier.
- Since November 2014, only one gynaecology operation had been cancelled that was not rebooked within 28 days. The trust overall performed better than the England average for cancellations, although we were not given cancellation figures specific to gynaecology procedures. Theatre staff told us poor pre-assessment sometimes led to postponement of gynaecological surgery.
- We asked for gynaecology clinic waiting times at this site but were told they were not available. The combined figures for both sites between November 2014 to April 2015 were 83% were seen in under 30 minutes, 14% within an hour.

Learning from complaints and concerns

- Managers told us complaints about the antenatal and labour ward had decreased but complaints from women about postnatal care and care after discharge persisted. Other themes of maternity complaints were recognising deterioration and escalation. As these had been themes of earlier incidents, we were concerned that improvements were not being embedded. We saw some examples of complaints and considered the responses rather formulaic.
- We also noted complaints gathered from 'walk the floor' supervisory audits, antenatal and postnatal listening session, which commented on communication, conflicting advice, lack of debrief before discharge, out of date leaflets, waiting times for antenatal appointments and unprofessional behaviour by staff. Midwives did not get regular feedback on the themes of complaints and incidents.
- Complaints were discussed in meeting notes we reviewed in terms of numbers and administration rather than analysing what complaints were and what could be learned from them. There had been 27 formal complaints since April 2015. Complaint numbers were flagged red on the maternity dashboard. The only action in response to complaints related to concerns about poor communication. Mandatory communication workshops were planned for 2016.
- We learned a new complaint handling process had been introduced which would better enable the complaints team to monitor directorate's responses to complaints and speed up responses which records showed had been slow earlier in the year. They were also seeking to improve the quality of responses. Maternity complaints were 16% of trust complaints
- Gynaecology complaints were mainly about communication and waiting times.

Are maternity and gynaecology services well-led?

Inadequate

Leadership and governance in maternity in particular, was not sufficiently focused on providing a high quality care experience for the majority of women.

Risks were identified in various different meetings and documents, but not pulled together in a coherent risk register with a focus on timely resolution of risks. Key risks were not the subject of regular audit and not triangulated with incidents and complaints. Overall midwife shortages were not always escalated to the Maternity Board.

The culture was hierarchical and not all senior midwifery managers were considered to be visible or supportive. Staff felt there was an element of blame attached to reporting incidents. Staff morale was low, particularly in community midwifery.

The involvement of obstetricians in governance meetings was sporadic by comparison with the involvement of paediatricians. Issues identified were not always followed up in a timely way. The use of data and audits in the day to day running of the service was poor, and hindered by so much reliance on merged data for the two units. We did not identify any forum that discussed St Helier specific maternity data even though separate maternity dashboards were available. The populations served by each unit were different, and each maternity unit was run, for most purposes, as a separate unit by different staff. Although we saw evidence of a small number of audits taking place, this appeared to be a senior staff activity and did not always lead to action.

Vision and strategy for this service

- There was no overriding vision for women's services shared by obstetricians and midwives. A five year plan agreed in September 2015 agreed the continuation of maternity services at each site, but consultants had different visions for the service as a whole depending on their speciality. There were plans to grow fetal medicine to include fetal MRI and become engaged in national research. Assisted conception was also expanding.
- Midwives we spoke with were unsure about the future direction of the maternity service. Managers did not draw on the views of staff on how to develop maternity care in this area of London. However, although improving continuity of care for women was one of the objectives for the maternity service, the plans for this, at the time of our inspection, only related to reorganising new and community midwives which was not conducive to establishing an integrated midwifery service. The pattern of medical cover was not being changed to improve continuity for women on the wards.
- Management expectation of general growth in the service did not seem to fit with the static number of births.
- The vision for gynaecology was clearer than in maternity. Their was a recognition that provision required modernisation by increasing day cases to 90% (from 70%) and reducing inpatient beds, as well as offering improved patient experience by providing more community based clinics, and telemedicine.

Governance, risk management and quality measurement

- St Helier Hospital did not have an effective governance framework for the continuous improvement of care. We reviewed minutes of governance meetings, a maternity monitoring short report, risk meetings and directorate management meetings. Minutes of governance meetings indicated limited scrutiny and challenge. No active comparisons were made between the two maternity units in the trust, and there was minimal comparison of performance with other maternity units or with national standards.
- The maternity board, which met monthly, reported to the Chief Nurse. Its stated primary function was to monitor clinical performance of maternity services and focus on risk. The risk register was neither current nor reflective of the risks we saw in the service. Senior managers told us items were added to the risk register in reaction to events. The risk register contained few clinical risks and did not cross reference either to risk areas on the maternity dashboard or to the maternity safety thermometer, even though the unit at St Helier was an outlier on some measures. Some of the risks had been on the register since 2011.There was no proactive management of risk and risks identified by site did not always reflect risks evident from the local maternity dashboard for each site. The trust wide risk register did not record some key risks we identified on inspection, and about which staff told us: the static or declining number of births, the poor patient flow across the maternity wards, staffing and skill mix and the risk of post-partum haemorrhage.
- Maternity performance data collected by the trust did not cover the full spectrum of indicators to manage an effective service.The reason for flagging items as red on the maternity dashboard should be to lead to immediate action to try to meet thresholds or targets. We saw no evidence of urgent action. Data was poorly used, the emphasis being more on immediate comparison with the previous month's performance rather than on trends. Scrutiny from the patient safety

and quality committee in July 2015 had asked some challenging questions and not had robust answers. There appeared to have been no revaluation of practice in response to these questions.

- The maternity dashboard contained no data on epidural rates, delays to caesarean section or delays to suturing, or staffing. The absence of reported data on vacancies, sickness rates, or agency use meant that managers could not be assured staffing levels were safe and sufficient to provide quality care. During our inspection we asked for data in a number of areas and the trust were unable to provide this. In some cases they carried out snapshot audits after the inspection. There was no data quality strategy and the audit programme was not based on risk assessments as would be good practice.
- Action plans for improvement were not tightly monitored and there was no evidence that individuals were held accountable for change.
- Consultant attendance at risk management meetings was sporadic and some meetings took place without medical representation from both maternity units.
- We were told the trust board received a maternity report, via the Patient Safety and Quality Committee, which identified the latest performance standards and key risks within the maternity service. We noted the maternity dashboard had only been to the trust board three times in two years and the focus had been on the performance in the Friends and Family Test. We were not confident the trust board was able to assure itself about the quality of the maternity service.
- The governance of the gynaecology division had clear structures and shared the formal clinical governance framework with the general surgical Division. The clinical governance meetings for gynaecology were monthly.
- Information from clinical governance meetings was inconsistently shared with staff. There was little evidence on the wards of staff discussing revised clinical guidelines and implementing change from the ward level up.
- Some staff told us about problems with IT and other equipment which impacted on their work. IT improvements were included in the trust's five year plan.

Leadership of service

- Staff told us the new chief executive was visible. However, front line staff said senior midwifery managers were not sufficiently visible; the structure was hierarchical and the management style formal and directive. Managers did not prioritise the participation and involvement of women or frontline staff. Neither junior doctors nor midwives were involved in service development, and were notified of decisions rather than being involved as partners. Staff felt they were blamed if they raised concerns.
- We did not see strong leadership at ward level. Shift leaders needed development for their role, to be made accountable for their performance, and be role models for the midwives. Training was needed to ensure staff were able to use the structured communication tool, SBAR effectively. Skill mix needed to be reviewed so midwives had sufficient support.
- Several midwives said the management structure in midwifery felt 'top heavy' in relation to the number of births in the unit. Some midwives mentioned limited clinical leadership.
- The community midwives in particular felt undervalued by management. They had been moved out of their former accommodation to a base room. They were not well informed about proposed changes which would affect their work. They were unhappy they were not alerted to advertised positions within the service which would have offered development opportunities.
- Gynaecology leadership was clear and staff understood the direction of travel. The matron for gynaecology was visible to staff and had the respect of staff.

Culture within the service

- Many staff had worked in the unit for a long time and told us the hospital 'feels like a family'. However, little experience from outside the hospital meant that staff had become complacent about working practices and unwilling to learn and develop. Few Band 7 midwives had worked in other units, and opportunities to learn from good practice within the South West London Maternity Network had not been taken up. Some new staff considered the cliques of longer serving staff made it difficult for them to integrate, especially if they were not from the local area. There was a perception that while new staff were expected to work in particular ways, existing staff did not need to change. This was an issue managers needed to tackle.
- Midwives reported feeling under pressure and sickness rates were high (6% in November 2015). Levels of vacancy and turnover were high which are all known to

be adversely affected by insufficient staff. Midwives who attended a focus group told us managers were not always supportive and there was a blame culture. Staff did not feel their concerns were listened to. For example, despite evidence of staff concerns about staffing levels, and staffing related incident reports for the previous year, staffing levels had only recently been added to the risk register.

- The maternity service was not contemporary in many ways. A lot of communication was written rather than delivered face to face. There were 'all staff' emails and other information was communicated through newsletters. There was a system of Flash alert for urgent information. However, these communication methods did not energise staff and were not effective in ensuring all staff understood and followed new policies and guidelines.
- There would be value to each maternity unit in understanding the strengths and weaknesses of the other trust maternity unit. Although a few midwifery managers worked across both units, most staff did not. Many consultants and almost all doctors in training worked entirely on one site. There were limited opportunities for staff at each site to learn from one another.
- Staff knew about the trust's 'raising concerns at work policy but said it was not always easy to initiate conversations with managers.

Public and staff engagement

- We were told about the Patient First programme in which some staff had participated but we did not feel women-centred care underpinned the maternity service.
- The hospital used the friends and family test to engage with women and seek feedback, but response rates were relatively low and staff did not supplement this with other methods of seeking women's views.
- Each month, the maternity management team completed a 'walkabout' to be visible to staff and to encourage dialogue. They had developed a staff management book – a 'you said we did' book for staff in each clinical area.

Services for children and young people

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

Information about the service

The children's service at Epsom and St Helier University Hospitals NHS Trust is provided on two sites; St Helier Hospital in Carshalton, in the London Borough of Sutton and Epsom General Hospital in Surrey. This report is about the St Helier service.

The majority of the service on the St Helier site is located in the Queen Mary's Children's Hospital where there is an 18 bedded inpatient ward. In addition, there is a six bed assessment unit, which opens from 8am to 8pm seven days a week. Children are admitted to the unit by the emergency department for periods of assessment and observation, prior to either discharge or in-patient admission. Children requiring regular tests and investigations could also receive these in this unit.

The children's outpatient department has 10 clinics seeing approximately 170 patients a day.

Surgery for children is carried out in the day surgical unit on the third floor of the children's hospital.

A children's community nursing team are based in the hospital, providing care for children within the local community following discharge from their original point of care.

X-ray and outpatient services are located on the ground floor of Queen Mary's Hospital.

A level 2 neonatal unit with 18 cots and children's accident and emergency are located in the St Helier Hospital itself.

The neonatal service provides high dependency, level 2 care which includes two intensive therapy, four high dependency and 12 special care cots. Women who are identified as having babies likely to require level two neonatal care are transferred for delivery at St Helier. In addition, protocols are in place to stabilise and transfer other less stable neonates who unexpectedly require level 2 support.

The children's service at St Helier hospital treated a total of 3275 children in 2014-2015. 56% were emergencies, 42% were day cases and 2% were planned inpatient admissions. During the inspection, we spoke with five parents and their children, as well as over 20 members of staff, including: nurses, student nurses, matrons, play specialists clinical nurse specialists, doctors, consultants and support staff. We observed care and treatment being provided.

Services for children and young people

Summary of findings

Throughout the inspection managers and staff told us they had concerns about staffing levels. We were told the trust had implemented the 'Safer Staffing' model for ensuring there were sufficient staff on duty to meet children's needs and the service met nationally recommended staffing ratios but we found examples of staffing ratios falling below these levels. There was also a large number of vacant medical staff posts and high use of locums to cover for medical staff who were off sick, posts were unfilled or on maternity leave.

There was a system in place for reviewing staffing levels and staffing levels/dependency scores were reviewed and RAG rated on an on-going basis throughout the day by the paediatric matrons. We were told staffing was uplifted in response to increased dependency and was evidenced by twice daily reports circulated to the senior team.

Staff recorded observations about children every two hours to monitor their condition. Records showed these observations were being carried out but we also found examples where the system for escalating concerns about a deteriorating child were not being followed.

Child protection notifications coming into the trust at St Helier hospital were not up to date on internal systems and there was a three month backlog in notifying concerns. Community paediatricians were unable to meet all statutory requirements of attending child protection conferences because of demand, capacity and vacancies within the service.'

Uncertainty about the future structure of the trust had contributed to difficulties recruiting and retaining staff resulting in staffing pressures on the ward. Developing a strategy for the service had also been problematic without clarity about the organisation's future. Managers had responded to the uncertainty by developing a five-year business and service strategy.

An executive director provided board level leadership for children's services.

Are services for children and young people safe?

Requires improvement

Throughout the inspection, managers and staff told us they had concerns about staffing levels. The trust had implemented the 'Safer Staffing' model for ensuring there were sufficient staff on duty and that service met nationally recommended staffing ratios but we found examples of staffing ratios, which fell, below these levels. There was a system in place for reviewing staffing levels and staffing levels / dependency scores are reviewed and RAG rated on an on-going basis throughout the day by the paediatric matrons. Whilst the trust reported that staffing was uplifted in response to increased dependency staff reported that this did not always occur in a timely way.

There was an age-appropriate early-warning scoring tool in place and children had their observations monitored dependent on their condition.Records showed these observations were being carried out but we also found examples where the system was not being followed.

Reports produced following the investigation of serious incidents analysed what happened and identified the actions required to reduce the risk of a similar event re-occurring. The discussions regarding SI investigations involved consultant medical staff and were not multi-disciplinary.

Child protection notifications from the trust were not up to date. There was a three-month backlog in notifying safeguarding concerns. Staff on the ward checked for any child protection concerns on the trust's computer system however they were unaware that this had not always been up to date. There was a risk that staff were unaware of children on the child protection register. Managers acknowledged there had been delays in completing safeguarding records and were working on reducing the backlog.

However, there were areas of good practice identified including: Medical and nursing notes providing a clear record of the care provided. Cannula site stickers were used in children's records to indicate where a cannula had been inserted. Patients admission sheets had all been

completed, checked and signed by medical staff. Children were assessed when they first arrived on the ward and pain assessments tools were used to assess the level of pain a child was experiencing.

Incidents

- There had been no never events reported by the hospital between April 2014 and October 2015. There were two serious paediatric incidents requiring investigation. One incident related to the service at Queen Mary's Children's hospital. A child had developed a pressure ulcer. The incident was investigated as required by the trust's policy for reviewing and learning from any issues identified.
- The manager recalled details of one serious incident, which had been referred to the Coroner. They said the learning would be discussed once the Coroners inquest investigation was completed. The manager reported that they considered the culture of reporting incidents amongst staff was good. They told us the main theme they saw reported was lack of staff.
- A quality report for 2014 -2015 showed there were 239 level 1 incidents, the lowest level, resulting in no harm, 127 level 2 incidents resulting in low levels of harm, 27 level 3 incidents causing moderate harm and two level 4 incidents causing severe harm.
- A quarterly report for the first three months of 2015-2016 showed the number of paediatric and neonatal incidents had increased from 101 to 129. This represented an average increase per month from 34 to 43 over the six month period. Of the 129 incidents 99 resulted in no harm and 30 resulted in harm. This compared with 27 harm and 52 no harm incidents in the previous three months. 10 incidents relating to inadequate staffing had been reported between April and June 2015. Staff reported incidents using the hospital's electronic reporting system and received feedback on the incidents they reported. The learning from these was discussed at ward and directorate team meetings.
- A nurse who worked in the out patent department (OPD) said team meetings had started recently. A further meeting was planned for eight weeks time and the focus would be on discussing incidents. They said training on the incident reporting system was not part of their mandatory training but they could find their way around the system and their manager had offered to provide training. Staff were familiar with the triggers for reporting incidents in the community, neonatal unit and inpatient areas. The triggers were derived from a nationally recognised tool, the Safer Care – Paediatric Trigger Tool 2010. Examples of incidents requiring reporting included neonates transferred to another hospital because a cot was not available, or baseline observation missing from a child's records on the ward.
- Two of the 12 junior doctors we spoke with told us they had reported incidents. The other 10 told us they knew how to report incidents but had nothing to report. One doctor told us they had received an immediate response when they had reported an incident. Staff were able to give examples of changes made following incidents. For example, an age-appropriate paediatric early warning system was implemented for all ED attendances following a serious incident. A practice development nurse post had also been created to support nurses develop their clinical skills to care for the more acutely ill child, respond to more complex children being discharged from tertiary centre and support training across the Trust where children and young people were seen.
- Staff were also able to provide an example of a change in practice following an investigation into an incident involving a nasogastric tube. As a result of the incident, two nurses now checked nasogastric tubes were sited correctly. The nature and frequency of incidents was reviewed by the directorate management team as part of their performance meetings. The trust's 2014-2015 quality report described the process for reviewing a child death or serious incident. A lead investigator reviewed the case notes and produced a report for discussion at mortality and morbidity meetings. Senior medical staff attended mortality and morbidity meetings which were held every three months. We saw examples of the reports which had been produced as a result of the investigations which contained a detailed analysis of the what happened and any action required to reduce the risk of a similar event re-occurring. We also saw the minutes of the meetings where the incidents were discussed but these were not detailed. Incident reports showed the service had reported occasions where there were inadequate staffing levels. There were nine incidents reported in the three months between January and March 2015, eight incidents in the quarter September 2014 to December 2014 and seven in the three months prior to this. Staffing levels had also been included on the service's risk register.

Services for children and young people

Duty of Candour

- Staff told us they had received training on the NHS's Duty of Candour and understood the importance of being open and transparent about incidents and complaints and apologising to parents and carers when things went wrong. Records showed staff had discussed what they had learned from their Duty of Candour training at a ward meeting.

Cleanliness, infection control and hygiene

- Cleaning staff followed cleaning schedules which were checked by cleaning service managers. Ward based cleaning staff could call on a specialist team to provide a deep cleaning service. For example, if an isolation room needed to be cleaned after a patient with an infectious condition was discharged.
- Clinical areas were visibly clean and there were three monthly infection control audits. These audits reviewed infection control practice in 10 specific areas. Areas of poor practice were highlighted and actions highlighted to improve compliance. Wards failing to attain compliance were audited by the matron until a compliant score of 85% and above was attained. We observed staff used appropriate personal protective equipment such as gloves and aprons and use hand gel when entering or leaving ward areas. The results of a quarterly infection control audit for the three month period April –June 2015 showed the ward achieved 94% compliance with the nine infection control measures monitored. These included following hand hygiene procedures (90%) and cleaning equipment (100%).

Environment and equipment

- Wards and departments had medical equipment schedules which showed equipment was regularly safety checked
- The accommodation provided for children in the bays on the main ward area was cramped and we saw it was difficult for staff to carry out some procedures at the bedside. There was a treatment room where children received more complex care.
- There were single rooms for patients who were infectious or whose immunity was supressed and needed to be cared for in isolation.
- Parents were able to stay with their child overnight, sleeping in a reclining armchair or a folding bed stored on the ward. The main ward area was divided into the main inpatient area and a paediatric day care assessment unit. The paediatric assessment unit provided care for children requiring periods of assessment and observation prior to potential admission to the ward or discharge, as well as for medical investigations and day care facilities. The day unit had one or two patients being treated in contrast to the main inpatient area which was full.
- Managers acknowledged that the accommodation did not meet the needs of young people / adolescents. They told us there were plans to provide the main operating and day theatres together with better links to the out-patient department. Children whose condition deteriorated and were awaiting retrieval to paediatric intensive care in another hospital were cared for in the anaesthetic area on the day surgery floor. Children requiring more major surgery were operated on in the main adult theatres
- Staff stored emergency equipment on a trolley according to the size of the child and there were records of daily equipment checks. This meant staff could be confident that the correct equipment could be accessed in an emergency.
- Staff told us there was a good electroenchalogram service (EEG and imaging service). The service was provided by a professional who specialised in neurophysiology. An EEG is used to help diagnose and monitor a number of conditions affecting the brain for example epilepsy.

Medicines

- The ward had previously had dedicated pharmacy support. However, they were waiting for a replacement pharmacist to be appointed. The pharmacy service provided interim support for the ward but this was not provided by someone who specialised in paediatric medicine. The trust subsequently informed us they had appointed to this post.
- Ward staff told us they were concerned about the absence of pharmacy support. They said the absence of pharmacy support, sometimes led to delays in discharging patients. Staff were also concerned about the inability to obtain medicines at weekend. The hospital pharmacy was only open at the weekend from 9 am to 12noon on Saturday. Pre-packs of commonly used medicines were available on the ward to facilitate discharge out of hours and an on-call pharmacist is also available for advice and to provide access to urgent medicines.

- We reviewed five prescription charts on the ward and found these reflected good practice. Three of the five charts had been checked by a pharmacist. All the records had weights and allergies recorded. Medicines were stored appropriately on the ward. A pharmacist visited the ward every day to pick up drug orders and check prescription charts and stock levels.
- A quality report produced in July 2015 for the period April 2015-June 2015 showed there were 10 medication incidents over that 3 month period. The number of medicines incidents had fallen in the nine months from October 2014 to June 2015 compared with the same period in the previous year. Issues with medicines was the highest category of reported incidents. The report did not provide an analysis of the incidents or contain any action plans for further reducing these figures.
- Staff in both the paediatric and the neonatal unit have their medicines competencies tested every year. This involved checking their understanding of drug dosages, administration and knowledge about medicines. Staff received further training if they did not meet the required competencies.

Records

- We reviewed medical and nursing notes and found these provided a clear record of the care provided. We saw an example of good practice where cannula site stickers were used to indicate where a cannula had been inserted. Admission sheets were completed, checked and signed by medical staff. Records showed children were assessed when they first arrived on the ward and pain assessments tools were to record the level of pain a child was experiencing. We saw examples of completed the safeguarding assessments.
- We reviewed three sets of notes on the neonatal unit which provided a good record of the care provided. For example, we saw there was a real time record of a baby being resuscitated. The record had been reviewed afterwards to confirm the treatment had been delivered appropriately. We saw records of handovers which were well documented and contained all the relevant information.
- We looked at two sets of surgical records. The preoperative assessment sheet in both was designed for adults and was not specific to children. One of the surgical assessments was not signed. The names of staff were recorded elsewhere but without a signature it was unclear if the same staff had conducted the assessment. The second set of records were fully completed and signed and contained a good surgical review. We saw examples of completed World Health Organisation (WHO) surgical checklists which recorded safety checks prior to surgery, during and afterwards.

Safeguarding

- Training in safeguarding vulnerable children had been provided for 82% of the staff required level 3, 89% of staff requiring level 2 and 88% requiring level 1.
- Ward staff told us information about children on the "Child at risk" register could be accessed when they were admitted on the trust's computer system. During our inspection, we learned that child protection notifications from the trust were not up to date. There was a three month backlog in notifying safeguarding concerns. Managers acknowledged there had been delays in completing safeguarding records. Staff on the ward were unaware of this and there was a risk staff were unware that a child was on the child protection register. Managers were working on reducing the backlog.
- We saw an incident, reported in January 2015, where a member of staff was unable to produce a safeguarding report for a child protection conference. The member of staff had not been able to find the written or electronic information they needed within the trust. A safeguarding conference had been held but there were no minutes and the person preparing the report was unaware of the health issues involved.
- Child protection supervisors were in place. However, they were currently only able to supervise 66% of staff who required child protection supervision due to capacity issues. Group supervision was in place where possible, in order to capture as many people as possible. Staff told us they had good access to the safeguarding nurse who visited the ward every week to discuss any issues. Managers acknowledged that increasing safeguarding supervision was a key objective for the directorate.
- Community paediatricians were unable to fulfil the agreed standard for attending or providing reports for child protection conferences in the London Boroughs of Sutton and Merton because of demand, capacity and vacancies within the service. Medical staff had attended 33% of the meetings they were expected to attend between October 2015 and January 2016. Staff had

submitted incident reports about problems accessing the information required for child protection conferences. Community paediatricians were not always able to attend meetings within the timescales provided. This was recorded as a high risk in the service's risk register. The community paediatric service tried to ensure case conferences received written reports if a paediatrician could not attend in person.

- An example of good practice in this area was the Trust's participation in a review of the initial health assessment process for looked after children to improve the service. Actions were agreed to address the issues which included improving referral documentation and reviewing of clinic times to offer appointments.
- Nurses who worked in outpatients said they had level 3 safeguarding training and all staff nurses and health care assistants were level 3 trained. They said staff had also received female genital mutilation (FGM) awareness training.
- Information about escalating and reporting safe guarding concerns was displayed throughout the unit. We spoke with junior medical staff who told us they had all received level 3 safeguarding training.

Mandatory training

- A registered nurse told us they had completed all the modules of the trust's mandatory training programme as part of their induction programme when they recently started to work on the ward.
- Staff training records were held on the trust's computer based training system 'wired'. Staff could check what training they needed and the system sent them reminders when training was due.
- 88% of staff were up to date with infection control training in July 2015, 89.7 in risk and health and safety management. There were five areas where staff training levels did not meet the target set by the trust which were staff appraisals 73.4% resuscitation 84.9, manual handling 85% and level 3 safeguarding 82%.

Assessing and responding to patient risk

- Staff used a system for identifying the most sick children on the ward and recognising when their condition deteriorated. There was a process in place for referring children who are deteriorating to the South Thames Retrieval Service. Children requiring intensive care management prior to retrieval were cared for by the anaesthetic/paediatric team and transferred to the anaesthetic area until retrieval took place. Staff had developed a policy for the management of the acutely ill child with escalation algorithms and the transfer and escorting of children.
- Early warning scores were communicated to staff at shift handovers. Scores were reviewed when the child's observations were recorded.
- We saw an example of an early warning assessment which had been completed but not scored. The information recorded that the child had a score of two and a senior nurse should have reviewed the child but this had not happened. Another early warning assessment indicated the child required one hourly observations, but the records showed they continued to be observed every two hours. We saw a third example of an early warning assessment which was completed correctly and the appropriate action was taken as a result.
- Procedures were in place for transferring children to other hospitals if their condition deteriorated. The ward was not able to provide high dependency or paediatric intensive care. The hospital managed the child's care until the South Thames Retrieval Service (STRS) team were able to transfer the child to a specialist unit if they required intensive care. Staff had developed a policy for the management of the acutely ill child with escalation algorithms and the transfer and escorting of children.
- We reviewed the levels of care required by children over several months and found there were many occasions when children required high dependency care and transfer. A business case to develop high dependency care on the ward had been prepared in response to the continuing need for this type of care.
- Medical staff were unhappy that no platelets were kept on site at St Helier.

Nursing staffing

- On the St Helier site 15 neonatal staff have undertaken a post-graduate course in neonatal intensive care which equated to 55% of staff in post. 4 staff have completed the special care module and two staff were about to start the course in January 2016. The number of posts in the St Helier neonatal service meant the service was 85% compliant with the British Association of Perinatal Medicine standard for staffing. There were 1.2 vacant posts on the neonatal unit.
- The children's in-patient ward had two paediatric trained nurses on duty at all times Nurses were all

paediatric trained. Nurses caring for children were trained in acute assessment of the unwell child, pain management and communication, and had appropriate skills for resuscitation and safeguarding. Staff received resuscitation training annually as part of the trust's mandatory training programme.

- The trust monitored the number of staff on duty against planned staffing levels. The monitoring reports showed staffing levels had improved during 2015. In March 2015, staffing levels were 82% of planned hours and by October 2015 this had increased to 90.3%. There were still concerns about the number of vacancies within paediatrics. There were 6.42 vacancies for registered nurses on the ward at Queen Mary Hospital in June 2015, four posts had been recruited to but were not in post; 2.2 post in the community, two had been recruited to; 1.2 posts in paediatric out-patients and 7.0 posts in the neonatal unit. Managers told us they had managed to recruit to four ward nursing posts and were waiting for new staff to start. Staffing was highlighted as a concern in the service's risk register.
- Staff told us they were usually able to cover vacant shifts with bank staff although when we looked at the staff rotas, we saw there were occasions where there were only two nurses and one bank nurse on duty at night.
- Staff ratios followed national guidance and were set at one member of staff to four children. Night shift ratios were one member of staff to four or five children. Senior nurses said staffing levels could be increased if a child's condition deteriorated or if acutely ill children were admitted. The staffing levels and the needs of children were monitored twice a day. A paediatric trained matron assessed the staffing levels required and could authorise additional staff if needed. A paediatric trained matron assessed the staffing levels required and could authorise additional staff if needed. The matron assessed throughout the day and provided plans and support for overnight staffing. There was no paediatric trained matron at night and this meant there was a risk the matron on duty might not prioritise the need for additional staff. The trust told us there was a clinical site team to provide support out of hours.
- There was a system in place for reviewing staffing levels and dependency scores which were reviewed and prioritised throughout the day by the paediatric matrons. Staffing is uplifted in response to increased dependency. Twice daily reports were circulated to senior managers. The trust told us Support from matrons and the practice development team increased in response to the needs of children and young people.
- We looked at children's dependency levels for the week of our inspection and on three of those days there was a child with level two dependency, the highest dependency level. This meant the child required one to one support, triggering the need for more staff, but we did not see that additional staff had been provided.
- The rota for the week before also showed there were two trained staff and one healthcare assistant on duty on one occasion, which was below the required staffing level.
- We visited the ward on several occasions during our inspection and found it was always busy. The ward manager was working on the ward and been added to the ward staff rota to ensure there was sufficient staff on duty. This had happened on two other occasions in the week before our inspection. The ward manager normally had a managerial role and was not included on the ward staff rota. The trust had introduced a system of supervisory days for ward managers which were recognised as being essential to providing high quality care.
- We observed the six bed bay area next to the main ward area.The paediatric assessment unit was located next to the main ward and had one patient when we visited The assessment unit had three staff on duty including paediatric trained staff who told us they could assist staff on the main ward area if needed but we did not see them providing assistance to the busy ward area.
- When a child deteriorated and needed to be transferred to another hospital, a qualified nurse cared for the child until the retrieval team arrived. A child who was deteriorating was cared for in the surgical theatres area on the first floor. This meant a qualified nurse could be away from the unit for several hours whilst they cared for the child awaiting transfer.
- Our overall view of the ward was that it was a busy area with staffing levels at or just below the required ratios. There were processes in a place to monitor children's needs, but we did not see examples of additional staff being allocated for example when there were children with increased needs.
- There were nine incidents involving staffing issues in the three months to June 2015. Previously in the three months between September and December 2014, there

had been eight incidents with seven between June to September 2014. Staffing compliance was monitored weekly via the matron's reporting. The matron told us it was difficult to maintain adequate staffing levels to meet children's needs. The trust had implemented the Department of Health's guidance 'Safer Staffing' to monitor staffing levels.

- Community staff told us they had re-prioritised the children on their caseload to support children with the greatest need until their vacant posts were filled. This led to delays in assessing children and discharging children.
- We observed a ward handover. Named nurses did not hand over their own patients. Information was passed to staff coming on duty on the child's diagnosis, test results, care plan, medication, fluids and nutrition and observations. Any known child protection concerns were discussed. Children awaiting planned admission or return from another unit, and using the assessment unit for patients who were waiting for beds, were discussed. The process for reporting any concerns about staffing levels was also discussed.

Medical staffing

- Medical staffing levels met the Royal College of Paediatrics and Child Health (RCPCH) standards for general paediatrics and the British Association of Perinatal Medicine (BAPM) standards for neonates
- Consultant medical staff reviewed children's care twice daily during the weekdays and once daily ward round over weekends.
- Emergency admissions were seen and assessed by a consultant in the paediatric emergency department until 10pm. Children admitted after 10pm were seen on the consultant ward round the next day.
- There were separate rotas to cover paediatric emergencies, general paediatrics and neonates.
- Paediatric medical staffing was discussed at the woman and children's directorate meeting in July 2015.There were 2 Consultants on maternity leave and one middle grade post vacant. There were no gaps or vacancies at the Junior level. Locum medical staff were used to maintain services. Pressures on medical staffing were identified as a high risk on the directorates risk register.
- We requested further information from the Trust about paediatric medical staffing. The figures supplied by the trust showed there were 2.3 consultant vacancies at St Helier Hospital, 12 specialty registrar and 17 senior house officer vacancies. An analysis of bank and agency staff showed that between April 2014 and June 2015 between 10 and 13 posts were being filled by temporary medical staff.
- A specialty doctor's post in community paediatrics was advertised together with two locum consultants posts.
- We saw the report of an external review of medical education in 2015. At a previous visit in February 2012, there were concerns regarding the medical staffing rota and trainee supervision. A more recent visit found training opportunities had improved but the teams required continuing support from the trust to continue to develop. A recent survey of junior medical staff satisfaction found by comparison they were less satisfied with the training they received for medical handover, clinical supervision and overall clinical experience.
- We observed the medical handover on the neonatal unit and found this was an effective process. Detailed printed information about each of the babies on the unit was used to inform the discussion about each baby.

Major incident awareness and training

- Plans were in place for maintaining services in an emergency. Senior nursing staff told us they were confident the plan would enable them to continue to provide services.
- The trust contributed to resilience plans to ensure services responded to increased workload pressure during the winter period.

Are services for children and young people effective?

Requires improvement

Staff were able to access clinical guidelines on the trust's intranet but these were not always reviewed and updated. The service contributed to national audits and undertook their own local audits. Whilst the service had a process in place a number of policies and guidelines were out of date and were in need of review; the trust acknowledged that whilst the guidelines required review, the content of the expired guidelines were consistent with current practice.

Clinical audit half days took place six times a year, to allow presentations of audits which to show areas of improvement within the service, share areas of good

practice and agree actions for improvement. The minutes of audit half days highlighted any significant issues which required improvement and any the specific actions plans from each meeting.

The service had developed links with other hospitals for children who required specialist treatment. There were links to the Brompton for children with cystic fibrosis and cardiac conditions, and St George's for trauma and neurological conditions. The trust has identified the need for guidelines for improving transfer arrangements with multi-disciplinary teams in all specialities to ensuring children's needs were reviewed and documented. Similar policies and procedures were used by staff on the neonatal unit at St Helier hospital and special care baby unit at Epsom, which meant the care babies received was the same if they were transferred from special care if they needed more specialised care.

The trust aimed to achieve the London quality standards for children's services by April 2017. The service was reviewed in 2015 to assess which standards the Trust met. The London quality standards were developed to reduce variation in services arrangements and patient outcomes between hospitals and within hospitals, across weekdays and weekends.

Evidence-based care and treatment

- The neonatal unit held the World Health Organisation's baby friendly level 3 accreditation and were working alongside the maternity service are towards achieving a Bliss award. These schemes provided a way for health services to improve and maintain the best standards of care for all mothers and babies for example by promoting breastfeeding and safe bottle feeding and to strengthen mother-baby and family relationships.
- Staff accessed clinical guidelines which were stored on the trust's intranet. We reviewed a sample of the guidelines and found the neonatal guidelines had been reviewed and were shared between the St Helier and Epsom hospital sites. This meant staff were using the same policies and procedures for any babies transferred from the level 1 service at Epsom to the level 2 site at St Helier, reducing the risk of staff using different processes.
- Some guidelines were out of date and had not been reviewed for example the hypoglycaemia guidelines and prolonged rupture of membranes.
- The trust told us that although the guidelines had not been updated the guidelines being used were not unsafe. The trust informed us there was a neonatal guideline group which reviewed and approved guidelines and that nursing guidelines were approved through the senior nurse committee. Paediatric emergency guidelines were reviewed through the paediatric emergency medical board.
- The bronchiolitis guidelines referred to the National Institute for Health and Care Excellence (NICE) guidance and there were guidelines for example for diabetic ketoacidosis written by a consultant at St Helier Hospital. The asthma guidelines we reviewed were different to the ones being used at Epsom General Hospital and we did not find some guidelines, for example for cardiology. The guidelines did not include information about the process used to approve them.
- Medical staff had undertaken an audit of autism in children and young people in July 2015. The audit reviewed the care provided for 56 children and reviewed 38 care records to assess the service's level of compliance with the quality standards. The audit found high levels of compliance with the diagnostic standards but only 9% of children were followed up within the six week nationally set timescale.

Pain relief

- Children admitted to the ward received pain assessments. A review of four care records showed staff were assessing pain levels.
- Neonatal and paediatric specific pain assessment tools were being used. There was a policy for managing pain in children based on the Royal College of Nursing guidance on the "Recognition and assessment of acute pain in children". Pain scores used on the children's units include the visual analogue scale and FACES scale (Wong- Baker) for children to self-report their pain. FLACC is the tool of choice for children with cognitive impairment and complex needs and any child unable to self-report their pain score.
- We spoke with the parent of a small child who told they were happy staff had assessed their child's pain and provided pain relief when they needed it.
- The trust score "About the same" in the 2014 CQC Children's survey question: Do you think staff did everything they could to help your pain.

Services for children and young people

Nutrition and hydration

- Children nutritional needs were met. Parents said the children enjoyed the food and were able to have snacks if they were hungry.
- The trust scored "About the same" in the 2014 CQC Children's survey question: Did you like the hospital food.

Patient outcomes

- The trust aimed to achieve the London quality standards for children's services by April 2017. The service was reviewed in March 2015 to assess which standards the Trust met. The London quality standards were developed to reduce variation in services arrangements and patient outcomes between hospitals and within hospitals, across weekdays and weekends There were 20 standards for children's services. The service met 16 of the standards.
- The service contributed to several national audits which enabled outcomes to be compared with similar services elsewhere.
- The results of the asthma and epilepsy audits shows the number of emergency admissions for asthma and epilepsy were lower (better) than the England average.
- The paediatric diabetes audit showed that the number of patients with a HbA1c test result of less than 7.5% was 5% worse than the England average in 2013/14 (11.9 versus 17.1 nationally).
- The Paediatric Diabetes Audit 2013-2014 showed the median HbA1c (mmol/mol) was better than the average for Queen Mary's site.
- Staff made improvements to the service as a result of the audits. For example following review of the national diabetes audit results an information leaflet screening was provided to all patients at their first annual review and when the patient is 12 years old. Information on exercise was also added to the new diagnosis pack. Families are contacted annually and offered an appointment with a dietician.
- The neonatal unit at St Helier hospital submitted data to the national neonatal audit programme (NNAP). This national audit supported improvements in neonatal services by providing comparative information about babies who were born too early, with a low birth weight or who have a medical condition requiring specialist treatment. This was a continuous audit which required staff to submit information weekly. Each new group of doctors was informed about the data to be collected. The hospital reported three of the five audit measures as being in line with the national average.
- The service also submitted data to the Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)
- The latest report published in 2015 used data collected in 2014 on nine key areas for example temperature on admission, consultation with parents, recording blood stream and cerebrospinal fluid cultures, infections, neonatal unit transfers, retinopathy of prematurity (ROP) screening, mother's milk at discharge, clinical follow-up at two years of age. The trust was one of 174 units submitting data across England and Wales.
- Local audits included; a review of outcomes of new imaging for children with developmental delay, a re-audit - Assessment of paediatric echocardiography against national standards, an audit of guidance for inter-hospitals transfers of children requiring emergency inpatient care under the paediatric medical team, IV antibiotics in neonates

Competent staff

- Staff reported clinical supervision was good and there was a good culture of incident reporting. Induction training was mostly accessed on line.
- Junior medical staff all had supervisors and met with them when they first joined and mid-year. They said the service had made improvements as a result of feedback received and felt overall their training was good.
- Junior doctors said the paediatric radiology service was good. One doctor had been able to get an urgent MRI scan which enabled a rapid diagnosis for a baby on the neonatal unit. The paediatric neurophysiology service was also good and would test babies on the unit. Consultant cover was good and consultants were very willing to attend out of hours and at week-ends.
- Consultants undertaking surgery on children were paediatric immediate life support trained and there was training for consultants on the on-call rota to ensure all consultants were trained by April 2016.
- Nursing staff we spoke with were not aware what the trust had developed to support them with re-validation, which was scheduled to commence in 2016. The

director of nursing told us they were prepared to launch their re-validation programme and had not wanted to launch it too far ahead, because some staff would not have to go through the process until the following year.

Multidisciplinary working

- The service had developed links with other hospitals for children who required specialist treatment. The trust had identified the need to develop guidelines to improve transfer arrangements by establishing multidisciplinary teams in all specialties to ensure children's needs were fully reviewed and documented. The trust had also highlighted the need to create a comprehensive directory of email and phone contacts to facilitate patient care at consultant level.
- Child and adolescent mental health services were provided by the local mental health trust. Children and young people were assessed initially, usually in the emergency department, by a mental health liaison nurse or a specialist registrar who would decide if the young person required admission to hospital.
- Staff could call one number to access child and adolescent mental health services between the hours of 9am and 4pm seven days a week. Outside these hours, a doctor was available over the phone to risk assess the child and provide nursing and medical staff with advice. Children were admitted if required and seen the following day but not always within 12 hours of arrival or call.
- The trust's strategy for developing clinical services highlighted the need to improve the mental health services provided for children with a neurodisability.

Seven-day services

- Diagnostics services were not available at weekends.Physiotherapy services were available between 9-5 every day of the week, including weekends.
- Consultant ward rounds were held twice daily in the morning and early evening during the week and once a day at weekends. The trust had developed plans to extend the twice daily ward rounds to seven days a week.

Consent

- A consent policy was in place which was based on the Department of Health's Reference Guide to consent for Examination or Treatment, 2nd Edition (Department of Health 2009). The policy dealt with issues relating to mental capacity, the treatment of young people aged 16-17, treatment of children under the age of 14 and Gillick competencies. Gillick competences are concerned with a young person's ability understand the potential risk and benefits to make a decision about treatment. There was also guidance for staff on post mortems for a baby or child. Staff were familiar with the requirements of the policy.
- Consent to treatment was audited quarterly as part of the trust's clinical audit programme. The audit reviewed which clinicians obtained consent and whether they has received the appropriate training prior to obtaining consent particularly when this task has been delegated. The audits were completed for the directorate governance group.

Are services for children and young people caring?

Good

Parents spoke positively about the care families received and said nursing and medical staff were approachable and explained the care provided.

Staff provided care which was compassionate and empathetic. Parents told us the care was good even though staff were so busy.

The trust had participated in a patient experience survey which showed the service was better than average on six questions, similar to other trusts surveyed on 52 questions and compared less favourably on one question, The trust was one of 69 organisations which had commissioned the survey for their children's service.

Compassionate care

- We observed staff at St Helier Hospital provide compassionate care for children and families. Parents told us staff were kind and caring and provided reassurance
- Staff arranged a taxi for a child returning from another hospital rather than travelling by train. They said a train journey would be too stressful because of the child's condition.
- Families were encouraged to give feedback on their experience of using the service. The results showed 73% of those who responded would recommend the service to friends and family but the response rates were low at

16%. We saw friends and family feedback forms were available throughout children's services. The manager thought the response rates were reasonable. Staff said some families used the services often and did not wish to complete the same feedback form more than once.

- Children were encouraged to comment on the care by filling in 'Tops and Pants' cards about the things they liked and disliked. The results of the children's feedback were on display on the ward for people to read.
- The trust had participated in a patient experience survey. The report, published in March 2015, provided information about both paediatric services in the trust at Queen Mary Children's Hospital and Epsom General Hospital. The survey results were better than the average on six questions. 95% of parents felt they were treated with respect and dignity by staff compared to the average of 85 % for other Trusts. 81% of respondents felt staff communicated with the child in a way they could understand compared with an average of 67% elsewhere. 92% of parents felt that staff were always friendly compared to an average of 82% and 91% of parents felt their child was always well looked after by staff compared to an average of 82% elsewhere.
- The responses for the trust were significantly worse on one question. 25% of children felt they were not fully told what would be done during their operation compared to an average of 9% elsewhere.
- A recent children's young person's audit demonstrated parental and child satisfaction. The areas identified, which could be improved, were waiting times in the paediatric assessment unit.

Understanding and involvement of patients and those close to them

- We observed medical and nursing staff provide children and parents by explanations about the care being provided.
- In outpatients, we saw administrative staff spoke directly to children about their appointment.

Emotional support

- There was access to psychology to support child with long term conditions for example diabetes and cystic fibrosis.
- There is an annual assessment of emotional well-being for all young people with diabetes.

Are services for children and young people responsive?

Requires improvement

The service had developed a strategy for developing services based on an assessment of the strengths and weaknesses of the current services, the extent to which services met national and local objectives and met the needs of the local population. Children admitted from the emergency department were accommodated in a six bed bay if they had to wait for a bed to be available.

Parents told us they had concerns about the care of children with complex needs. The service had developed plans for a child development centre to improve diagnostic care and follow up. The trust recognised the need to ensure services were compliant with national guidelines and the statutory requirements of the 2009 Autism Act. The clinical lead for children with a learning disability had plans for improving the diagnosis and support the Trust provided. Two nurses who specialised in caring for people with a learning disability were planning to develop a strategy next year based national guidance.

St Helier Hospital provided level two neonatal care. Women who were identified as having foetuses likely to require level two neonatal care were electively transferred for delivery at St Helier and protocols were in place to stabilise and transfer other less stable neonates who unexpectedly required level 2 support.

Service planning and delivery to meet the needs of local people

- The service had developed a strategy for developing services based on an assessment of the strengths and weaknesses of the current services, the extent to which services met national and local objectives and the needs of the local population. The strategy identified the need to increase paediatric day surgery and more neonatal intensive care (NICU) level 2 care and for developing specialised services for children with attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorder (ASD) and cardiology. One of the highest priorities was development of high

dependency facilities in response to the number of children with complex needs and to reduce the need to transfer children to other hospitals for high dependency care.
- We were told there were no mechanism in place for children being involved in service design. There was also no specific adolescent services – but a transition policy was in place and the arrangements seemed well thought through with adult consultants.
- Staff were able to offer accommodation in single rooms for young people over the age of 14.

- A wide range of speciality clinics were provided to meet the needs of the population for children with asthma hearing problems, autistic spectrum disorders and attention deficit hyperactivity deficit, chronic handicapping conditions, community paediatrics, diabetes and endocrinology, epilepsy, haematology, oncology, gastroenterology, homecare team and paediatric surgery.
- Paediatric community nurses supported children with complex health problems to be cared for at home.
- The directorate recognised the need for a Child Development Centre (CDC) to develop a comprehensive assessment and treatment service for children with complex needs.
- The service had introduced paediatric assessment observation beds as part of a local resilience plan for responding to winter pressures.

Access and flow

- Children who were admitted from the emergency department could be accommodated in a six bed bay if they had to wait for a bed to be available. This six bed area was next to the main inpatient area. Children who needed tests and investigations could also be accommodated in this area which was open from 8am until 6pm. The area was also open at weekends. There were separate cubicles for children who needed to be isolated during their stay because their condition was infectious or they were at risk of contracting an infection.

- St Helier Hospital provided level two neonatal care. Women who were identified as having foetuses likely to require level two neonatal care were electively transferred for delivery at St Helier and protocols were in place to stabilise and transfer other less stable neonates who unexpectedly required level 2 support

- There were discharge planning meetings for children with complex needs in collaboration with community services.

Meeting people's individual needs

- We spoke with the parents of two different children who told us they did not feel the trust supported children with complex needs. A nurse who specialised in supporting people with a learning disability was able to provide staff with advice but there was no dedicated support for children with a learning disability. The directorate management team told us the clinical lead for children with a learning disability was working on a strategy for improving the diagnosis and support the trust provided. We discussed this with directorate managers and clinical leads who acknowledged this was an area where improvement was needed. We spoke with one of the nurse leads for learning disability who acknowledged the requirement for a trust wide approach to supporting people with a learning disability to comply with Department of Health policy.

- A parent who had brought their child for a dental X-ray told us staff had tried to take the X-ray but had failed. Their child had a learning disability. They said, "There is no way he is going to allow anyone to do any dental work while he is awake. " I am hoping they can see my child soon as they took his name off the sedation list, I wish they would just listen." "I feel no one was listening to us."
- Another parent told us, "The nurses do not have basic knowledge about children with complex needs. They said their child was on lots of medicines and did not communicate verbally. They said, "Staff should know how to communicate with children with special needs." There was no communication passport. They said, "Staff stand at the desk chatting and don't seem to consider the needs of a child who doesn't communicate verbally. There isn't much support for children with special needs and their parents."
- Medicines and dressings were stored in the treatment room. This meant a child receiving treatment was cared for in a room which was frequently accessed by staff. We observed children receiving treatment with a large number of people in the room. There were some toys to distract the child but the room was not decorated for children.
- Staff requested school work from the child's school if they were in hospital for more than a few days. The

hospital did not have an area which could be used for school work or employ a teacher. Staff said the majority of children stayed for one or a few days and so only experienced a brief interruption to their education.
- Young people told us they would have liked to have WiFi access to use during their stay.
- Parents could make a drink or have something to eat in a kitchen area designated for parents.
- There were play specialists in all areas including outpatients and inpatients.
- Child friendly information leaflets were available for head injury, bronchiolitis, epilepsy, asthma and diabetes.

- We spoke with the housekeeper who showed us the children's menu. The menu provided appealing choices for children. Children who may have missed a meal could order a snack box or a hot meal. The menus were colour coded to identify meals which were milk free, easy to eat or energy dense. Meals were frozen when they were received on the ward and warmed on the ward. The housekeeper told us they could also offer options to meet children's cultural or religious needs for example halal meat. The housekeeper said they ordered sandwiches for the evening although it was never a problem ringing for a sandwich box at night. We observed that the children did not have a dining area and meals were served in the bays. Ward staff said they would like a dining area.
- Parents often stayed with their child. Folding beds and reclining chairs were available for parents who stayed overnight. The bays on the ward were cramped particularly if a child had a lot of medical equipment and nursing staff told us it was sometimes difficult to deliver care particularly in an emergency.
- Children receiving day surgery were operated on in a well-equipped theatre on the first floor. The waiting and recovery areas had been decorated with children in mind.

Learning from complaints and concerns

- Directorate performance reports showed 50% of complaints were answered within target time. Staff sickness and an increase in the number of complex complaints had resulted in slower response times.
- We saw examples of action taken as a result of complaints. Additional training was delivered by the neonatal practice development nurse to improve communication skills. Guidelines were reviewed for monitoring of patients on oxygen. The department's transfer policy was updated. A 'Traffic Light' risk assessment system was in place to assess type of escort required.

Are services for children and young people well-led?

Requires improvement

The trust had developed a strategy for clinical services, approved by the board in November 2014. The strategy outlined plans for paediatrics including the development of the Royal College of Paediatric and Child Health 'Facing the Future' model for acute paediatrics care.

A further business and service strategy had been developed in September 2015 which had not yet been considered by the trust's board.

Uncertainty about the future structure of the trust had contributed to difficulties recruiting and retaining staff resulting in staffing pressures on the ward. Developing a strategy for the service had also been problematic without clarity about the organisation's future. Managers had responded to the uncertainty by developing a five-year strategy.

165 children and parents had responded to a patient experience survey commissioned by the trust. The survey provided valuable feedback and comparisons about children's services on both the St Helier and Epsom sites. The service compared better on six questions, about the same on 52 and worse on one.

An executive director provided board level leadership for children's services. Paediatric services were part of the Women and Children's Directorate with clinical leadership from a consultant obstetrician and a consultant paediatrician.

Vision and strategy for this service

- The trust had developed a clinical strategy which had been approved by the board in November 2014. The strategy outlined plans for paediatrics including developing the Royal College of Paediatric and Child Health 'Facing the Future' model of acute paediatrics care. The plans included increasing paediatric day surgery and neonatal intensive care unit level 2 care,

developing specialist services for example for children with attention deficit hyperactivity disorder (ADHD) autistic spectrum disorder, and cardiology. The development of high dependency facilities was also planned in recognition of the number of children with complex needs requiring higher levels of care and the risks associated with transferring children to other specialist units.

- A combined clinical and business strategy had been developed in October 2015 which was due to be considered by the trust board. A series of internal focus group meetings had reviewed services. Staff had been able to contribute to the development of the strategy although there had not been any formal consultation meetings. Few staff were aware of the strategy or what it contained.

Governance, risk management and quality measurement

- A monthly quality report was produced which reviewed trends in incidents and any associated risks. The trust told us the directorate management team had overall responsibility for governance within the directorate. The directorate management team included the head of nursing, clinical director and general manager.
- Directorate managers discussed governance issues at a monthly local governance meeting which reported into clinical quality and assurance committee, and paediatric emergency medicine board (PEMB), paediatric surgical committee and trust safeguarding committee. The Trust Paediatric Emergency Medicine Board (PEMB) and The Paediatric Surgical Committee (PSC) met quarterly to ensure appropriate clinical governance issues were addressed. The groups discussed audit results, complaints, incident reports patients and carer's views and experiences.
- The directorate management team reviewed their risk register and to improve the process for capturing risks identified by staff and managers. 12 out of a total of 36 risks for children's services had passed their review date. The risk register recorded concerns about unwell children requiring high dependency care as a high risk; because if they could not be transferred to a high dependency unit, they had to remain in the emergency department until their condition stabilised. The risk register also highlighted concerns about the adequacy of ward staffing levels for looking after children who required high dependency care. To reduce the risk, there was a process in place for liaison and discussion with the regional paediatric intensive care unit and the subsequent transfer of children needing this facility. An escalation process was agreed for senior nurses to manage the risk and adjust staffing accordingly.
- A quality scorecard provided directorate management teams and the board with information about staffing levels, training, patient safety issues such as incidents, clinical effectiveness for example compliance with clinical guidelines and patient experience feedback from the friends and family test.
- Records of the women and child health directorate performance meetings showed clinical quality, clinical governance, performance, workforce and strategy issues were discussed monthly by the service's leadership team.
- Women and Children's Directorate monthly business report monitored risk and recorded changes or updates to the risk register. Infection rates, incidents, staff sickness, performance against targets, use of bank and agency staff were reviewed.
- The service had produced an annual quality report in July 2015 for the year 2014-2015. This analysed the severity of incidents during the year. The main types of incidents were related to medicines, health records, safeguarding children, care and treatment, issues around lack of staffing and one issue around security.
- The most serious incidents were highlighted. These included a cardiac arrest during elective change of tracheostomy tube and a preventable hospital acquired pressure ulcer. The incidents had all been investigated and reports on the learning disseminated to staff. They were included in the quality report to help identify if there were any similarities or trends when compared to other years. A list of incidents which would trigger an incident report for community and hospital was included. There was an analysis of complaints and the actions taken by the service as a result.
- Risk meetings were also held monthly which reviewed incidents, audited compliance with the world health organisation surgical checklists, the results of other local and national audits, updates to the risk register, safeguarding issues, medical devices alerts and national patient safety alerts.

Services for children and young people

Leadership of service

- Children's services were managed as part of the Women and Children's Directorate. There were clinical and nursing leads for both sites who met regularly as part of the directorate management team.
- An executive director had been identified to provide board level leadership for children's services. They said they recently agreed to take on the role but it was not clear how this would fit together with their other responsibilities. There was no non executive lead at board level for the service. The director of nursing was responsible for safeguarding across the trust.
- Clinical leads were working closely to integrate working arrangements across the two trust sites, for example bringing guidelines together. They told us uncertainty about the future of the organisation had led to delays in addressing strategic objectives, but they were keen to develop more joint working between the sites. They had made a start, but acknowledged there was still considerable work to be done.

Culture within the service

- Staff were proud to work in the service, but told us uncertainty about the future of the trust had contributed to difficulties recruiting and retaining staff. This in turn led to staffing pressures on the ward. Some staff felt managers were responding to these concerns, for example by developing a five year strategy setting out a future for the service which would consolidate and expand the role of the paediatric service for the local community.
- Staff felt positive about the future whilst recognising that problems with the buildings and split site working meant the creation of an integrated service across two sites was a sizeable challenge. Staff supported integration and told us they were developing closer working links and working flexibly across sites.

Innovation, improvement and sustainability

- The trust actively participated in the South West London Provider Collaborative. This was a programme of work involving four south west London acute trusts had working together to develop sustainable, high quality clinical, financially viable services
- The service aimed to meet the London Quality Standards for children's services by April 2017. There were 21 standards relating to a range of quality standards for example providing seven day services.
- The service was working with partners to develop the care for children with complex and acute needs to be nursed within the community.
- The service was developing a community neonatal team to support families once they left hospital. The service implemented a quality improvement in 2014-2015 for increasing number of premature babies having retinal screening for premature babies. The target was 90% for babies with a birth weight of weighing less than 1501g or less than 32 weeks gestation. Retinopathy of prematurity (ROP) is one of the few causes of childhood visual disability which is largely preventable
- The service planned to improve the discharge for babies under 36 weeks gestation resulting by providing more support in the community in increased capacity within the service for mothers who have booked to have their baby at the hospital and for babies who needed to be cared for by the neonatal service. The scheme is an NHS England initiative. The service was planning to submit information to the paediatric safety thermometer by establishing the process for data collection and agreeing targets for harm reduction with commissioners.

End of life care

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

Information about the service

The trust's Specialist Palliative Care Team (SPCT) provided patient-centred advisory services to any patient with progressive illness in need of specialist support across the two hospitals of the trust. The team consisted of three consultants, one middle grade doctor, two junior doctors, seven palliative care clinical nurse specialists and two social workers. Medical and nursing staff referred patients to the SPCT for symptom management.

Specialist palliative care was provided as part of an integrated service across both St Helier Hospital and Epsom Hospital. The SPCT worked six days a week, 9am to 5pm Monday to Saturday, and the consultant was on-call out-of-hours and at weekends. The trust had secured Macmillan funding to expand the number of clinical nurse specialists and were planning to start a seven-day service in January 2016. The SPCT worked closely with the chaplaincy team and they provided spiritual and religious support to patients and their families 24 hours a day.

During the inspection, we visited various wards that provided palliative and end of life care(EOLC), including A6, A5, B5, B4, C6, C5, C4 and C3. Weobserved end of life care and treatment and reviewed 12 sets of medical/nursing records. We also visited the bereavement office, multi-faith centre and mortuary. We spoke with three palliative care medical consultants, junior ward doctors, head of nursing, matrons, palliative care clinical nurse specialists, registered nurses, bereavement officers, matrons, porters, mortuary staff and the hospital chaplain in order to assess how end of life care was delivered. We also spoke with 12 patients and their relatives about their experience of end of life care at the hospital.

The SPCT was actively involved in ward based formal and informal staff education on EOLC. They had delivered educational courses and presented at medical and nursing team meetings as well as had designed an end of life care resource folder for ward based teams.

End of life care

Summary of findings

The Specialist Palliative Care (SPCT) team provided end of life care and support six days a week, with on call rota covering out-of-hours. There was visible clinical leadership resulting in a well-developed, motivated team.

Patients told us the ward based staff and the palliative care clinical nurse specialists were caring and compassionate and we saw the service was responsive to patients' needs. The SPCT responded promptly to referrals. There was fast track discharge for patients at the end of life wishing to be at home or their preferred place of death.

Staff throughout the hospital knew how to make referrals to the SPCT and referred people appropriately. The team assessed patients promptly, to meet patient needs. The chaplaincy and bereavement service supported patients' and families' emotional and spiritual needs when people were at the end of life.

Most hospital staff were complimentary about the support they received from the SPCT. Junior doctors particularly appreciated their support and advice, and said they could access the SPCT at any time during the day. They recognised that the SPCT worked hard to ensure that end of life care was well embedded in the trust.

The director of nursing had taken the executive lead role for end of life care, along with a non-executive director (NED), to ensure issues and concerns were raised and highlighted at board level. The trust's board received EOLC reports, outlining progress against key priorities within the EOLC strategy, including audit findings, themes from complaints and incidents, evidence of learning and compliance with end of life training requirements.

The SPCT provided a rapid response to referrals, assessed most patients within one working day. Their services included symptom control and support for patients and families, advise on spiritual and religious needs and fast-track discharge for patients wanting to die at home.

The National Care of the Dying Audit 2013/2014 (NCDAH) demonstrated that the trust had not achieved three out of seven organisational key performance indicators. We saw evidence of the implementation of action plans for the three KPIs which were not achieved.

At the time of the inspection, the trust had not fully rolled out the replacement of the LCP, and this delay meant that staff were not fully supported to deliver best practice care to patients who were dying. The leadership failed to apply enough urgency to have an individual plan of care in place.

End of life care

Are end of life care services safe?

Good

There were procedures in place to support safe care for patients at the end of their life. The processes for incident reporting and investigation appeared robust, and staff were aware of their responsibilities to report incidents. Learning from incidents were shared with staff. The EOLC strategy board and clinical governance committee discussed learning from incidents at their meetings.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were generally completed consistently, following a discussions with the patients and their families. Attendance at palliative care and end of life care training by general ward nurses was only 85%. The trust target for mandatory training was 95%, however palliative care and EOLC training was not mandatory for general ward staff.

Staff prescribed and administered medicines in line with national guidance and we saw good practice in prescribing anticipatory medicines for patient's at the end of their life. We saw specialist palliative care nurses worked closely with medical staff to ensure appropriate prescribing for patients at the end of their life, including the use of local guidance for alternative prescribing for patients with renal impairment.

Incidents

- All staff we spoke with knew how to report an incident and described the electronic incident reporting system to us. Staff told us they received an acknowledgement and feedback on incidents they had reported.
- SPCT members told us incidents were discussed at the weekly team meetings and action plans and learning arising from an incident were disseminated to ward based staff at handovers. The action plans were available to staff on the ward in incident report folders.
- Staff told us of learning which had resulted from incidents; this involved the use of syringe drivers and the recommendations for priming them. We saw that written advice was produced and shared with staff.

Duty of Candour

- Managers and senior staff had a good understanding of Duty of Candour and had attended relevant training about their responsibilities in disclosing to patients when an incident has occurred that could cause harm.

Medicines

- The trust had its own medicine guidelines for prescribing medicines at the end of life, based on National Institute for Health and Care Excellence (NICE) guidance.
- Some of the clinical nurse specialists within the SPCT were nurse prescribers and supported junior medical staff in prescribing medicines at the end of life. We observed nurses working closely with medical staff on the wards to support the prescription of anticipatory medicines at the end of life (medication that patients may need to make them more comfortable). Junior doctors told us prescribing the appropriate end of life medicines was made easier because of the guidelines, alongside the fixed set of anticipatory medicines.
- We examined the records of nine patients receiving end of life care and found nursing staff had administered prescribed anticipatory medicines appropriately.
- The SPCT and the nursing staff told us the system for prescribing EOLC medicines was effective and they were confident patients would receive the appropriate medication even at short notice.
- Standardised syringe drivers were used to administer regular and continuous EOLC medicines to patients who needed them. Nursing staff told us the syringe drivers were always available when needed from the medical equipment library.
- Nursing staff told us there were adequate stocks of appropriate medicines for end of life care available including controlled drugs and these were stored and managed appropriately in line with national guidance and trust policy.
- Consultants from the SPCT worked across the community and at the local hospices, which improved safety and continuity of patients care in the community.

Records

- We reviewed the arrangements for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR).The community DNACPR was not legal in the hospital and vice versa. When a patient was admitted with a community DNACPR, hospital doctors completed another DNACPR form. When the patients were

discharged home, their GP had to visit them at home to complete another DNACPR form. The London-wide unified DNACPR documentation is expected to be agreed in 2016 and this would be valid in both hospital and community settings when that happens.

- We reviewed eight sets DNACPR forms and all of them were completed accurately with notes about the discussions with family. Patients' notes included records of discussions about DNACPR with patients and relatives. In all cases, we saw decisions were dated and kept at the front of the patient's file.
- The SPCT were responsible for completing advanced care planning and we saw evidence of this in use in the hospital. However, some nurses on the ward were not aware of advanced care planning completed for their patients by the SPCT.
- Patients' healthcare records were stored in a secure trolley that promoted confidentiality and were kept at the nurse's station. Nursing observations records were stored at each individual patient's bed space.
- The bereavement office kept records of all hospital deaths and funerals that was organised by the hospital when there was no next of kin or means for families to arrange a funeral.
- Deceased information recording systems were in place in the mortuary to ensure details were kept accurately. Deceased people with similar names were flagged up to avoid mix up
- We viewed records that included detailed information about the management and control of symptoms, interventions and discussions with the patient and their relatives. We also saw that when patients were seen by the specialist palliative care team information and advice was clearly recorded so that nursing staff could easily access the guidance given and planned patients care accordingly.

Safeguarding

- Staff we spoke with had a sound understanding of their responsibility in relation to safeguarding adults. The trust had a dedicated adult safeguarding lead nurse.
- There were adult safeguarding policies and procedures in place. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.
- The SPCT members had attended mandatory safeguarding training for both vulnerable adults and children.
- Senior managers told us safeguarding training was mandatory and most of the staff we spoke with were provided with safeguarding level two training as part of their mandatory training.

Mandatory training

- Newly recruited nursing staff received training on end of life care on induction, as a part of the mandatory training.
- The specialist palliative care team offered a rolling education programme on end of life care for all staff. We saw evidence of staff attendance at the training.
- Syringe driver training was not mandatory for ward staff, but new nursing staff were trained as part of their competencies working with EOLC patients and were required to complete it. The nursing staff we spoke with confirmed that, they were trained in the use of syringe driver for administration of medicines. They were trained by the senior nurses on the ward or the SPCT and were assessed as competent in syringe driver medicines administration.
- We spoke with overseas nurses about their adaptation and overall training at the hospital, and they confirmed they had been provided with end of life care training as part of their induction and they had booked onto different palliative care and EOLC study days.

Assessing and responding to patient risk

- The SPCT received referrals from the doctors and nurses to see EOLC patients The team responded to referrals within 12 - 24 hours of the referral being received. Patients were assessed for treatment by the SPCT to ensure an appropriate care and treatment was provided as soon as the referral was received.
- The SPCT held a weekly team meeting to discuss ongoing patient care.
- The trust used an early warning score (NEWS) which highlighted if escalation of care was required. Additionally, they used an electronic system for recording patient's clinical observations called Vitalpac. Paper documentation was used for indwelling devices such as central lines and catheters.
- Ward staff told us the SPCT had a visible presence on the wards and changes to patient's conditions prompted a visit by the SPCT. We saw patients' daily notes by nursing, medical and therapy staff with updates on changes recorded clearly.
- For patients where the deterioration of their illness was clear, the amount of medical intervention was reduced

to a minimum. Care plans were based on ensuring the person remained as comfortable as possible, at all times. Proactive, anticipatory care plans were put in place to ensure that non-specialist staff were aware of the best way to manage symptoms that were likely to present as part of the illness's progression.

Nursing staffing

- The hospital had eight specialist palliative care nurses, equating to seven WTE specialist palliative care nurses working on a full time basis; they supported cancer and terminal ill patients in the hospital.
- Nursing staff we spoke with confirmed there were always sufficient staff nurses to ensure that people who were very close to the end of life would have a dedicated member of staff with them at all times. Ward staff routinely provided end of life care with specialist support from SPCT.
- We were told there were no end of life care link nurses on individual wards.

Medical staffing

- The SPCT had 2.9 WTE equivalent consultants in post; two consultants covered St Helier Hospital and the other covered Epsom General Hospital. Two of the consultants in palliative medicine held joint posts with the local hospices and a consultant from a local hospice did a single session at the hospital. Middle grade doctors supported the consultants.
- Most of the consultants were working across hospitals, the community and the local hospices, allowing for improved continuity and management of patients.
- The palliative medicine consultants were able to demonstrate continued professional development in line with the requirements of revalidation by the General Medical Council.

Major incident awareness and training

- The mortuary had a business continuity and escalation plan available for staff to reference. Mortuary staff we spoke with were aware of this plan. The mortuary manager informed us about the surge and escalation plans contained in their business continuity plan. This meant that should there be a sudden surge in demand for refrigerated mortuary space, the trust had an agreement with local undertakers to provide additional facilities or to transfer bodies to other trust's locations.
- Each ward had a plan for evacuating patients safely in the event of a major incident. Staff told us their procedures for major incidents such as fire, had been tested to ensure that they were fit for purpose.

Are end of life care services effective?

Good

The SPCT were following best practice guidance and provided advice and support to staff at all wards. Nursing staff on the wards provided care with tools and pathway to assist them. Trainees and new staff received EOLC training from the SPCT.

The trust was not fully compliant with all the Key Performance Indicators (KPIs) of the National Care of the Dying Audit (NCDAH) for 2013 – 2014; they achieved four out of seven KPIs. The end of life care policies and procedures were in line with the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care for Adults.

There was monitoring of patient outcomes in relation to end of life care taking place across the trust. There was an action plan to address the three 'not achieved' areas of the National Care of the Dying Audit for Hospitals (NCDAH) for 2013 -2014. The action plan showed that the trust had implemented their action to address the three 'not achieved' areas of the National Care of the Dying Audit Hospitals (NCDAH) for 2013-2014.

When staff identified patients as lacking the mental capacity to be involved in DNACPR decisions, they consulted family members about decisions taken in patients' best interest. However, staff were not recording mental capacity assessments in relation to DNACPR decisions.

The SPCT was a multidisciplinary team and as such when supporting referred patients all contributed to their care and treatment.

Evidence-based care and treatment

- The trust had in place end of life care policies and procedures, which were based on the Department of Health's End of Life Strategy 2008, Quality Markers and Measures for End of Life Care, NICE Quality Standards for

End of life care

End of life Care for Adults, the Report of the Independent Review of Liverpool Care Pathway – "More Care Less Pathway" and finally the Report of the Leadership Alliance for End of Life Care.

- The trust participated in the NCDAH in 2013/2014. The report published in 2014 showed the trust had not achieved three out of seven of the organisational key performance targets. The trust's executive lead spoke of their future aspirations to address the outcomes. We saw evidence of the implementation of action plans for the three KPI's which were not achieved.
- Funding had been secured from Macmillan to support a seven day face to face palliative care service and a dedicated non-executive board member had been appointed to the EOLC Strategy Board.
- The trust had taken action in response to the 2013 review of the Liverpool Care Pathway (LCP), removed it from use and developed the Priorities for Care of the Dying – Duties and Responsibilities of health and care staff. The palliative care specialist nurses told us it was a tool for staff to provide a holistic approach to care for patients in the last days and hours of their life.
- However, only one ward at St Helier Hospital had piloted the tool in the last two months and not all nursing staff at the hospital were aware of this tool or the pilot. The SPCT hoped to roll out the tool after it had completed the pilot.
- The care plans for end of life patients were based on the Five Priorities of Care (One Chance To Get It Right").

Pain relief

- Ward staff had ready access to pain relief to use for end of life care patients. We saw evidence that pain relief was being given, but did not see much evidence that's its effects were being monitored, for example site, intensity and type of pain.
- Patients we saw appeared to be comfortable and pain-free.When we spoke to family members they confirmed their relatives were pain-free.
- Some staff described how they would assess pain in patients who couldn't communicate such as; through observations of behaviour, facial expressions and movements.
- Doctors we spoke with confirmed they were aware of the pain management guidance available to them and were familiar with contacting the SPCT for advice.

Nutrition and hydration

- Patients told us they were happy with the quality and quantity of the food and felt they had plenty to drink. One patient told us, 'the food is very good especially the different types of food provided' and we saw patients being offered drinks at regular intervals.
- Staff providing end of life care were aware of the requirements for nutrition and hydration at the end of a person's life; this included the option of clinically assisted feeding.
- We noted that assessments of patient's hydration and nutrition needs were completed. Families were informed and understood when their relatives who were actively dying had a reduced interest in food and drink and this was documented in their medical notes.
- The trust scored 54% in the 2013/2014 NCDAH review of the patient's nutritional requirements, which was better than the England average of 41%. With the hydration requirements, the trust scored 64%, which was better than the England average of 50%. We requested a location specific data; however, the trust was not able to provide us with such data.

Patient outcomes

- The trust supported patients to achieve their preferred place of death, either through fast track discharge home, hospice or nursing home, or by ensuring that high quality end of life care was provided for patients who wished to die at the hospital.
- The trust had systems that ensured that there was timely identification of people needing EOLC on admission or who moved from active treatment to palliative or end of life care whilst as an inpatient at the hospital.
- In the NCDAH of 2013/2014 the trust scored 64% for reviewing interventions during a patient's dying phase, which was better than the England average of 56%. They scored 86% for reviewing the number of assessments undertaken in the patient's last 24 hours of life, which was better than the England average of 82%. We requested a location specific data; however, the trust was not able to provide us with such data.

Competent staff

- The palliative care specialists provided formal and informal EOLC training to junior doctors and nursing staff.

End of life care

- Most of the nurses we spoke with demonstrated a good knowledge of planning care for EOLC patients and were clear about when to seek input from the specialist palliative care team.
- Nursing staff told us they were given the opportunity to attend end of life care training and some had received an update on the priorities of care.
- Mortuary staff trained porters on how to handle bodies with dignity and care. There were procedures and protocols within the mortuary area for safe back care of staff.
- The SPCT provided us with their training programme for end of life care. We were told the training was often not well attended, as nurses found it difficult to be released from the wards for to attend training sessions. Some nursing staff told us there were limited opportunities to attend some of the EOLC training due to staffing shortages across the trust. The team also supported staff informally whilst on the wards.
- The SPCT maintained records of staff who had attended end of life care training. For example, we saw that 503 clinical staff across the trust had attended EOLC training.
- The mortuary technician we spoke with was able to clearly explain their role and responsibilities. They told us they had attended mandatory training. They had also attended other specific training that supported them in their role such as advanced communication with bereaved relatives.
- One of the key component of the SPCT teaching programme was educating nursing and medical staff on the fast track discharge process. Whilst the SPCT were instrumental in supporting the fast track process, discharges were driven by the ward clinical team.

Multidisciplinary working

- Members of the SPCT participated in multidisciplinary team (MDT) meetings; they worked with other specialists to provide good quality end of life care across clinical specialities.A weekly specialist SPCT MDT meeting was held at the hospital. Members of the MDT included consultants, CNS, social worker, end of life care administrative staff, and a Chaplin.
- Discussion at the MDT included all new patients referred to the SPCT, patients who had died or been discharged from the service, patients of particular concern where a team member sought support and advice from the team.
- The SPCT met on a weekly basis at a multidisciplinary team (MDT) meeting to discuss all incidents, referrals, changes in patients' condition, discharges and deaths of patients they were involved with. We attended one of the meetings and were shown minutes of previous meetings and other governance meetings; they included feedback from clinical incidents in hospital and the community.
- The MDT worked well together to ensure that patients care and treatment was planned and co-ordinated. We noted that patients had good holistic assessment and there was evidence of emotional support and anticipatory prescribing to support patients.
- The bereavement office reported good working relationships with the wards, CNS, chaplaincy and mortuary staff. They also had easy access to the coroners and mortuary staff.
- The bereavement office received a daily list of patients who had died in the hospital the previous day. The medical notes were delivered to the office and checks would be made with the ward doctors to find out whether any case needed to be referred to the coroner's office.
- The chaplaincy team told us they worked together with the SPCT in the development of the end of life care plan.
- The 2014 NCDAH, the trust achieved 73% for multi-disciplinary recognition that a patient was dying compared to the England average of 61%. We requested a location specific data; however, the trust was not able to provide us with such data.

Seven-day services

- The palliative care specialists were available at the hospital during working hours from Monday to Saturday. The trust operated a 9am to 5pm visiting CNS service six days a week, Monday to Saturday, and a 9am to 5pm Monday to Friday for medical work, administrative support and social work service.
- The trust was working towards a seven day 9am to 5pm CNS visiting service from January 2016 and had already secured a funding from the Macmillan Cancer services.
- There was a medical consultant on-call for advice andattended the hospital if required during out-of-hours.
- The SPCT told us, nurses and doctors needing support on Sundays to care for end of life patients had to manage with telephone support only. Ward staff we

spoke with told us the Sunday arrangements was satisfactory as they can always get support over the phone and had not experience any problems in the past.

Access to information

- We were given a copy of the bereavement pack which were given to relatives when they collected the death certificate and other belongings from the hospital. The pack had useful information about what procedures to follow and gave some bereavement advice.
- The SPCT, the chaplaincy team, medical and nursing teams had access to patients' records. We saw risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant care plans to meet their individual needs.
- The community DNACPR was not recognised at the hospital and the hospital DNACPR was also not recognised at the community. This might mean hospital staff providing treatment and/or resuscitation to patients unnecessarily when they attended the hospital in an emergency. Staff told us there was a need for better liaison between the hospital, community and GPs to ensure best practice and adhere to people's wishes. The London-wide unified DNACPR documentationwas expected to be agreed in 2016 and this would be valid in both hospital and community settings when that happens.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing staff had undertaken Mental Capacity Act (MCA) and Deprivation of Liberty Standards (DoLS) training, and they understood and described to us what mental capacity assessment meant.
- We observed that medical and nursing staff, prior to any intervention with patients, asked for their consent where the patient was able to communicate.
- The SPCT members demonstrated an awareness of the issues around mental capacity and best interest decision making, and all the SPCT members had attended MCA and DoLS training.
- We examined eight DNACPR records and all them had a mental capacity assessment form completed appropriately.
- A current mental capacity assessment tool was available at the hospital and used as part of the DNACPR discussion where patient's capacity was in question. We spoke with medical and nursing staff, and they all had mixed views with regard to when a mental capacity assessment should be undertaken. Some nurses were clear when mental capacity was lacking, an assessment should be undertaken, and others thought it was the doctor's decision to ensure that mental capacity assessment had been completed.

Are end of life care services caring?

Good

Staff at St Helier Hospital provided dignified and compassionate EOLC to patients. We saw staff were committed to providing good care to patients that focussed on meeting their holistic needs. There was good recognition of the importance of family and friends during the last days and hours of life.

We found the care and support given to relatives after the death of their family member by the mortuary staff, chaplaincy team and the bereavement officer to be good. Feedback from patients and relatives was entirely positive about the care they had received.

The chaplaincy team supported ward staff and other professionals delivering end of life care. The chaplain attended the SPCT MDT meetings and was part of the team that developed the end of life strategy of the trust.

We were told that when the SPCT were involved in the care of the dying patient, the patient and relatives received a good level of care, felt involved in discussions and decisions; and had a clear understanding of the support being given to them.

Nursing staff in all the wards we visited demonstrated a commitment to providing a high quality service to their patients. We saw examples of MDT working when patients were identified as needing fast track discharge so that they could reach their preferred place of death.

Compassionate care

- Staff were caring and compassionate and understood the need for sensitive communication with patients who were approaching their end of life. We observed interactions between staff and patients were caring, dignified and respectful.

End of life care

- Nursing staff were aware of patients who were receiving end of life care. They were able to discuss their needs and the support that they required. They showed a good understanding and demonstrated compassion and respect.
- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly and patients told us they were looked after well.
- Where possible, staff cared for patients at the end of life in a side room to ensure that their dignity was maintained.
- The bereavement office staff told us they contacted each bereaved family and met them when they collected the cause of death certificate and their loved ones belongings from the office.
- We were told how respectful hospital porters were when caring for the deceased before they were transferred to the mortuary. Hospital staff treated the deceased with dignity and respect, and we saw that mortuary staff referred to the deceased in a respectful manner.

Understanding and involvement of patients and those close to them

- Patients told us they were informed about their care and understood the treatment and choices available to them. We were told by a relative of EOLC patient that medical and nursing staff had fully explained to them the care and prognosis of their loved one.
- Patients and their families we spoke with told us they felt involved in their care and treatment.
- We saw visiting hours were relaxed for family and friends when patients were at the end of life and this allowed the relative to visit at any time. We noted that relatives were able to stay with patients at the end of life if they wished.
- We saw that staff discussed care issues with patients and relatives where possible and documented these conversations in patient's notes. We observed the specialist palliative care nurses asking patients about their wishes and choices, for example about where they preferred to be cared for.
- We saw information readily available offering advice for relatives with guidance on viewing arrangements, how to register a death and details of funeral directors.

Emotional support

- The SPCT, the chaplaincy and bereavement officers were available to provide support for families and carers during the day, including out-of-hours. The team provided a dedicated service, which supported people through the end of life process.
- We observed that most patients who were dying had family members with them, so they could support their relatives and start the grieving process.
- We saw that visiting times were flexible for family and friends when patients were at the end of life and we saw that relatives were able to stay with patients at the end of life if they wished.
- The bereavement office supported relatives/friends after the patient's death by explaining all the legal processes, and what to expect after someone has died. The bereavement officers told us they always supported families or friends wishing to see the deceased by accompanying them to the chapel of rest.
- There was a chapel and multi-faith room available for patients, staff and visitors. The chaplaincy services within the trust were geared towards providing emotional support to patients and their relatives irrespective of their individual faith or if they did had no faith.

Are end of life care services responsive?

Good

The trust had an EOLC Strategy Board, which met quarterly to discuss service planning and delivery, audits and action plans and training needs for staff involved in EOLC. There were weekly EOLC MDT meetings to discuss end of life care issues and the opportunity to update staff on new initiatives, training and share information around end of life care in the ward area. The trust had an EOLC guidance for handling complaints, which includes reviewing complaints and concerns from relatives about end of life care.

Fast track discharge protocols and processes were in place, and were effective in getting people to their preferred place of care prior to their death. The hospital engaged and worked with local commissioners of services, the local authority and other providers to coordinate care and facilitated access to appropriate services.

End of life care

The DNACPR records we looked at had documented that appropriate discussions had taken place with relatives regarding the decision.

Relatives were able to stay with the patient in a side room should they request to do so. The bereavement and mortuary services took into account people's religious customs and beliefs, and were flexible around people's needs such as releasing the body and providing death certificates within 24-hours.

The trust had a multi-faith room where all faiths were welcome. There were also a number of chaplains from different denominations.

Service planning and delivery to meet the needs of local people

- The SPCT provided a fast-track discharge for patients who wished to die at home, in a hospice or nursing home. Staff told us they facilitated and supported patients who wished to die in their place of choice.
- The trust had an EOLC Strategy Board, which met quarterly to discuss service planning and delivery, audits and action plans and training needs for staff involved in EOLC.
- There were weekly EOLC MDT meetings to discuss end of life care issues and the opportunity to update staff on new initiatives, training and share information around end of life care in the ward area.
- The SPCT received referrals from many specialties within the hospital, with the medical division being the largest user. The hospital did not record the number of patients dying in their preferred location. Staff said one of the reasons for this was that sometimes patients were not fully aware of their prognosis so staff did want to ask. Clinical leadership confirmed that this was an area of improvement for the trust and they were currently auditing it.

Meeting people's individual needs

- We observed the SPCT supporting patients who had complex needs and they utilised appropriate members of the SPCT to access specialist input for patients including social workers and chaplain.
- The bereavement and mortuary services took into account people's religious beliefs and customs, and were flexible around people's wishes such as releasing the body within 24-hours of death. Death certificates could be issued within 24-hours if everything was in order.
- The trust had a protocol with the coroners to ensure bodies were released to family members promptly to comply with religious and cultural obligations.
- The emergency department had a relative's and viewing room for families who wished to spend time with the deceased. There was a dedicated viewing room in the mortuary with a waiting area. The room was well decorated, clean and tidy and had no religious signs or symbols.
- Information leaflets from the bereavement office on what to do after a death were not available in any alternative languages or formats. Staff said they may ask the interpreters to translate information if needed. Interpreters were available when needed and staff had access to a language line for interpretation services.
- The trust did not achieved NCDAH 2013-2014 on access to specialist support for care in the last hours or days of life. This was because they did not provide face-to-face specialist palliative care services from 9am to 5pm seven days a week, despite the national recommendation that this should be provided. However, there was a six days a week CNS services and a 24 hour access to on-call advice from the consultants. We requested a location specific data; however, the trust was not able to provide us with such data.
- The SPCT supported teams to communicate clearly with the patients, their family and primary care providers. The SPCT also supported trust discharge co-ordinators in the completion of fast track documentation and liaised with the required primary care service through their close links with the community palliative care services and the hospices.
- Chaplaincy service sat the hospital was particularly good at meeting the needs of people receiving EOLC. There was also good links to other religions, with a local Rabbi providing support to Jewish patients and a Muslim Chaplin providing support to Muslim patients. The newly developed Priorities for the Care of the Dying patients care plans, included a section to demonstrate that people's spiritual needs had been assessed and chaplains wrote in the patients' records when they had visited the patients
- Relatives and friends could arrange an appointment to view their family member's body. This was usually organised through the bereavement office or with the ward staff during out-of-hours. The ward staff and the porters accompanied them to the chapel of rest for the viewing.

End of life care

- The bereavement office managed funerals for people without a next of kin. They planned and organised a dignified funeral for the deceased.

Access and flow

- The SPCT received 1,203 referrals from April 2014 – March 2015. The patient referrals included 58% who had a cancer and 42% who had other terminal illnesses
- The SPCT told us the team saw patient nearing the end of life if referred by their medical or the nursing team. We saw that the team reviewed referrals within hours, and team members visited the patient and provided support to both patient and ward staff. The SPCT saw approximately 90% of all EOLC patients who were referred to them for end of life care support and symptom management.
- Most patients referred to the SPCT also had a referral to other services including chaplaincy and discharge coordinators.
- The SPCT received referrals from any hospital team and also from community teams. They accepted referrals for any adult patient who needed specialist palliative care input. They also provided telephone support and signposting for teams who only required advice. Referrals were picked up throughout the day by the SPCT.
- We spoke with the SPCT and they told us of their commitment to ensure patients' symptoms could be stabilised and patients could be discharged quickly to ensure that they were able to end their life in a place they had identified in their advanced care plan.
- We saw fast track discharge planning which supported the fast track discharge of patients who wanted to end their lives in their own home or other place of their choice. Fast track discharge protocols and processes were in place, and were seen to be effective in getting people to their preferred place of care prior to their death.
- Fast Track discharge numbers were rapidly increasing: The hospital initiated 237 fast track discharges in from April 2014 – June 2015 compared to 76 in 2012/13, and out of the 237 initiated fast track discharges, 160 patients were successfully discharged to their preferred place of care.
- We observed specialist palliative care nurses assessing and monitoring patient's needs as part of their daily work. We noted that patient care was individualised and observed discussions around care and treatment decisions with patients and their families that demonstrated this.
- We saw that advance care planning (ACP) was one of the trust's priorities in strengthening the EOLC services, however did not see any specific ACP documentation in use on the wards but SPCT staff told us this was an area they were working on.
- Where possible, patients at the end of life were given the option to move to a side room to ensure their privacy and dignity were maintained and to have quality time with their relatives and loved ones. One ward manager we spoke with told us they would ring around to find a side room for patient's at the end of life.
- The SPCT received referrals daily from the hospital staff. Urgent referrals were responded to within hours of the referral been received by the team from Monday to Friday. Others patients were responded to within 24 hours. Most of the referrals came from the clinical staff. Nursing staff told us the circumstances under which they made referrals to the SPCT were symptom control and pain management for patients who were deemed as nearing the end of life.

Learning from complaints and concerns

- Patient Advice and Liaison Services team (PALS) told us they had not received any complaints specifically about patients receiving EOLC.
- Nursing staff directed families and relatives to the PALS office for support to make a complaint or to request a meeting with the senior medical officer if they had concerns. PALS staff directed families and relatives to the medical team if they were not happy with, or did not understand their relative's cause of death.
- The bereavement officer also offered meetings for families who have struggled with medical events leading to bereavement to discuss issues with healthcare professionals involved. The SPCT were involved to discuss issues with families through these meetings.
- The trust had EOLC guidance for handling complaints, which included reviewing complaints and concerns from relatives about end of life care.

End of life care

Are end of life care services well-led?

Good

There was a clear strategy for End of Life Care and the management team understood the vision of achieving good end of life care. There was evidence of Board involvement in the EOLC strategy. We saw evidence of good leadership at board level and we saw a good approach to investing in services when a need and business case had been identified.

The SPCT had reported an increase demand of its services, and one extra CNS had been recently employed to provide support for Sunday services, which would allow the service to provide seven day services.

The EOLC clinical governance arrangements were well managed. The service was responding to local demand in a prompt and timely manner. Staff were noted to be clear about their commitment to providing care that ensured patients ended their life in a dignified and respectful manner in their chosen place of death. Care was guided by a SPCT who were supportive and provided good leadership to the rest of the hospital.

The SPCT had a key role in supporting the medical teams in this process. The trust had increased their SPCT Palliative Medicine Consultant and Clinical Nurse Specialist workforce following a successful Business Case to the trust and application for funding from Macmillan Cancer Support.

Vision and strategy for this service

- The trust had a clear vision and strategy for end of life care services and had applied resources appropriately to develop end of life care services as a priority, including the appointment of a non-executive director to lead on the EOLC strategy. The NED lead for end of life care had worked closely with the senior management of EOLC and the SPCT. The EOLC strategy was monitored through the End of Life Strategy Board.
- We spoke with staff who told us they were aware of the EOLC strategy and their role on how this would improve the dying experience for patients and their relatives.
- Staff were able to articulate the five priorities for the care of the dying person “One Chance to Get It Right” and the five key points for the End of Life Care.

Governance, risk management and quality measurement

- An independent review of the Liverpool Care Pathway (LCP) in July 2013 recommended the phasing out of the LCP over the following 6 -12 months and then the implementation of individual plans of care. At the time of the inspection, the trust had not fully rolled out the replacement of the LCP, and this delay meant that staff were not fully supported to deliver best practice care to patients who were dying. The leadership failed to apply enough urgency to have an individual plan of care in place.
- Clinical governance committee meetings were held monthly within the service and all staff were encouraged to attend including junior staff and administrative staff. Complaints, incidents, audits and quality improvement projects were discussed at these meetings. Minutes of the meetings we reviewed confirmed that incidents, complaints and audits were discussed with action points allocated to individual members of the committee
- Regular meetings of the End of Life Strategy Board and Clinical Governance Committee were held to discuss how the service operated and to highlight any areas for potential improvement. Staff said they were encouraged to play an active part in these meetings.
- The end of life strategy board complied with the audit standards of the trust. Audits were a key part of the delivery and monitoring of good end of life care for the trust. There were a number of audits led by the SPCT for example, audit of the fast track discharge process, survey of hospice to hospital transfer, national end of life care audit, bereavement survey and survey of patient satisfaction with palliative care service/team. The End of Life strategy board ensured audits were monitored to ensure that appropriate actions were taken to address and implement audit findings.
- The National Care of the Dying Audit 2013/2014 (NCDAH) demonstrated that the trust had not achieved three out of seven organisational key performance indicators, and there were action plan to address the gaps identified by the audit. We saw evidence of the implementation of action plans for the three KPIs which were not achieved.

Leadership of service

- There was committed leadership of the SPCT, led by the senior consultant, non-executive director and the chief nurse.

End of life care

- The leadership of the EOLC had defined responsibilities (audit lead, research lead, lead consultant for EOLC and lead nurse with service improvement role).
- There was a clear line of reporting to the trust's chief executive and board members so issues could be dealt with effectively.
- The SPCT demonstrated effective leadership and the leaders understood the challenges to provide good quality palliative and EOLC services across the three Clinical Commissioning Group (CCG) areas they were operating.
- The SPCT were encouraged to take up learning and development opportunities to expand their knowledge and skills to improve and enhance the service provided to patients.
- All the staff we spoke with felt their line managers and senior managers were accessible and supportive. They were also able to name members of the SPCT and gave examples of their involvement in end of life care for patients during their last days and hours of life. Ward nurses were very positive about the support and guidance provided by the SPCT.

Culture within the service

- The SPCT were passionate about providing good quality care to patients at the end of their lives. The support and advice offered to ward staff was responsive, they supported effective pain control, symptom management and good communication with families.
- There was evidence that the culture of EOLC was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of patients at the end of life.
- Nursing staff we spoke with demonstrated a commitment to the delivery of good quality end of life care; they felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.
- The SPCT reported positive working relationships across all the hospital disciplines. There was a culture of sharing knowledge and expertise demonstrated through formal training and informal teaching opportunities provided to ward nurses.

Public and staff engagement

- The trust had not achieved the organisational KPI for the National Care of the Dying Audit (NCDAH) for the process of obtaining formal feedback regarding bereaved relatives/friends views of care delivery. The trust had developed an action plan to address this gap, this includes auditing of patients feedback and ward nurses to obtain feedback from patients and relatives on EOLC. The trust had developed and implemented a formal bereavement survey in November 2014.
- Training and education programmes delivered by the SPCT were designed to bring about skills and confidence in the delivery of good quality end of life care.We saw the training program, which encompassed all the EOLC priorities. Staff confirmed that the EOLC training met their learning needs.

Innovation, improvement and sustainability

- The SPCT were slow in implementing the replacement of the LCP; however there were plans to implement the individualised care of the dying patients, but that was not going to be fully operational until the end of pilot in March 2016.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at St Helier Hospital are mainly located on the first floor of the hospital and are served by several reception desks in different clinic areas. There were a total of 523,084 outpatient appointments at this site between January 2014 and December 2014 for first and follow up appointments.

The trust runs a wide range of specialties and medical conditions clinics including cardiology, neurology, ophthalmic, gastroenterology, diabetes, renal, respiratory and care of the elderly. There were surgical clinics for ear, nose and throat, colorectal, vascular, orthopaedics and trauma including pre-operative assessment clinics.

Phlebotomy, pharmacy and therapy services were also provided within the outpatient department areas. The radiology department supported the outpatient clinics as well as inpatients, emergency and GP referrals. They provided imaging for the diagnosis and interventional treatment of a number of conditions.

The hospital radiology services were provided on the first floor, serving mainly outpatient and inpatient referrals. There was a separate X-ray unit on the ground floor opposite the accident and emergency department and a further unit in the dedicated children's hospital. St. Helier Hospital also had one computed tomography (CT) and one magnetic resonance imaging (MRI) machine. The diagnostic imaging department provided all types of imaging which included plain film, fluoroscopy, interventional, ultrasound, nuclear medicine, CT and MRI.

The pathology department at St. Helier Hospital is across three floors in one area of the hospital. They provide a wide range of chemistry tests including some national and international referrals and neo-natal screening tests across a wide geographical area. Blood sciences, blood transfusion, immunology, cytology and microbiology are also routinely provided.

During our inspection we spoke with 17 patients along with some of their relatives. We also spoke with 25 members of staff including reception and booking staff, nurses of all grades, radiographers, healthcare assistants, medical students, doctors, consultants, secretaries, managers and domestic staff. We observed care, received comments from our listening and staff focus group events and from patients and the public directly. We received comments from our listening event and from people who contacted us to tell us about their experiences. We also reviewed the systems and management of the departments including the quality and performance information.

Outpatients and diagnostic imaging

Summary of findings

Overall, we found that outpatients and diagnostic imaging were good. The service was rated as good for safety, caring, responsive and well-led. The effective domain was inspected but not rated. Some aspects of the delivery of safe patient care in relation to radiation safety were excellent.

Patients, visitors and staff were kept safe as systems were in place to monitor risk. Staff were encouraged to report incidents and we saw evidence of learning being shared with the staff to improve services. There was a robust process in place to report ionising radiation medical exposure (IR(ME)R) incidents and the correct procedures were followed. The pathology department had a comprehensive quality management system in place with compliance targets set at higher than the national average to improve safety and quality. There was evidence of excellent practice for the monitoring and administering of patient radiation doses to be as low as possible.

The environments we inspected were visibly clean and staff followed infection control procedures. Records were almost always available for clinics and if not, a temporary file was made using available electronic records of the patient. Staff were aware of their responsibilities within adult and children safeguarding practices and good support was available within the hospital.

Nurse staffing levels were appropriate and there were few vacancies. The diagnostic imaging vacancies were higher, particularly ultra sonographers. There was an ongoing recruitment and retention plan in place.

There was evidence of service planning to meet patient need such as the emergency eye service offered Monday to Friday 8.30am to 4.30pm for patients with sight threatening eye conditions, requiring urgent specialist ophthalmic treatment. National waiting times were met for outpatient appointments and access to diagnostic imaging. A higher percentage of patients were seen within two weeks for all cancers than the national average, but the cancer waiting times for people waiting less than 31 days from diagnosis to first definitive treatment and the proportion of people waiting less than 62 days from urgent GP referral to first definitive treatment were both below the national average.

Staff had good access to evidence based protocols and pathways. There was limited audit of patient waiting times for clinics, but patients received good communication and support during their time in the outpatients and diagnostics departments. Staff followed consent procedures and had a good understanding of the Mental Capacity Act 2005.

We observed and were told that the staff were caring and involved patients, their carers and family members in decisions about their care. There was good support for patients with a learning disability or living with dementia.

Staff were aware of the complaints policy and told us how most complaints and concerns were resolved locally.

The outpatients and diagnostic imaging departments had a local strategy plan in place to improve services and the estates facilities. From December 2015, the current outpatient services that are in Clinical Services Directorate will move to a new Outpatients and Medical Records Division. Staff expressed some concern over these changes.

Governance processes were embedded across outpatients and diagnostics. The directorate was commended on its risk register in a recent review of risk registers in the trust. Senior managers told us the newly appointed quality manager had made significant improvements in making sure priorities, challenges and risks were well understood. Good progress was evident for improving services for patients.

We found good evidence of strong, local leadership and a positive culture of support, teamwork and innovation.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

There were example of outstanding practice in diagnostic imaging as regards to radiation dose levels. Incidents were reported and investigated appropriately and learning was shared. Patients were informed about incidents and were provided with copies of the reports and given an opportunity to discuss in more detail.

Some areas in the general and emergency X-ray department did not have the adequate space or capacity to deal with the demand on the service. This was particularly due to the narrow corridors where there was limited room for patients in beds.

Cleaning and routine checks on equipment were in place and complete. The environment was very clean despite the age of the building. We saw staff adhering to infection control procedures. The diagnostic imaging department had robust policies and procedures in place based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The IR(ME)R regulations are to protect patients, staff and the public. The department had good support networks in place for expert advice and were consistently demonstrating lower doses of radiation than the national average.

There were sufficient staff in outpatients to manage the service but vacancies in diagnostic imaging meant the ultrasound service in particular was under strain to manage the workload. Staff were well supported for training but mandatory training levels were not meeting trust compliance levels overall. Staff had a good understanding of safeguarding procedures.

The majority of records were available for outpatient appointments. There was evidence of the WHO checklist being completed and audited in interventional radiography. Patient protocols were in place in radiology.

Incidents

- There were no 'never events' reported between August 2014 and July 2015. (never events are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented.)
- The trust provided the datix incident log covering outpatients and diagnostic imaging from September 2014 to August 2015. The outpatients and diagnostic imaging services reported a total of five serious incidents during this time. The majority of incidents reported were of low or no harm.
- We saw that incidents had been investigated and root casue analysis had been completed to identify the causes of the incidents. Patients and their families had been involved and informed, as had any relevant stakeholders and commissioning groups.
- Incidents were reported and managed appropriately using the trust's electronic incident reporting system (DATIX.) Actions and learning were disseminated to staff in various formats such as the newsletter and morning staff meetings. Staff we spoke to demonstrated a good understanding of the incident management process which was accessed via the hospital intranet.
- Senior managers told us they encouraged a culture of open incident reporting and staff confirmed this. Staff told us they received the feedback and lessons learnt via staff meetings and the trust wide 'Risky Business' bulletin.
- We looked at the minutes for the Clinical Services Directorate Clinical Governance meeting covering May, June and July 2015. Reports on incidents were broken down by level of severity and trends were discussed. Diagnostic imaging staff gave an example of how practice was changed in the patient identification process following a trend in incident reporting. The results were analysed and improvements made. We observed the new process in action and senior staff confirmed there were no more incidents reported for this issue.
- We looked at the minutes from the Radiation Protection Committee held in August 2015. A recent incident in CT was discussed and we saw changes had been made to the request form to prevent the error from occurring again.
- We saw the trust's Duty of Candour policy and templates for duty of candour letters. Staff we spoke to told us about their understanding of the duty of candour and their obligations. They were confident systems were in place to ensure patients were fully informed of the circumstances which led to any incident resulting in moderate harm.

Outpatients and diagnostic imaging

- The hospital had processes in place to report any radiation incidents to the Care Quality Commission (CQC) under Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).

Cleanliness, infection control and hygiene

- On visual inspection all areas we visited in St. Helier outpatients and diagnostics appeared clean and tidy, including the toilets and changing rooms. Records of daily cleaning were visible and complete in all the areas we visited.
- We observed staff using good infection control practices. Posters prompting hand hygiene were clearly displayed.
- The outpatient Springhall Unit had achieved 95% on the National Cleanliness Score and the Springhall Annexe had achieved 96% for September 2015.
- We saw all staff were 'bare below the elbows' in clinical areas. This reduced the risk of infections to staff and patients and was in line with good practice.
- All sinks were hand wash stations and fully compliant with HBN 0009 Infection Control in the Built Environment (March 2013), which is department of health best practice guidance.
- All soft furnishings were wipeable and in good condition. The vinyl floor in the departments was in good condition.
- There were adequate supplies of personal protective equipment (PPE) including glove and apron dispensers throughout the outpatient areas.
- We observed good hand hygiene practices and good use of hand sanitiser gel. Gel was available at numerous points including reception desks although was less obvious in the Mackenzie Unit.
- The outpatient department was given prior notice of infectious patients by the infection control team. There was not a dedicated room but once the clinic room had been used, the rapid response cleaning team would be contacted and the room deep cleaned before making it available for further use.
- The hospital reported that 94.29% of staff from the outpatient department had attended infection prevention and control training against a target of 95% in the year to date.
- Infection control policies were available on the intranet and staff were able to show them to us easily.
- The outpatients department had infection prevention and control link nurses in place that attended infection control meetings and then reported back to the rest of the team.
- We saw a patient led assessment of the care environment (PLACE) audit for the Powell outpatient department undertaken in May 2015. This showed the environment had been inspected in areas such as cleanliness and appearance. The area scored 99.04% and 93.18% respectively.
- Blood and mercury spillage kits were readily available and staff told us they had been trained in their use.
- Radioactive spillage kits were available in nuclear medicine and staff knew how to use them. All radiation waste within nuclear medicine was disposed of appropriately and the process fully documented. Reports were sent weekly to the Radiation Protection Advisor and monthly to the Environment Agency.
- We observed good waste streaming with the use of hazardous waste bins and recycling bins
- There were clear notices around the hospital detailing hand hygiene and infection control measures for patients and visitors.
- Hand hygiene audits were carried out monthly using the World Health Organisation (WHO) 'Five Moments' audit tool based on WHO guidelines for hand hygiene. We looked at the audit from August 2015. The department was 100% compliant for equipment cleanliness and documentation of cleaning and 83% compliant for correct hand hygiene techniques used. Overall the audit demonstrated 93% compliance.

Environment and equipment

- The department's risk register included replacing ageing imaging equipment. The manager was aware of the limitations and put measures in place to ensure the equipment was used appropriately.
- There was resuscitation equipment available across outpatients and diagnostics. On the days when nuclear medicine undertook cardiac scans, the resuscitation equipment was checked by nuclear medicine staff and situated outside the treatment room for ease of access. We looked at resuscitation trolley checklists and found them to be checked and signed on a daily basis.
- The cardiac stress room in nuclear medicine was small and not suitable for such procedures. This issue was

highlighted on the trust risk register in June 2015. The trust has put measures in place to improve the space where possible by putting monitors on the wall to free up floor space
- A bariatric bed and chair was available in outpatients and staff knew the policies and protocols around their use.
- There was a dedicated phototherapy treatment room and radiation warning signs were in place. There was a contract in place for the maintenance and calibration of the ultraviolet therapy machines. This happened every six months and the last calibration date was August 2015.
- The hospital medical physics department checked all outpatient equipment on an annual basis. A decision was made as to whether the equipment will be serviced in-house or outsourced to a private company. All Portable Appliance Testing (PAT) testing of outpatient equipment we checked was in date.
- We observed radiology staff wearing specialised personal protective aprons. These were available for use within all radiation areas and on mobile equipment. Staff were also seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation.
- Some patient waiting areas in outpatients were small and cramped. Fracture clinic patients were waiting in the corridor. The newly opened eye clinic was bright, well decorated and welcoming to patients.
- The corridors to access the emergency X-ray room and some of the ultrasound rooms were too narrow to transport patients in beds. Patients had to be moved to a trolley before accessing these rooms.
- A programme of redecoration was in progress.

Medicines

- The medicines cupboards we inspected were locked and secure, all stock was within expiry date and there was evidence of stock rotation.
- Fridge temperatures were checked and recorded dailyand were within the required range.
- Prescription pads were stored securely in locked cupboards and drawers. We saw good systems in place throughout outpatients including signed and dated log books.

Records

- We observed that medical records in use in the outpatient department were stored securely in locked cabinets. Staff told us they took the key with them when the holding area was unattended. We observed this in action. Some patient information was also stored electronically such as referral letters, clinic appointments, blood and X-ray results.
- We spoke to a receptionist who told us medical records were collected each morning from the medical records department. We were told missing records was an issue but when this happened there was a system in place to set up a temporary record using the electronic patient information. The temporary files were clearly marked so that they could be reconciled with the permanent record when located.
- All the notes were available for the clinics we inspected. One clinic was missing two sets of notes at the start of the clinic but these were quickly located and delivered to the clinic prior to the patients being seen.
- We looked at the audit of records pulled for appointments. This demonstrated an improvement from 97% being available in August 2014 to 99% in August 2015. Staff expressed concern that some of the patient notes were incomplete. Senior staff told us that regular meetings are held between the Medical Records Manager and the outpatient team to discuss this issue.
- To support the tracking of patient files the trust has moved towards a technology system of Radio Frequency Identification (RFID) tagging. We were told this was an efficient and effective system and notes could be easily located across the hospital.
- The receptionist we spoke to had a good understanding of patient confidentiality and data protection and had attended information governance training. We saw the receptionist demonstrate this by double checking patients details when they attended and placing medical records face down when placed ready for the nurse.
- The diagnostic imaging department had a central electronic patient records system to record comprehensive details of each patient's imaging history. Any paper records such as MRI safety checklists were scanned into the system. We looked at the MRI paper records and saw they were checked and signed by the radiographer.
- Staff in the diagnostic imaging department were able to show us how the radiation doses were recorded on the system for each procedure.
- A service level agreement had been set up with each of the Point of Delivery Units (PODs) to improve the

medical records service. Health record engagement forums were held across the trust to listen to the problems the staff had with records and to make improvements. These included the creation of dedicated email accounts to improve communications.

Safeguarding

- The outpatients department reported a compliance level of 100% in November 2015 for staff attendance at adult safeguarding training against a target of 95%. Compliance for children's level 2 safeguarding training was 70.54% against the trust target of 95%. We saw that staff had been booked into this training where they were non-compliant.
- We saw policies in place and in date for both safeguarding children and adults.
- The staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. One member of staff showed us the safeguarding policy on the intranet and in a hard copy file kept within the department. They could access further support from senior staff if needed.
- A link nurse was in place to attend the trust safeguarding meetings and report back to the outpatient's team. We saw their details on the staff noticeboard.

Mandatory training

- Mandatory training included infection control, health and safety, fire safety, conflict resolution and safeguarding.
- Staff told us they were not achieving mandatory training targets but that this was due to insufficient access to computers in the workplace.
- Mandatory training included e-learning and face to face meetings. Staff told us the quality of the training was good.
- The trust target for all mandatory training was 95%. Targets were not being met in outpatients for the majority of subjects. 100% compliance was achieved for conflict resolution, equality and diversity and safeguarding adults. Non-compliance was in blood transfusion, fire, information governance, resuscitation, patient manual handling and children's level 2 safeguarding.
- Diagnostic imaging achieved a compliance level of 85% collectively across all training modules. Plans were in place to improve this position by the end of the financial year (March 2016).

Assessing and responding to patient risk

- The hospital had a medical physics expert commissioned from a neighbouring hospital, available and contactable for consultation to give advice on radiation protection for medical exposures in radiological procedures. This was in line with IR(ME)R guidance.
- The diagnostic imaging department had a named Radiation Protection Supervisors (RPS) to give advice when needed to ensure patient safety and minimise radiation risk. They were adequately trained and had all attended annual refresher training.
- Quality assurance tests on the X-ray equipment were done every morning prior to the service starting. We saw the results documented in each room. Any trends or increases in exposure were reported to the RPS and investigated immediately.
- The RPSs worked closely with the expert advisor to optimise the radiation doses. This meant the lowest possible dose was given to patients whilst maintaining good diagnostic quality.
- Dose reference levels were evident for X-ray rooms. The paediatric unit in Queen Mary's Hospital for Children told us they had the lowest doses in the country. This information had been fully researched and presented at a national Medical Physics conference. In general, dose levels were amongst the lowest in the country.
- An adapted version of the World Health Organisation (WHO) checklist was used for all interventional procedures. We saw copies of these scanned into the patient electronic record.
- A radiation safety policy was in place which included the Ionising Radiation Medical Exposure Regulations (IRMER) procedures. There was also a protocol for the management of contamination, monitoring and spillage of radioactive material and a procedure for the disposal of radioactive waste.
- We saw local rules were in place and available for all staff to follow in the imaging areas we visited. There were also clearly visible on the mobile imaging equipment.
- A nurse told us clinical observations such as temperature and blood pressure were monitored and recorded prior to, during and after any interventional procedure. This meant the patient was monitored to detect any deterioration in their condition. Systems were in place to contact an emergency response team.

Outpatients and diagnostic imaging

Nursing/ radiology and pathology staffing

- There were dedicated nursing and healthcare assistant staff across the outpatients department. All staff rotated across the specialties allowing for cross cover for holiday and sickness.
- The outpatient sister felt the staffing levels were adequate, although there was a demand for extra clinics to meet waiting time targets. Clinics were open from Monday to Friday with extra clinics scheduled in the evening and on Saturdays.
- Bank staff were used to fill gaps in staffing in the outpatients department. Induction was thorough andno agency staff were used.
- We saw evidence of planned staff for clinics to meet consultant and patient need.
- There were 22.89 vacancies across all staff groups in the diagnostic imaging department against a full time establishment of 158.95.
- Bank and agency staff were used in the diagnostic imaging department but most of these staff had a long term relationship with the hospital.
- There was a shortage of sonographers across the ultrasound service. The service had been successful in training 'in-house' and employing these staff after training had finished. However, it was only possible to train one sonographer per year.
- Diagnostic imaging services offered student radiographer placements. One staff member who had previously been a student at the hospital told us they felt the department offered them a varied career pathway with good support.

Medical staffing

- Across the outpatient service medical staffing was adequate although there were some vacancies due to retirements. There were enough consultants to see the booked patients although the longest waits were in trauma and orthopaedics clinics.
- Consultant appointment times were aligned to clinic times.
- Two new consultant posts have been funded for radiology services and were due in post by March 2016. Replacement radiologist posts have been filled. There is currently a 0.4 whole time equivalent vacancy in medical staffing for the department.
- There was a vacant histopathologist post in the pathology department which was out to advertisement at the time of the inspection.

Major incident awareness and training

- Emergency evacuation plans were clearly visible on the walls of all the departments we visited.
- The trust had a major incident plan in place and there was evidence of business continuity plans for both outpatients and diagnostic imaging.
- Staff understood what actions to take in response to a major incident and in particular for a fire.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.

Staff obtained written and verbal consent to care and treatment which was in line with legislation and guidance.

Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal on their performance. Appraisal rates were below the trust target, but there was a plan for delivery of appraisals by December 2015.

We saw staff worked collaboratively to meet patients' needs in a timely manner.

Evidence-based care and treatment

- Staff had access to evidence based protocols and pathways based on NICE and Royal Colleges' guidelines.
- Relevant clinical guidelines, technology appraisals, interventional procedures, quality standards and diagnostic guidelines that are published by NICE, were noted in the directorate performance report.
- We saw that clinics were in line with best practice and NICE guidelines in relation to appropriate referral, availability of information and completion of checklists.
- NICE guidelines and minimum standards from the British Association of Dermatologists were followed for phototherapy services.
- National Royal College of Nursing guidelines were used regarding the self-administration of anti-rheumatic drugs.

Outpatients and diagnostic imaging

- Examination audits had been completed to comply with IR(ME)R safety policy. The 2014 annual RPA's report showed compliance with radiation regulations.
- Diagnostic reference levels (DRL) were monitored and audits of the levels completed. Where levels were raised the equipment was checked in line with the manufacturer's recommendations. The staff in the department had regular contact with the radiation protection advisor.
- The outpatients and diagnostics department were currently involved with the national bowel, lung, head and neck and oesophago-gastric cancer audits. We noted that there was an audit plan for 2015/2016.
- We also looked at some pathology audits including the audit of inappropriate virology test requests in May 2015. Changes had been made to practice, improving the requesting of appropriate tests.
- We also looked at the diagnostic imaging local audit plan and looked at the audit meeting minutes from both radiology and pathology.
- In the imaging department, we observed the World Health Organisation (WHO) checklist for interventions was routinely completed.

Pain relief

- We observed FP10 prescription pads were available in clinics and we saw prescriptions for pain relief were recorded in patients' notes.
- Pain relief (analgesia) and local anaesthetics were available for patients who needed this during procedures.

Patient outcomes

- The DNA rate was consistently lower than the national average from January to December 2014.
- Radiology reporting times for GP referrals and accident and emergency referrals were monitored. The current London quality standards for 24hr turnaround of emergency referrals was not being met. Plans were in place to improve recruitment to meet this standard by January 2016.

Competent staff

- An induction plan was in place for all new staff to gain competencies for their job role. Continual professional development was promoted in the departments. Staff were encouraged to widen their understanding of different aspects of the service. Staff told us they were able to identify specific learning through the appraisal process.
- Completion of mandatory training levels was mostly high in all areas for example in the women's health outpatients it was recorded as 100%. Staff received clinical supervision with the clinical psychologist monthly including visual competencies when carrying out procedures.
- Specialist nurses worked within the outpatients department providing nurse-led clinics alongside medical colleagues.
- The imaging department had effective clinical supervision and mentoring systems in place for staff and they were proud to tell us they regularly developed their own staff. We saw imaging had competency frameworks for equipment use and nominated key trainers for each item of equipment.

Multidisciplinary working

- The outpatient department held pre clinic briefings each morning and evening.
- Verbal referrals were made between departments and the Lorenzo system supported the process of transfer of details.
- Written referrals were arranged when care was to be continued at another hospital. Letters were sent to GPs regarding their patients and a summary of consultations, treatments and investigations from the outpatient clinics.

Seven-day services

- The outpatients department was open Monday to Friday 8am to 5.30pm, with occasional 'waiting list reduction' clinics being held on Saturday mornings and evenings.
- The radiography department were available seven days a week. The MRI and CT service were open Monday, Wednesday and Friday from 7.30am -5pm with extended hours til 8pm on a Tuesday and Thursday. Saturday morning clinics were routinely available for both CT and MRI with ad-hoc Sunday sessions as required.
- Radiologists were on site until 8pm each weekday evening, and 9am-12 noon on Saturdays and Sundays, with the on call provided by an external provider.

Outpatients and diagnostic imaging

- Pathology laboratory was available out-of-hours on an on call basis. Blood sciences were available seven days a week, 24 hours a day. Microbiology service was available Monday to Friday 9am to 5pm and there was an on call service out-of-hours..

Access to information

- Staff told us and we saw that they had access to trust policies and procedures on the intranet.
- X-ray and diagnostic imaging results were available electronically which made them promptly and readily accessible to staff.
- Electronic access to pathology, microbiology and radiology results were available.Explanatory leaflets were available to assist staff to explain procedures and investigations to patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated confidence and competence in seeking verbal and written consent from patients. Verbal consent was observed in the X-ray room and the gynaecology outpatient clinic.
- Staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity; they demonstrated a knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).
- Staff knew the procedures to follow to gain consent and understanding from patients, including involving other professionals. Carers were encouraged to escort their relative to appointments to offer support.
- We saw examples of accurately completed consent forms.

Are outpatient and diagnostic imaging services caring?

Good

Throughout the inspection we witnessed good care being given. Patients were kept informed at all times and emotional support was given.

There was a strong person-centred culture across both outpatients and diagnostic imaging teams and this came across clearly from all the staff we spoke with.

We observed and patients told us the staff were friendly and approachable. All patients we spoke with gave examples of good care. Several patients described the care as 'excellent.'

We observed the staff supporting patients that required any assistance. There were quiet rooms available for patients who were to be given bad news.

Staff demonstrated a good understanding of the privacy and dignity needs of their patients. We observed staff being respectful at all times.

Compassionate care

- We observed excellent interactions between nurses, radiographers, medical staff, healthcare assistants and administration staff and their patients. It was clear that the departments put the patients first and senior managers confirmed this was their ethos.
- We spoke with 17 patients and carers across the departments. There were no negative aspects of care highlighted to us. We were told the staff were very compassionate.
- One patient told us they attended regularly and always received good care. They told us the care was "brilliant."
- We were toldchaperones were available for all patients and we saw signs displayed in the waiting areas.
- In the 'bed bay' within imaging, we saw patient's privacy was supported using curtains. The space, however, was not sufficient for the number of beds arriving in the department and privacy and dignity was easily compromised. .
- We observed patients being greeted in a friendly manner by staff. We observed many examples of staff explaining to patients the procedure and process of their investigation. Staff gave patients time to ask questions and address any concerns.

Understanding and involvement of patients and those close to them

- All patients we spoke with felt well informed about their care including any investigations that were planned. One patient showed us their information leaflet about attending for a CT scan and said they found it helpful. Another patient attending for the acupuncture clinic also told us the information leaflet was helpful, staff explained the procedure and outlined what to expect during and after treatment.
- Pre-operatively, patients had discussions with the nursing staff to ensure they understood the procedure.

Outpatients and diagnostic imaging

Emotional support

- Patients told us staff were caring and professional. We observed staff acting in a professional way, offering discreet assistance to patients where necessary. One patient told us that with her consent, the staff had fully involved their partner in all communications which was very helpful.
- There was a bereavement and chaplaincy service. Outpatient staff we spoke with said they would refer patients to this service if required.
- Staff in the phototherapy service told us they offered a one stop clinic for removal of lesions. These appointments would often over run, so staff showed us a small kitchen, where people could get hot and cold drinks, whilst they waited. Staff also told us they would offerred patients a link to charities able to support their conditions.
- Staff told us a quiet room would be made available for breaking bad news. This was often scheduled in advance by discussing the patient potential needs with the consultant prior to the start of the clinic.

Are outpatient and diagnostic imaging services responsive?

Good

People were able to access services for assessment, diagnosis or treatment when they needed to and were often given a choice of locations. The trust was meeting national waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for the incomplete pathways. Cancer waiting times were variable across the targets, although waiting times for all urgent referrals were within two weeks.

'Did Not Attend' rates were lower than the England average but the clinic cancellation rate was above at 11% compared to the national average of 7%. Most of the people cancelling their appointments gave over six weeks' notice. The primary reasons given for clinic cancellations were annual leave, study leave or sickness.

There was good support for patients with a learning disability and the departments worked closely with the community learning disability lead. Staff were also aware of patients with dementia. There was access to interpreters for patients whose first language might not be English.

Self-service touch screen units for booking in were available in some of the outpatient clinics. Clinics often ran late, but we observed good communication with the patients.

The service closely monitored any complaints and no recent complaints were left open which meant they had all been satisfactorily resolved.

Service planning and delivery to meet the needs of local people

- Waiting times were displayed on digital or white boards in all the waiting areas for patients.
- Signage to outpatients and diagnostic imaging services was clearly displayed at the main reception and in the corridors.
- During our inspection, we visited the phlebotomy clinic. This was a walk-in clinic meaning patients did not need to make an appointment. We noted there was a 30 minute wait for blood tests at the time we inspected. We spoke with one patient who said, "the wait is usually quite quick, but they are very busy."
- The capital replacement and refurbishment programme was planned and senior staff told us how the services were to be reconfigured to meet patient need. There was limited space in the nuclear medicine department.
- Voice recognition reporting in diagnostic imaging was in place and used effectively.
- 98% of GP plain X-rays were reported in less than seven days. The target of 100% reported in less than 48 hours for emergency department plain films was under target in August 2015 at 46%. The department leads told us the recruitment of new radiologists would help improve this target by January 2016.
- The majority of in patients' X-ray results were returned to the ward within 24 hours.
- Radiographers had been trained and were competent in some aspects of radiology reporting.
- The histopathology laboratory offered same day reporting for specimens received by 1pm.
- Patients arriving by ambulance at the eye clinic were seen immediately to avoid a long wait for any return transport.
- Bariatric chairs were available in the eye clinic in each waiting room. The couches were designed to take increased weight.

Outpatients and diagnostic imaging

Access and flow

- Hospital Episode Statistics for January 2014 - December 2014 showed that 523,084 outpatient appointments were made at St. Helier Hospital. This represented 81% of the overall appointments across the trust.
- Out of the total appointments made at the hospital, 7% had been cancelled by the hospital and 6% by the patients.
- The referral to treatment rate for non-admitted pathways between April 2013 and July 2015 ranged between 97% and 93%. The percentage had been below both the standard and the national average of 95% since June 2015.
- Referral to treatment rates for incomplete pathways was above both the standard and the England average of 92% from April 2013 to July 2015.
- The percentage of people seen by a specialist within two weeks for all cancers was above 96%, which was above the England average from quarter one 2013/14 to quarter four 2014/15.
- The percentage of people waiting less than 31 days from diagnosis to first definitive cancer treatment was below the England average from quarter two of 2014/15. The target was met before that time.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive cancer treatment was below the England average from quarter three of 2013/14 to quarter four 2014/15.
- In November 2014, the trust requested the support from the NHS Intensive Support Team (NHS IST) to review systems and processes. The NHS IST visited in November 2014, for two days, and gave initial feedback to the trust in early December 2014. An action plan is now in progress. Improvements have been made by utilising a patient tracking list specifically for cancer patients.
- The percentage of people waiting over six weeks between July 2013 and August 2014 was below the England average. From November 2014 onwards, the percentage of people waiting over six weeks rose 1% to 7% in February 2015.
- The hospital had only recently started collecting data to show the percentage of patients waiting over 30 minutes to see a clinician. The OPD management team were in the process of working on methods to collect and report this information robustly on an on-going basis. This was in order to identify any areas where clinic waiting times were consistently long and enable action plans can be drawn up to address this. We saw waiting times of over one hour in more than one of the afternoon clinics.
- We spoke with the reception staff as to how they managed long waits. They updated the electronic information and/or white boards with the current clinic time wait and informed the nurses and the patients on arrival. We observed patients being updated on the waiting times. One patient we spoke with said, “It can be a long wait, but they do tell you what is going on.”
- The directorate team acknowledged there were often long waits for patients in the clinics. We were told a new directorate specifically for outpatients and medical records would be formed in December 2015. The team were keen to implement new ways of working to bring the waits down.
- An analysis of radiology services undertaken by London Cancer Alliance (LCA) in December 2014, showed that the trust was the most productive CT service within the LCA, with 30,000 CT scans from the trust’s two CT machines – 15,000 scans per machine. This compared with an LCA average of 9,700 per machine. To cope with existing demand and in order to reduce the wait for a CT scan, the trust had procured a mobile machine to operate on three days per month between March 2015 and March 2016.
- Bi-weekly performance meetings were held to monitor the backlogs of appointments. Waiting list initiatives had demonstrated effectiveness against waiting times. Ophthalmology waits had been significantly reduced.
- Waiting times for diagnostic imaging were monitored and recorded. The percentage of patients waiting more than six weeks for a diagnostic test ranged from 0.2 – 0.5% from January 2015 to June 2015. This was significantly lower than the England average.
- Requests for laboratory diagnostic tests were sent electronically from the wards and GP surgeries.
- 95% of results were available electronically within one hour for routine tests.
- The histopathology department offered a same day reporting system for any specimens received by 1pm. Histopathologists were available every afternoon to report renal tests.
- Patient follow up to new rate was slightly above the England average.

Outpatients and diagnostic imaging

Meeting people's individual needs

- We noted that water dispensers were available throughout the outpatients department and a small café was located near the main outpatient's area.
- Staff told us interpreting services could be booked for patients attending outpatient appointments, if the original referral letter stated an interpreter would be required. We saw posters clearly displaying information about accessing translation services.
- The staff we spoke with demonstrated a good understanding of the needs of patients with dementia and learning disabilities. We were assured the patient who may be distressed or confused would be treated appropriately.
- Patients we spoke with were very positive about the outpatient and diagnostic imaging services and told us they received good treatment and were happy to attend these departments.
- The outpatient staff liaised closely with patient transport services to ensure this ran smoothly.We saw clear pre and post-operative guidance notes for patients having day surgery including emergency contact numbers.
- We saw the outpatient department kept a wide choice of patient information leaflets which meant that patients were supported to make informed choices about their care

Learning from complaints and concerns

- We were told following the factual accuracy check that from August 2014 to July 2015, the general outpatients department received one written complaint and two were received for the haematology/immunology outpatients. Radiology had 11 complaints in this time period.
- The outpatient's senior staff told us the main reason for complaints in the department was waiting times. There was a system in its infancy for monitoring patient waiting times.
- Complaints were handled in line with the trust policy. Complaints were reviewed and discussed at the monthly Clinical Services Directorate Governance Meeting.
- Staff told us learning from complaints was shared at the daily outpatients meeting. Staff were able to explain the complaints procedure to us.
- We saw PALs signs were situated throughout outpatients and imaging department, which explained how to raise any concerns or complaints.

Are outpatient and diagnostic imaging services well-led?

Good

The outpatient and diagnostic imaging department was well-led. Staff and managers had a vision for the future of the department and were aware of the risks and challenges they faced. This included the move to a new outpatients and medical records directorate by December 2015. Staff felt supported and were able to develop and progress within the organisation. Staff talked about an open culture and were able to raise concerns and put forward ideas for improvement of services.

Staff stated the senior managers were visible and approachable. The staff we spoke with said the chief executive was making a difference and provided clear leadership.

Staff we spoke with were aware of the trust vision. They were proud to work at the hospital and felt valued.

Vision and strategy for this service

- All the staff we spoke with were fully aware of the trusts vision and values. We were told they felt listened to. Some pathology staff felt more work needed to be done to further progress some of the good quality improvements that had been started.
- We looked at the five year vision strategy for the outpatients and diagnostics departments. This included further quality improvements in pathology, more automation in pharmacy services, improving cancer pathways, providing a modern radiology seven day service, consolidation of outpatient areas and improved IT systems. Staff were aware of the strategy and were supportive. There was some anxiety raised about the move to a new directorate. We spoke with the senior team about this and they told us the process was being 'well-managed', with staff central to the discussions.
- All the staff spoke with pride about their services. Where it was obvious that changes needed to be made to the existing environment, staff worked around the issues to provide the best solutions possible.

Outpatients and diagnostic imaging

Governance, risk management and quality measurement

- Governance arrangements were in place. Staff were aware of these and participated in them such as undertaking risk assessments, audits and attendance at meetings.
- A newly appointed quality manager for clinical services was in post. They produced monthly quality reports looking at trends in incidents and any associated risks. Senior staff told us this post and the quality of the report produced had made a real difference to reviewing risks and completing necessary actions.
- Staff were given feedback about incidents and lessons learned comments, compliments and complaints. We were told there was a morning meeting to share information in outpatients. We also saw trust and departmental newsletters sharing information.
- We saw the departments had updated risk registers in place and the ones that had been identified in our discussions were reflected on these registers. These included radiology equipment and the size of nuclear medicine testing room.
- Vacancies for staff were all advertised. The reduced staffing impacted on the quality of the service received, for example increased waiting times in outpatients.
- Audit systems were in place to measure the quality and accuracy of work carried out within the departments. This included audit half-days for staff to attend.
- Good governance processes were in place for radiation safety monitoring. For example, although dose reference levels were below the national levels, they were monitored to still comply with these low levels of radiation doses.
- There were clear lines of accountability across the departments and we found the outpatients and diagnostic imaging staff worked well as a team.

Leadership of service

- We found competent staff managing each of the clinical areas we visited. Staff told us they had confidence in their leadership. They made comment that the chief executive was a good appointment for the trust and they felt optimistic for the future.
- The outpatient senior team told us they had requested an external review to look at the cancer pathways. We saw the report and the progress being made to implement the recommendations.
- The radiology service was well-led by a team of competent radiologists and radiographers. The leadership of the children's service was well-respected by other colleagues.
- Pathology services had been reconfigured in the last two years and improvements were being made, such as locating all the operating procedures onto one system for all staff to access. The senior lead told us recruitment and retention had improved.

Culture within the service

- We heard of a friendly, open culture within the outpatients and imaging departments. It was evident that quality and patient experience were seen as a priority for the services and was everyone's responsibility.
- Good working relationships and support networks had been built with the local hospitals and with external services such as radiation protection.
- The majority of staff described a positive working environment. Many of the staff had worked at the hospital for many years.
- Staff felt there was an open culture and they could raise concerns and be listened to.
- Pathology had undergone a reorganisation that had improved the service with some tests being centralised on one site only. owever, there was feedback from senior staff that there was still a reluctance to change by some staff.
- We noted a culture of adaptable working. Staff would routinely rotate across different areas to develop new skills and be flexible in their approach. Some staff told us this was a good reason for working in the radiology department as they gained a good range of experience.
- There was evidence of a strong education culture for medical staff in training. There were named educational supervisors in place who held regular supervision sessions with staff.

Public engagement

- The departments actively sought feedback from patients.
- They took part in the friends and family test across the various units. We saw the result were high, such as 91% of patients would recommend the service to friends and family in the Powell Unit. However, the response rate was very low at 4%, which would suggest the survey needs to be promoted more widely.

Outpatients and diagnostic imaging

Staff engagement

- Staff told us and we saw the weekly bulletin from the chief executive. Staff told us it was informative and contained the right level of humour to make it engaging.
- A new weekly directorate newsletter was now sent following the appointment of the general manger.
- Staff had all received the new hospital five year strategy outlining the plans for the future. Staff told us it was reassuring to know that plans were more stable for the immediate future.

Innovation, improvement and sustainability

- Advanced practice was evident in the radiology department with reporting radiographers.
- The hospital offered an appointment reminder service where patients were reminded of their outpatient appointment by a free text message.
- Ophthalmology was a service that had experienced demand and capacity issues in the past which had greatly impacted on the service. We looked at the newly designed clinic which was clean, bright and well designed. The senior staff told us the transformation of the service was now in place and waiting times had greatly reduced and patient experience was improved.
- We visited the cardiology investigations unit. We were told this was the only accredited department with the British Society of Echocardiography in South West London. The department was well-led and staff told us there was a strong drive to improve and exceed standards. The department offered a walk-in ECG service for GP referrals. There were very short waiting times for tests.
- The radiology department had an excellent approach to reducing radiation doses across all departments.

Renal

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

Information about the service

The Renal Unit at St. Helier Hospital is a tertiary renal referral centre. It is part of the South West Thames Renal and Transplantation Unit providing services to patients living with kidney related disorders and diseases in South West London, Surrey and Surrey Borders. Services are provided at the hospital and at eight satellite haemodialysis units, two of which are under direct clinical management from the Epsom and St Helier Trust, six being contracted to private providers. There are also 15 outpatient clinics operating across the region.

The unit has 52 inpatient renal beds on Beacon, Secombe and Richard Bright wards and an onsite 35 station haemodialysis area; split into a maintenance and more acute facility unit and four individual rooms for isolation purposes. Services provided include plasma exchange facility, advanced kidney care clinics, an ambulatory care centre, a peritoneal dialysis unit and a dedicated renal out-patient clinic with a phlebotomy service. The unit is registered to provide long-term haemodialysis treatment to people with renal disease. The Renal Unit receives approximately 200 new outpatient referrals each month. A number of specialty clinics are run including combined renal and rheumatology clinics.

Acute Transplantation Surgery is provided at a nearby hospital though transplant work up and acute post-surgical follow up is provided on the St Helier site and at outreach clinics in Surrey. Vascular access services are provided in a network arrangement with surgeons based at St George's Hospital, Tooting, who provide inpatient, outpatient and surgical services on site at St Helier. Interventional radiology is performed on site and at St George's Hospital, Tooting.

Two satellite dialysis units, the Croydon Dialysis Centre and Manorgate Dialysis Centre in Kingston, are provided directly by the trust for patients over the age of 18 years with renal disease who do not require dialysis in a hospital setting. At Croydon, there were 20 stations for dialysis. The service was open 7AM to 11PM, and covered by a ratio of 1 registered nurse to 5 patients. There were 94 patients in total using the service at the time of our inspection. Outreach clinics and home dialysis team to assist patients to dialyse at home is also provided, supported by contracts with external providers. At Manorgate Dialysis Unit in Kingston, there were 15 stations, including three beds, for patients requiring isolation and 2 side rooms. The unit was open for three shifts on Monday, Wednesday and Friday between 7AM and 11PM and two shifts between 7AM and 6PM on Tuesday, Thursday and Saturday. The unit is nurse led, with consultant visits weekly. The unit looks after patients from both St Helier and the nearby hospital Trust with patients having a named consultant from their respective base. There are separate protocols and guidelines for each trust and separate medical records for the patients.

We spoke with 14 patients, observed care and treatment and looked at 16 care records. We also spoke with 28 staff members at different grades, including consultants, junior doctors, ward managers, matrons, nurses, clinical nurse specialists, health care support workers and

members of the senior management team. In addition, we received comments from our listening event and from people who contacted us to tell us about their experiences.

Summary of findings

Overall, we found renal services were good. Reviews of care through incident investigation and morbidity and mortality were completed throughout the service and opportunities for learning were shared with staff. Infection control practices were robust in all areas. Staffing levels and skill mix were appropriate in all areas across the service with low agency staff usage.

Patient outcomes were in line with or exceeded national standards and effectiveness was regularly assessed and benchmarked. There was effective multidisciplinary working, with specialist nurses and allied health professionals and joint clinics were held with relevant specialties including diabetes. However we noted that standards for vascular access for haemodialysis were not met.

Most patients' spoke positively of the care they received within the hospital, and individual patient needs were met. Delays in transport were noted as a particular concern by patients' and their carers.

The environments in the dialysis units were cramped and in some areas, including at St Helier, facilities for patients were limited.

The service was well led with a clear vision and strategy and effective governance and risk management processes. Managers in the service were aware of shortfalls and took steps to address them. Staff spoke positively of the leaders and culture within the service.

Renal

Are renal services safe?

Good

We found incident reporting and investigation processes worked well and opportunities for learning were shared with staff. Infection control was practiced and monitored in all areas, and was robust.

We identified staffing levels and skill mix met the Renal Association standards across the service. Agency usage was rare and skilled bank nurses who had previously worked in the service filled gaps. Dialysis clinics provided by the service were multi-disciplinary with consultant and senior nursing leadership.

Care was consultant led on inpatient areas and there were sufficient numbers of medical staff to cover the rotas.

Incidents

- Staff could describe clearly how they would report an incident. Staff were aware of the incidents reporting systems, how to report incidents and were encouraged to do so.
- There was evidence of learning from some incidents, for example changes to standard operating procedures and recruitment of a phlebotomist. Approximately half of the staff we spoke with were aware of learning from specific incidents that had occurred within the trust or were aware of the outcomes of investigations. However, staff were less aware of specific incidents that occurred within renal services.
- In data we received prior to our inspection, the trust provided a list, which showed between 1st September 2014 to 31st August 2015 there were 605 incidents reported by the renal unit.
- One Never Event had been reported by the service in 2015. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The incident involved piece of guidewire that was retained during insertion of a temporary dialysis catheter and was identified the day after the index procedure by a radiologist at the trust. We spoke with senior nursing, medical and managerial staff to identify actions taken following the investigation into this Never Event. At the time of our inspection, the final report following the serious incident was not available.
- Incident investigations where moderate, serious harm or death resulted were undertaken but there was a lack of evidence of subsequent actions and insufficient assurance of learning, communication or change in practice to mitigate or prevent similar events. In data we received prior to the inspection, one serious incident and involving an unexpected clinical outcome and eight moderate incidents, of which four were patient falls, two were hospital associated venous thromboembolism (VTE), had been reported and investigated in the preceding year. We reviewed these investigation reports and found incidents were investigated. Senior managers told us there was feedback at monthly Renal Service Meeting, monthly band 7 meetings however the incident investigations showed evidence was not available to demonstrate that actions were always implemented and lessons learnt from these incidents, further supported by feedback from staff.
- Minutes of the September 2015 renal management meeting highlighted that staff were finding it difficult to complete root cause analysis investigations due to excessive workloads. Staff we spoke with also confirmed this was the case. We were told that a masterclass was planned to be held in 2015, though this had not yet gone ahead as investigators had not yet been identified.
- The duty of candour was upheld when a never event or incident that caused moderate harm, serious harm or death occurred. A designated quality manager was responsible for coordinating the contact between clinicians' involved and affected patients and their families. We saw this was usually applied within the timeframes stipulated by the trust policy.
- The unit held medical morbidity and mortality meetings, which senior staff told us has improved since June 2015 as they had a fixed agenda and terms of reference. These meetings were not routinely multidisciplinary. Minutes of these meetings revealed that all patient deaths and harms were reviewed.

Safety thermometer

- The unit participated in the NHS Safety Thermometer scheme. Data was collected on a single day each month

to indicate performance in key safety areas in respect of staffing levels, patient falls, and catheter acquired infections, urinary tract infections, as well as the incidence of pressure sores.

- Daily results of the indicators used in the safety thermometer were displayed on notice boards in the inpatient and outpatient areas at St Helier hospital. Both areas showed staffing levels and skill mix was maintained at the planned, safe, ratio of four nurses and one health care assistant. On Richard Bright and Secombe wards, we noted one pressure ulcers and 12 falls had been reported within the month preceding the inspection.
- Between April and October 2015, the nursing data scorecard on the renal inpatient ward areas the unit had reported three pressure ulcers graded 1 to 4, 64 falls and 0 catheter acquired urinary tract infections. Incident reporting data showed there were on average 20 falls per month in the renal inpatient areas. Senior nurses told us root cause analysis investigations into pressure ulcers were underway and a falls prevention programme commenced in September 2015 to reduce the frequency.
- There were no mixed sex breaches reported by the service in 2015.

Cleanliness, infection control and hygiene

- The trust infection prevention and control team provided training to the inpatient renal ward staff on a monthly basis.
- The unit and satellite sites were visibly clean and well maintained. The unit employed approximately 13 WTE dedicated domestic staff of which at least twowere always on site. Patients we spoke to all commented on how clean the premises were. We observed that bedside clinical waste bins were changed between each patient. Staff transferred clinical waste to a dedicated locked area for storage until collection by a waste management contractor.
- Staff adhered to the principles of five moments of hand hygiene (recommended by the World Health Organisation, which defines the key moments for hand hygiene, for example before patient contact).
- Staff educated patient's in the important infection control practice and we witnessed patient's adhering to these principles for example when handwashing.
- There was a good supply of personal protective equipment (PPE), which was used by both staff and relatives when required. Ward curtains were changed quarterly.
- Each ward, the outpatient area and both satellite clinics had side rooms for use as isolation rooms for patients identified as having an increased infection risk, for example, patients with a blood born virus, clostridium difficile (c.diff) or patients who had returned from holiday in a high risk area. Patients identified as high risk had dedicated dialysis machines that were used for them alone.
- Two episodes of cases of c.diff were reported in the preceding twelve months. Root causes were identified and infection control training was provided to the inpatient areas as a result.
- At Croydon, there was one patient positively colonised with MRSA who was dialysed in an isolation room during our visit. In Kingston, there had been no blood borne infections on the unit
- At the satellite units, patients diagnosed with hepatitis B were referred to other nearby satellite units with the required technology and equipment. The two satellite units offered exchange holiday arrangements for visitors to the UK to use the dialysis facilities. Affected patients were dialysed in the isolated rooms to minimise infection risk.
- Water quality testing was performed to monitor micro-bacterial and endotoxin levels (bacteria that in high levels can be dangerous to dialysis patients). This was monitored by the provider's central laboratory on a monthly basis. In the last twelve months, unacceptable levels were identified and acted upon. In May 2015, results were not taken as the monitoring contract was changed. However, since then all results have been taken and reported on appropriately.
- Machines were automatically sterilised between each patient as part of the dialysis machine cycle in accordance with trust infection control policies.
- Monthly hand hygiene audit results demonstrated between inpatient areas routinely failed to achieve the expected 85% compliance rate, with some areas not reporting compliance for several months in 2015. Staff told us this was being closely monitored by senior nurses, across the trust, as compliance was low in many areas.

- Monthly catheter audits performed by ward managers, matron quality rounds, infection control reviews on 'clinical Tuesdays' and infection control audits were undertaken quarterly, though results were not made available to us.
- Antibiotic prescribing rates were monitored.
  The antibiotic prescribing rate for indication was 100%, with review completed at 67% for August 2015. Averaged over eight months, the renal service scored 92% in this antibiotic audit with only two months scoring below 96%.
- There was a weekly microbiology multidisciplinary team meeting on the renal unit.

Environment and equipment

- All dialysis machines within the unit and in the satellite clinics had been serviced within the last twelve months. A record was kept of the yearly servicing and calibration of the entire unit's equipment.
- Resuscitation trollies were maintained and regularly checked in all ward areas and within the dialysis units, as per the recommendations of the trust policy and current national guidelines (2010 Resuscitation Council Guidelines UK) which were attached to these trollies.
- Blood glucose monitoring equipment was regularly services and there were sufficient stocks of single use strips.
- It was recognised that the environment in a number of areas, particularly the satellite clinics, was cramped. Some principles of the productive ward were visible for example on Beacon ward, where there were signs for storage of kit, which had been refurbished in the weeks prior to our inspection. Environmental audits were undertaken by the trust facilities team with no feedback provided. This has been escalated to the trust executive committee by the renal senior management team with plans awaiting approval to relocate the satellite sites in 2017.
- At both satellite sites, the space was cramped and there was limited room to move between stations on the unit and in the waiting area.
- The Manorgate unit had undergone a change in floor plan as the original access involved stairs, which several patients and those in wheelchairs could not climb. The new arrangement was to use an emergency exit as an entrance. Patients complained this door was not always closed fully resulting in draughts. The new arrangements also resulted in the previous fluid store being converted into a cramped patient waiting area and fluid supplies stacked into a dialysis station slot.
- Patients told us the air conditioning did not always function effectively; the unit was notably warm during our visit.
- At Manorgate we noted the floor between bays 5 and 6 was ridged and could put patients at a greater risk of falls.

Medicines

- Medicines were stored, managed, administered and recorded safely and appropriately in inpatient renal wards, renal outpatients and in the satellite dialysis units
- Audit records confirmed that medicines requiring cold storage were maintained at the correct temperature. There were processes for ensuring that medicines were kept securely in cabinets and fridges on the ward. Medicines fridges were found to be locked. Fridge temperatures were taken daily throughout all areas.
- Controlled drugs were stored according to legal requirements. Staff were observed to be carrying out routine stock checks of controlled drugs. There were no controlled drugs stored within the outpatients unit.
- We saw that clinical waste bins were not overflowing operated according to instructions and staff told us they were changed regularly.
- No patients were self-medicating during our inspection.
- Pharmacy checks were completed daily and staff checked ward stock weekly. A dedicated pharmacist undertook regular audits on prescriptions and provided regular feedback to ward staff to improve prescribing.
- At Croydon we identified saline ampules that were left on the side of the nurses' station.

Records

- We looked at 16 patient records. These were kept securely, updated consistently and available when required.
- Evidence based and standardised risk assessments were in use across on the inpatient wards, including falls and bed rails risk assessment, hourly rounding observation chart, early warning scores, venous access care plan, diabetes monitoring chart, enteral feeding regime, circulation care plan, nutrition screening tool (MUST), elimination care plan, skin integrity, turn chart, Waterlow and a nursing evaluation

- In the satellite clinics, records were kept in a closed cabinet. During their treatment, patient's records were moved to a folder on top of the dialysis machine beside the patient's chair or bed. This provided access to them for the nurse during dialysis. These notes included clear printed treatment charts and detailed care plans.
- A system for patients to view blood results (a national system available in most renal units whereby laboratory results were accessible on line) and to encourage self-management was in place but staff reported it was rarely used. We were told following the factual accuracy check by the trust, that this was because patients were provided with monthly print outs of their blood results, with explanations where appropriate. Patients could ask for blood results, but staff were unable to tell us how frequently they did this, and we could not judge how well the system worked.

Safeguarding

- Staff demonstrated an awareness of the procedure to follow if abuse of a patient was suspected or alleged. Adult safeguarding training was provided annually for all staff. The service had a suitable adult safeguarding policy in place.
- Staff completed training in safeguarding adults. An average 92% of renal staff at St Helier hospital had completed adult safeguarding training. We were not provided with a breakdown of staff for the satellite sites but told the compliance was 90%.

Mandatory training

- Mandatory training for staff working in the unit included topics such as basic life support, safeguarding, manual handling, hand hygiene, blood borne virus, blood transfusion and anaphylaxis training.
- Training was delivered using a combined learning approach, either as electronic learning, face to face or work based training.
- Training uptake was inconsistent across the topic area, location and staffing groups. Equality and Diversity, Infection Control and Manual Handling training all have had excess of 95% compliance.
- Staff told us there was no dementia training provided for those working at Croydon Dialysis unit, though staff confirmed patient's affected by dementia were screened and dialysed at another clinic with appropriately trained staff.

Assessing and responding to patient risk

- The inpatient wards used the national early warning score (NEWS) system for standardising the assessment of acute illness severity. We found clear directions for escalation and staff were aware of the appropriate action to be taken if patients scored higher than expected. Completed charts demonstrated that staff had escalated correctly, and repeat observations were taken within necessary timeframes.
- Staff described their roles and could identify the necessary steps to take in the event of a clinical emergency. They were able to identify the location of emergency equipment and how to access the crash team.
- There was a formal policy or process in place for patient identification at the satellite clinics; this was undertaken by asking a patient their name. We observed this taking place prior to administration of medication.
- Patients who became unwell during dialysis were assessed by staff and transferred to the inpatient wards. Staff at the satellite clinics told us this had not occurred in 2015.
- Handover meetings occurred at the beginning of each shift. We were told that staff were informed of any changes within the service and any high risk cases during these meetings. Individual patient care was allocated to a named member of staff for each shift. Bay allocations for nursing staff and the nurse in charge for the shift were written on a board in the unit. However, due to the close proximity of patient dialysis stations to the nurses desk, nurses had to whisper during the handover in an attempt to ensure patient confidentiality.

Diagnostics

- Two consultant renal histopathologists were employed, covering Epsom and St Helier and another hospital trust. Most renal biopsies were undertaken at St Helier, including processing and special strains. Specialist laboratory techniques were done on request at other locations. If biopsies were received by 1:00PM, they were processed on the same day with a verbal report, otherwise reported on the following day. Over 70% of written reports for biopsies were completed within three days. The MDT was attended by both pathologists and trainees.
- The renal unit kept their own database of renal diagnoses though it was recognised that it was not

possible to retrieve all groups of patients with specific conditions, for example progressive kidney conditions such as Focal segmental glomerulosclerosis (FSGS). Technicians prepare sections and the pathologists report. Electron microscopy was undertaken on 30% or more of patients.

Nursing staffing

- Planned nurse staffing levels were met. The Safer Staff Nurse tool was used to plan staffing levels and skill mix.
- Budgeted establishment was 266.5 whole time equivalence (WTE) nursing staff, there were 246.2 staff in post leaving a vacancy rate of 7.6% or 20.3 WTE nurses. Senior nurse managers told us of the lack of trained nurses in the renal specialism and thus had to rely on bank staff, who had worked in the service before, to cover vacancies and absentees. Agency nurses were rarely used.
- The percentage of nurse staffing shifts filled on the inpatient wards were between 78% and 81%. Staff told us all areas were well staffed.
- Staffing levels and skill mix were safe in all areas and maintained in line with recommendations of the British Renal Association. On the Dialysis, units staffing ratios were consistently maintained at one registered nurse to four patients with a healthcare support worker and supernumerary senior nurse. On the inpatient, wards staffing ratios were consistently maintained at one registered nurse to three patients, with healthcare support workers and a supernumerary nurse cover during the day. Most we spoke with told us that staffing levels were suitable for the level of patient care provided.
- There was a formal programme of rotation around the service for all nurses to increase skills and competencies.

Medical staffing

- The unit employed 12 WTE consultant nephrologists, supported by 17 junior medical staff.
- There was consultant-led ward provision at St Helier through the introduction of a 'Consultant of the Week' model.
- There were twice daily consultant ward rounds and handovers.
- The vast majority of care was Consultant level. Consultants provided 88% (2368/36773) of outpatient appointments in 2014/2015.
- The middle grade rota was fully staffed so that inpatient renal specialist registrar cover was available 24/7, The 9 specialist registrars contributing to the middle grade ward provided long term and consistent clinical cover and meant there was no use of locum or agency staff to cover gaps.
- Consultant clinical reviews of patients were performed during outpatient clinics held at the unit.
- At the Manorgate satellite site, consultant led clinics were held on site, every fortnight. Some of these appointments but not all, were arranged to fit in with patients attendance for dialysis. A consultant nephrologist was always available to support clinical issues in all satellite dialysis units.

Major incident awareness and training

- At St Helier, there was a major incident policy highlighting the actions to take and each individual's responsibilities in the event of an emergency. Staff were able to show the inspection team how to access the emergency contact details and police. Patients would be transferred to the local hospital A&E department in case of emergency.
- At the satellite sites, senior staff described actions they would take because of a power failure to maintain patient safety and treatment.
- Late night dialysis was provided at St Helier if the satellite units were closed in the case of an emergency.

Are renal services effective?

Good

Patient outcomes were in line with or exceeded the national average across most areas provided by the service. Policies and guidelines were in place that were consistent with national best practice and based on recommendations by organisations such as the National Institute for Health and Care Excellence (NICE) and the Renal Association.

There was evidence of learning applied from national audit activity.

There was effective multidisciplinary working across the service and good cross working between relevant departments in outpatient clinics.

Renal

Evidence-based care and treatment

- There was a process to monitor the data from each ward, outpatient department and the satellite sites, and compare the performance and clinical outcome figures against other units. This data included audits of patient records, medicine management audits and patient dialysis hours.
- Patient needs were assessed and care and treatment was delivered in accordance with the National Institute for Health and Care Excellence (NICE) quality standards and guidelines including NICE CG182 (July 2014) Chronic Kidney Disease.
- National guidance for diagnosis and treatment of central venous catheter related infections was in use. In line with the recommendations, all staff were trained in taking blood culture tests when indicated.
- Protocols and policies were up to date and reflected national standard. Staff confidently demonstrated how to locate and when they would refer to them.
- The unit participated in the National Kidney Care Audit and the National Renal Registry Report. The unit was performing in line with or better than other units in the country on most of these measures, however the data in the 2014 report is from 2013.
- The unit also participated in the Renal Replacement Therapy Audit; results were due to be published in December 2015. The unit was involved in the Peer Review of London Renal Services, as part of the London Strategic Clinical Network for renal care, due to be published in 2016.
- A local audit programme was in place.
- Key performance indicators of the satellite units and services provided by external contractors were reported monthly.

Pain relief

- On the inpatient wards staff carried out regular comfort rounds to assess whether patients were in pain, and recorded these onto the electronic system. This meant that staff wound be able to give appropriate medication or pain relief promptly if it was needed.
- Pain scores were compulsorily calculated for each patient using a standardised assessment tool. There as access to the acute and chronic pain team.
- A pain awareness week was held across the trust for November 2015, though this was not apparent on renal wards.

Nutrition and hydration

- Renal menus on the inpatient wards were available, identifying a wide range of choices that were suitable for those with renal disease and co-morbidities including diabetes, cardiovascular disease and obesity.
- Staff provided drinks and biscuits to patients during dialysis and patients were encouraged to bring their own appropriate food to their sessions.
- All patients were screened on admission for risk of malnutrition using the British Association for Parenteral and Enteral Nutrition's 'Malnutrition Universal Screening Tool' (MUST) assessment. Patients who were assessed as high risk were referred to the dietitian who identified a specific diet, e.g. low glycaemic index for patients with diabetes.
- Dieticians worked closely with the inpatient wards, undertaking annual reviews of stable patients and more frequent reviews of higher risk patients.
- In the dialysis units, dieticians reviewed the patients monthly after their blood results were available; alternatively, patients could contact the dietician for advice. The importance of good nutrition was highlighted to patients as being an integral part of their treatment. Patients who had stable blood potassium and phosphate results were seen by the dietitian annually.
- Patients received drinks and biscuits when dialysing. Sandwiches and hot meals were routinely provided at St Helier for all at risk patients on haemodialysis, although, there were some issues in relation to suitable storage of meals.

Patient outcomes

- The department participates in the National Renal Registry. The most recent results available from the 2014 report relating to 2013 data showed patient outcomes and biochemistry parameters were at or above the national average though not significantly so. Patient survival and renal function following kidney transplantation was better than average though this is also attributable to the hospital where the transplants are performed.
- Monthly audits of patient outcomes were collated as a scorecard.

Renal

- Primary access in patients on haemodialysis on treatment for more than 90 days was below the national average at 80% for arteriovenous fistula and arteriovenous graft against a national benchmark of 90%.
- 798 patients on haemodialysis were dialysing for more than 90 days.
- Senior staff told us out of hours patient transfers occurred infrequently.
- The Renal Association vascular access for haemodialysis 2015 standards (80% of prevalent Haemodialysis patients should receive treatment via a functioning arteriovenous graft fistula (AVF)) were not being met. The percentage for overall prevalent maintenance pathways was 67%, which was a requirement of the Renal Association Standards.
- Medical staff and patients complained of delays in arranging vascular surgical review and intervention. There were also delays in arranging radiological vascular procedures the pathways being managed via the offsite vascular surgeons.

Competent staff

- Staff had the right qualifications, skills and knowledge and they told us they were keen take on new responsibilities when necessary.
- Learning needs of staff were identified through annual appraisals.
- There were three practice educators in post who worked with nursing staff to develop education protocols and competencies.
- The Appraisal Rate for the Directorate is 70.05% in August 2015 (up from 66.50% in July 2015) with Objective Setting at 43.91% (up from 38.33% in July 2015).
- Dietitians provided competency training to ward staff on a monthly basis.
- Blood culture training was delivered by the Haemodialysis practice educator.
- Middle grade doctors were trained by experienced staff to undertake line insertion and renal biopsies.
- A renal audit nurse attended the satellite units every three months to provide refresher training on the use of IT by staff to improve access to information.

Multidisciplinary working

- Multidisciplinary teams (MDT) comprising of the clinical manager, nephrologist and dieticians met monthly to discuss patient care. In discussions with patients, it was evident that patients were aware and involved in their own plans of care. Staff we spoke with from different disciplines told us there were appropriate reviews of patients and a spoke of a supportive working culture.
- Patients were discussed weekly in a MDT with Consultant surgeons, nephrologists and radiologists, and vascular access specialist nurses. This included access failure for inpatients, new patients awaiting access, failed, failing or difficult access, patients who have had fistulograms and/or fistuloplasty.
- Monthly progress assessment meetings were held with the multidisciplinary team including nephrologist, dietician and clinic manager. The British Renal Association (BRA) gives a recommended duration for treatment of patients to maintain blood target levels. If patients terminate their treatment early, then this can reduce the effectiveness of their care.
- There were renal specialist diabetes nurses in post. Caseloads had increased by over 30% in three years and ward nurses required more reactive support, though staffing levels remained the same.
- Different hospitals were managing a patient's diabetic and cardiology care and they worked effectively together to plan care.

Seven-day services

- Consultant nephrology cover was available at St Helier 24 hours a day, seven days a week.
- There was a 24-hour emergency vascular service at St Helier.
- The service employs four dieticians, all of whom work part time (3 WTE dieticians). Dietetic advice was available Monday to Friday during working hours.
- Two renal pharmacists and a renal pharmacy technician provided cover 8AM to 8PM, six days a week.
- There was a part time trained counsellor allocated to the service.

Access to information

- Information, including blood results were shared electronically between the commissioning NHS trust and the dialysis unit.
- Several electronic patient record systems were used concurrently for the same patient were not linked. Paper records were used for each dialysis procedure and results subsequently transcribed by nursing staff onto the clinical vision electronic record system.

Renal

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients confirmed and we observed the consent process was undertaken in line with the trust policy. Patients who spoke with us recalled being given sufficient information to enable them to make informed decisions about their treatment and care.
- A person's mental capacity to consent to care or treatment was assessed and recorded in their notes on admission.

Are renal services caring?

Good

Feedback from patients and their carers demonstrated that staff delivered a caring and compassionate service. Patient's told us felt they were fully informed and involved in decisions relating to their care. We witnessed patients involved in the planning of their care and we saw staff treating patients with dignity and respect.

Compassionate care

- The average Friends and Family Test (FFT) scores for in 2015 was above 60%, which were considerably better than the national level of 37%. FFT scores and response rates were consistently high for the ward areas. An annual patient survey took place at six of the satellite units and the unit plans to extend this to the remaining units in 2016.
- All the patients that we spoke with told us that staff treated them with kindness and compassion. We saw relatives welcomed into the unit and treated like family by the staff. Without exception, we were told that staff were polite, friendly, and approachable. One patient told us "you cannot fault the staff, it is like a club. They are very responsive to our needs." Another said, "I cannot fault St Helier in anyway. Every time I have had terrific support".
- Patients we spoke with told us the unit was clean and well-staffed.
- Patients told us that the trust transport was unreliable and spoke of delays and cancellations in getting to and from St Helier Hospital as the transport, service caused them difficulty.
- Staff knew patients well as many used the service on a very regular basis.

Understanding and involvement of patients and those close to them

- Patients we spoke with had a comprehensive understanding of their treatment pathway.
- Patients told us the consultants communicated clinical procedures well and spoke positively about the clinic sessions they attended.
- Patients told us they had "excellent" support in helping them choose their dialysis options
- Staff told us the consent and consultation processes give patients a lot of time to discuss options
- Peritoneal dialysis for patients at home, training provided by a contractor or at St Helier. Patients were offered further training, by staff, in their own homes.

Emotional support

- Patients we spoke with had received support the counsellor working in renal services.
- There was a renal social worker, a part time counsellor and renal palliative care manager who provided end of life care support who want to stop their treatment.
- During our inspections a patient, who had an up to date mental capacity assessment, had attempted to abscond. We witnessed staff interacting calmly and confidently with this patient, offering them a drink before the patient agreed to restart treatment.
- Emotional support for each renal patient was routinely discussed at MDT meetings.
- Support group information was available in the waiting area of the unit. The service worked closely with specialist charity groups and advocacy services.

Are renal services responsive?

Good

The services at the unit were responsive to the needs of the patient. Leaders in the service planned provision to suit patient demographics. Waiting times prior to treatment were minimal and appointments were flexible where possible to cater for any changes a patient requested. Complaints were infrequently received, responded to in a non-defensive manner and in a timely fashion.

However, delays in transport were noted as a particular concern by patients' and their carers.

Renal

Service planning and delivery to meet the needs of local people

- The service understood the needs of the population it served and was planning to expand the service in response to the increasing demand by moving the satellite locations to bigger sites by 2017.
- The service had analysed the socio-economic profile and demographics of its geographical surrounding areas. The increasing age of the patient's service, with multiple co-morbidities and greater social care requirements, was understood and planned for. Approximately 20% of new patients were of Asian origin, and 10% were from other non-Caucasian heritage.
- Approximately 80% of dialysis patients receive haemodialysis, 15% peritoneal dialysis and 3% home haemodialysis, and this was in line with other comparable units in England. The service plans to continue to expand all forms of home based therapy, that would allow patients more control and ownership of their treatment.
- The late opening of the unit and the provision of dialysis night shift at St Helier, allowed patients to access services after work.
- Inpatients were referred from seven acute hospitals and were seen by visiting consultants, or following inpatient transfer.

Access and flow

- Access management was coordinated between a team of specialist nurses, with surgical and pre-admission skills, the surgical team from St Georges Hospital and the Consultant Nephrologist team. There were guidelines guiding transonic monitoring, first use of AVF, failed and failing access, and the management of clotted access.
- Related, up to date and accurate guidelines were in place such as insertion of permanent haemodialysis lines, treatment of permanent line infections, PD catheter infection.
- All pre-dialysis starters were reviewed monthly and those starting with lines were investigated.
- 'Simple' access surgery occurs at St Helier on five lists per week, mainly elective cases, such as peritoneal dialysis catheter removal. An integrated care pathway was used for the assessment and investigation of suitability for access surgery. This includes assessment for clinical fitness. Patients were discussed with link anaesthetists and had anaesthetic assessment as required. Patients were provided with patient information leaflets, which covered the scope of the procedure, possible complications and contact details for emergency or concerns.
- There was a newly developed access protocol for thrombectomy of clotted fistulas and emergency thrombectomy of clotted fistulas are performed on the elective list where there were spaces.
- No patients had operations cancelled for non-clinical reasons since January 2015. All patients who had operations cancelled prior to this for non-clinical reasons were readmitted within 28 days.
- The outpatient clinic new to follow up ratio was 8:9, though this aggregated figure was not broken down by site.
- The rate of patients who did not attend their appointments at the outpatient clinic stood at 5.24%.
- There are approximately 870 patients on Haemodialysis, 140 on peritoneal dialysis and 750 transplant patients under the care of the unit. There are up to 120 new transplants performed per year
- The Renal Unit received approximately 200 new outpatient referrals each month.
- It was recognised that outpatients clinics were often overbooked, which sometimes led to longer than expected waits. Staff told us that this was done in consultation with the patient, many of whom were long term, so they could be seen within a certain timeframe. Senior staff told they were developing a questionnaire, which would include asking patients about preferences for clinic times, though there was no timescale for this.
- A small proportion of patients, though data was not provided to us on the specific numbers of patients affected, waited longer than thirty minutes at a time for commencement of treatment due to transport and staffing issues. This was supported by a period of observation during commencement.
- There was an on-site phlebotomy team in the unit for the all morning clinics and the busiest afternoon to avoid delays.
- Outreach clinics were both consultant doctor and nurse led so that the patients could get their treatment closer to home and not have to travel extensively, although this is not always possible. There was a home haemodialysis team. There was a recognition of the need to increase the number of patients on home haemodialysis and the training team is being increased to address this

- Transport delays were identified across the site, and access guidelines set by the service for transport of 30 minutes was frequently exceeded. We were told this was fed back to the contractor in monthly meetings, though improvements had yet to be seen.
- 81.6% of discharge summaries were sent to referrers within 48 hours.
- The length of stay was in line with the national average between; September 2014 and September 2015 was ranged from 4.38 to 6.25 days. Bed occupancy was between 82% and 95% over the same period, which was mostly in line with the England average of 88%. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients.

Meeting people's individual needs

- 71% of renal Staff had been trained in the trust Patient First scheme, and staff we spoke with spoke about the impact of this training. Some staff highlighted the positive effect of seeing the service through a patient's perspective .There was a criticism that the original scheme requires 2 days of training and some staff had only completed 1 day having to cancel subsequent attendance due to clinical pressures. A revised programme was being rolled out, though a timescale was not given for this.
- A quiet room was available following a recommendation from a patient complaint.
- There was clear signposting from the main entrance of the renal unit at St Helier to guide patients
- Flu vaccinations were available for patients on haemodialysis whilst they were on the Unit at St Helier
- Patient whiteboards with named doctor and nurse were displayed in the main entrance of each ward.
- Patients had contact numbers for consultants.
- There were dedicated phone lines to wards for relatives.
- In renal outpatients, dialysis started at 7:30AM every morning and finished at 11.30pm every evening, with an additional night dialysis shift three days a week for those who wished to access it.
- Patients told us the transport service was not routinely reliable, and on occasion were late for dialysis or appointments. Patient transport services were provided by an external company, and were solely for the use of the dialysis unit's patients. Drivers were available in the unit at the prearranged pick up and drop off times. Patients who used the service did not have to wait for their transport both before and following their treatment. There was a regular transport survey for all patients on dialysis and monthly contract meetings with the transport provider.
- There were sufficient free car parking spaces for those who drove to the unit.
- Call bells were available and in reach of all patients in each chair/bed space.
- Leaflets in the waiting room were available in languages other than English. Examples included nutritional information, feedback on the service, and how to make a complaint. Family members or members of staff were available to translate if necessary, which may not be best practice or appropriate. There were four members of staff that spoke six different languages to support their patients as required.
- Services were flexible when allocating dialysis slots and negotiate with patients to suit their lifestyles. We saw evidence of patients altering their dialysis time to facilitate family events. The unit accommodated flexibility and patient choice in timings**.** Patients and staff described a process for organising dialysis elsewhere in the country or abroad when the patients went on holiday.
- Lockable cupboards were available for storing patients' personal valuables during treatment. Free wireless internet services were available for patients to access during treatment.
- In the inpatient areas, individual bedside televisions were available for patient. Staff and patients tailored entertainment to their individual needs.
- There were a limited number of televisions in the outpatient area.
- At the Croydon satellite site, there was no television facilities. Patients had to pay for internet access. There was one patient toilet for 20 patients and one separate staff toilet for seven staff; and though there were plans to move to a purpose built site, the date for this was to be confirmed.
- At Manorgate, however there was free internet access and every station had a television provided by a specialist kidney charity. There was a lack of remote controls and suitable headphones. Clinics were conducted on the first floor, accessible by lift. The rear entrance had dedicated and free car park, with a flat surface and wheelchair accessible.

- More complex vascular access surgery was performed at the nearby hospital trust.

Learning from complaints and concerns

- Staff in the satellite units told us the unit rarely received complaints, but when they did occur they were responded to appropriately and staff received feedback about themes and trends.
- In 2014/2015, the trends in PALS and complaints received related to delayed transport and delays in the outpatient clinic. Of the complaints, 72.7% were responded to in the trust target timeframe of 28 days. Since April 2015, 33% of complaints were responded to within the trust target time of 28 days. The trust protocol allows for a response time of 35 days in complicated cases, with the agreement of the patient. we were told that all complaint responses from the renal service have met this standard.

Are renal services well-led?

Good

Renal services were well led. There was a strategy in place to identify the areas that required improvement.

Staff spoke positively of the senior management team, was positive about the culture within the unit and felt well supported and confident to raise concerns internally.

The service had governance systems, which meant that risks were identified and escalated appropriately within the service for appropriate management.

Vision, strategy innovation and sustainability for this core service

- The strategy of the service was to expand provision of locally-delivered through home-based dialysis therapies (HD and PD) and through consultant-led outpatient and inpatient services, satellite dialysis centres, low clearance MDT clinics, transplant follow-up clinics, and nurse-led home educational and training visits.
- The unit plans over the next five years to redevelop the renal infrastructure at St Helier and Croydon Hospitals, to extend the provision of acute dialysis facilities into other local providers, including expansion of haemodialysis facilities.

Governance, risk management and quality measurement for this core service

- The Renal Clinical Governance Committee, in which risks, policies and complaints were reviewed, discussed and actioned met monthly and had representation from management, nursing and medical staff.
- The renal management team met fortnightly, reviewed governance and performance information, which was cascaded to clinical and support teams at the monthly renal service team. Senior staff working in satellite units meet regularly at Band 7 meetings at St Helier and provided a further management link to offsite teams.
- There were monthly clinical governance meetings held at the unit. The trust told us clinical governance meetings were also held by each location outside the main unit, but did not provide evidence of this. The lessons learnt from the incident had been discussed at the Band 7 meeting and shared with ward staff.
- The quality manager within the service focussed on recording and responding to complaints, clinical incidents, quality assurance, and risk management.
- Minutes of renal management team meetings from 2015 a general discussion of the numbers and severity grading of reported incidents were held, but actions and learning points were not documented.
- The risk register was up to date, accurate and included detailed mitigations that managers we spoke to were familiar with. The October 2015 version reflected 12 high risks, including those we identified on the inspection such as the impact of the environment on patient care. However, we noted the issue regarding vascular access was not reflected on recent iterations of the risk register.
- Both Croydon and Manorgate dialysis units were under the St Helier renal unit governance frameworks.

Leadership/culture of service

- All staff groups we spoke with commended the leadership culture within the service. Nursing staff told us the lead nurses and matrons were visible and that regular ward meetings were held. Medical staff, including those at junior grades, were complementary about the senior medical leads and opportunities the service provided to them.
- Renal services were managed by a triumvirate comprising the clinical director, the clinical nurse manager and the general manager, with direct reporting to the trust executive committee and relevant executive directors. The renal management team met fortnightly.

Renal

- Sickness absence across the unit was lower than the trust average. The overall sickness absence rate has decreased by 0.63pp from 4.48% in July 2015 to 3.85% in August 2015, which was almost in line with the trust target. Short term absence and long term absence had also decreased in 2015.
- The Lead consultant of the day was pictured in main entrance area of each inpatient ward.

Patient engagement

- A kidney care charity worked closely with the service and its website was updated regularly to keep patients informed of changes.

Staff engagement

- The trust's 'Patient First' initiatives, including specific lanyards, ward telephone answering machines, were used within the service.
- Staff were familiar with the trust values.

Innovation, improvement and sustainability

- The service had developed an acute kidney injury bundle, which was used throughout both the service sites, and referring hospitals.

Outstanding practice and areas for improvement

Outstanding practice

- The leadership of the outpatients and diagnostic imaging teams was very good with staff inspired to provide an excellent service, with the patient at the centre.
- The diagnostic imaging department worked hard to reduce the patient radiation doses and had presented this work at national and international conferences.

Areas for improvement

Action the hospital MUST take to improve

- Ensure child protection notifications are always up to date.
- Ensure there are adequate numbers of nurses and midwives to deliver safe and quality care.
- Implement agreed guidelines specific to the critical care units.
- Ensure the management, governance and culture in the critical care units, supports the delivery of high quality care.
- Obtain feedback from patients/relatives in the critical care units, so as to improve the quality of the service.
- Make sure the 'Five steps to safer surgery' checklist is always fully completed for each surgical patient.
- Identify, analyse and manage all risks of harm to women in maternity services
- Ensure identified risks in maternity services are always reflected on the risk register and timely action is taken to manage these risks.
- Improve the care and compassion shown to patients in the medicine, surgical and critical care areas.

Action the hospital SHOULD take to improve

- Ensure that the consultant hours in the emergency department meet the RCEM recommendation.
- Ensure staff were not always carry out daily checks of resuscitation equipment in all areas.
- Ensure the children's 'At Risk' register in the ED is kept up to date.
- Ensure that the trust's infection control procedures are complied and theatre staff do not wear theatre gear such a gowns and head covers in public areas.
- Improve staff attendance at mandatory training
- Ensure clinical guidelines on the trust's intranet are always reviewed and updated.
- Ensure there are agreed guidelines specific to the critical care unit and that multidisciplinary working is well embedded.
- In maternity, ensure monitoring data is separated by location.
- Ensure 'best interest' decisions are documented for patients who did not have capacity to consent.
- Ensure staff appraisals are completed as required.
- Ensure all relevant staff are clear about how the Deprivation of Liberty Safeguards should be used.
- In critical care, ensure patients are always given the opportunity to be involved in their care, where appropriate.
- Improve the referral to treatment times in surgery.
- Improve the 31 day cancer waiting times for people waiting from diagnosis to first definitive treatment and the 62 day waiting time for people waiting from urgent GP referral to first definitive treatment.
- Improve the flow of women through the maternity wards and ensure women are cared for in the most appropriate wards.
- Ensure there are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments, the auditing of patient waiting times and the timely and appropriate follow up appointments.
- Improve the cohesiveness of risk management and address them in a timely manner.
- In critical care, ensure good team dynamics and better working relationships amongst staff; an agreed strategy for the unit that includes the critical care workforce across the two sites and that all risks are identified and on the risk register.
- In maternity, ensure risks are properly identified and managed in a timely way, leadership

Outstanding practice and areas for improvement

- Review arrangements for admission of women to maternity wards so that a member of staff can greet women and prevent unauthorised access.
- Ensure policies reflecting national evidence-based guidance are communicated to all staff.
- Ensure staff were able to use the structured communication tool, SBAR (Situation, Background, Assessment, Recommendation), effectively.
- Review the skill mix on the maternity wards.
- Increase the number of sonographers in radiology.
- Ensure that the paediatric emergency department comply with Royal College of Paediatric and Child Health guidelines.
- Ensure the servicing of equipment is undertaken on a regular basis and that broken equipment is removed from clinical areas.
- Ensure pain scores are routinely recorded in the emergency department.
- Improve the response times to complaints in the medical directorate.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Children were not being protected from abuse and improper treatment because child protection notifications were not always up to date; so staff were not always aware of children on the child protection register.** Regulation 13 (1)(2)(3)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided because;** 1. There were not agreed guidelines specific to the critical care units. 2. The management, governance and culture in the critical care units, did not support the delivery of high quality care. 3. Feedback from patients was not always obtained in the critical care units. 4. The 'Five steps to safer surgery' checklist was not always fully completed for each surgical patient. 5. All risks of harm to women in maternity services were not always identified, analysed and managed. 6. Identified risks in maternity services were not always reflected on the risk register and action to manage risks was not timely. Regulation 17 (2) (a), (b), (e)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were not sufficient numbers of suitably qualified, competent, skilled and experienced nursing and midwives in many areas but in particular, surgery, children and young people and maternity services because;** 1. Nurse staffing levels had a negative impact on patient care on one surgical ward and the children and young people services at St Helier Hospital. 2. There were risks to women due to the inadequate and poor deployment of midwives at St Helier Hospital. **Regulation 18 (2) (a)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care and treatment of patients was not always appropriate or met their needs because;** 1. The care and compassion to shown to patients in the medicine, surgical and critical care areas was at times lacking. **Regulation 9 (3) (a), (b), (c), (d), (e), (f), (g)**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Some premises and equipment was not properly used, properly maintained or suitable for the purpose for which they were being used because;** 1. Emergency equipment was not always checked in line with the trust wide policy.

This section is primarily information for the provider

Requirement notices

2. The existing estate in some areas was not fit for the purpose of delivering modern healthcare.
3. There were not robust processes in place for the maintenance of medical equipment.

Regulation 15 (1) (c), (d), (e)