Care Quality Commission

Ashford and St. Peter's Hospitals NHS Foundation Trust

St Peter's Hospital

Quality Report

Management Offices
St Peter's Hospital
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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	Good
Medical care	Good
Surgery	Good
Critical care	Requires improvement
Maternity and gynaecology	Good
Services for children and young people	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Ashford and St Peter's Hospitals became a foundation trust on 1 December 2010. As an NHS Foundation Trust there is greater freedom and scope to provide services for patients and the communities and more financial control of investments and expenditure.

The trust provides district general hospital services to a population of around 410,000 people living in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow and Surrey Heath. There are variations within those areas in terms of the ethnic diversity of the local populations and levels of deprivation. In Spelthorne and Runnymede the average proportion of Black and minority ethnic residents was 12.7% and 11% respectively, both lower than that of England of 14.6%. The average proportion of Black and minority ethnic residents in Hounslow was 48.6%, significantly higher than that of England (14.6%). Deprivation in all three areas was the same as the England average, but with higher-than-the-England-average rates of children in poverty and statutory homelessness in Hounslow. The trust also provided some specialist services including neonatal intensive care, bariatric (weight loss) and limb reconstruction surgery.

At the time of this inspection, there had been some recent changes within the executive team. The chief executive had been in post since September 2014, having previously been the chief nurse since 2010.The chief nurse had been in post since October 2014, having previously been the deputy chief nurse and associate director of quality. The chair had been in post since 2008.

We carried out this comprehensive inspection as part of our in-depth inspection programme. The trust had been assessed as band 6 and 5 in our 'intelligent monitoring' system between March 2014 and July 2014. (The intelligent monitoring looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations.) Our inspection was carried out in two parts: the announced visit, which took place on 3–5 December 2014; and the unannounced visit, which took place on 14 December 2014.

Our key findings were as follows:

Safety

- Safety required improvement in urgent and emergency care, medical care, surgery, critical care and children and young people.
- Staff were aware of the requirements for reporting of incidents which were investigated with findings and learning being fed back locally.
- There were concerns with the safe storage of medicines in some medical and surgical wards and that staff in the children wards were not all up to date with medicines management training.
- The trust was taking action and implementing changes to respond to an increased demand in some outpatient clinic services. Some additional clinics were being run and action was being taken to improve the patient experience with regards to appointment booking.
- All areas visited were seen to be visibly clean.
- We looked at a selection of resuscitation equipment across clinical areas and found that this was correctly serviced, cleaned and checked at regular intervals.
- Records were not consistently stored to maintain patient confidentiality. Some records were not accurate in reflecting the needs of the patient.
- There were challenges in clinical areas being able to recruit and retain staff which led to a lack of sufficient permanent staff and caused a number to work additional hours in theatres, critical care and the children's ward. Staff in other areas found it difficult at times to attend training.
- The trust was working to achieve a target of 100% for completion of the World Health Organization (WHO) checklist. There had been a recent re-launch and communication to staff as part of the drive for improvement.

Summary of findings

Effective

- All services were found to be effective.
- There was evidence of good multidisciplinary working. Of note was the competent specialist palliative care team who worked successfully throughout the hospital. They were accessible, visible and utilised.
- The clinical effectiveness of the services was good. Care and treatment was delivered by trained and experienced medical staff and committed nurses. The service followed national guidelines, practice and directives.
- Patients' pain was assessed in services using appropriate pain assessment tools and there was a dedicated acute pain team who were easily accessible to ward staff. For patients who had a cognitive impairment, such as dementia, staff used the Bolton Pain Assessment Scale to aid their assessment.
- Staff had access to policies and protocols which took account of requirements for National Institute for Health and Care Excellence (NICE) guidance relevant to their area of practice. For example, we specifically looked at the requirements of the guidance Acutely Ill Patients in Hospital (QS6), Preventing Falls in Older People (CG161) and IV Therapy in Adults in Hospital (CG174) and found that policies and practice met the guidance.
- Although no data was provided at this early stage, the Abbey Birth Centre was reporting improved outcomes for reduced uptake of pain relief, mobility in labour, less use of Syntocinon for augmentation of labour and fewer operative deliveries.

Caring

- All services were found to be caring.
- Caring staff throughout the hospital were seen to treat patients at the end of their lives and patients' relatives with dignity and respect.
- The chaplaincy department of the hospital was proactive in its support of end of life care. The chaplain and volunteers visited the wards daily providing support to those patients who needed spiritual support. The chaplain was also present on the end of life steering group to ensure that the spiritual needs of patients continued to be in focus. The chaplain had also reintroduced the end of life care group for relatives to provide further support.
- Children and young people were encouraged by staff to be involved in their own care. Two young people told us that they were able to do a lot of things for themselves but that the staff were available if they needed any extra help or support. They were also able to speak to clinicians on their own.

Responsive

- Aside from urgent and emergency services all were found to be responsive.
- The emergency and urgent care services at St Peter's Hospital were not always able to achieve and sustain delivery on the expected targets, despite their best intentions. This impacted on patient flow and there were frequent occurrences of patients staying in the department for excessive hours, awaiting ward beds.
- The trust had introduced a telephone reminding service for appointments. This had helped to reduce the rate for patients not attending appointments from 13% to an average in the last 12 months of 8%.
- To reduce the number of times a patient may have to attend for several outpatient appointments, staff aimed to arrange to have more than one appointment on the same day. Patients' experience was that this worked well and, though they had a long wait at times, they were please they only had to visit the hospital once.

Well-led

- We judged improvements were required in the well led domain for critical care, services for children and young people and maternity and gynaecology services. All other services were found to be well-led.
- In critical care we found there was no robust programme of governance, risk assessment, assurance and audit. The governance arrangements of the service were not providing feedback on incidents, audits, or results from those quality measures it had. There was a lack of accountability for driving through actions and improvements.

Summary of findings

- In maternity and gynaecology We found a considerable number of staff had been impacted by what had been acknowledged as some inappropriate leadership behaviours. The new Associate Director of Midwifery had been in post for 14 months and a new engaging leadership style was evident. The current leadership team had developed a vision and were working on an action plan following the external review which focused on quality and team work.
- In services for children and young people staff on Ash Ward told us they had not had any formal leadership for the last six months and it had been a very difficult period. We were told of a number of new appointments to senior posts that were just about to start, meaning that all of the wards and departments would have their current designated senior posts filled. A Recent senior nursing staff appointment had been welcomed as there had been a period of time without leadership within the paediatric services.
- All staff we spoke to across the hospital were aware of the trust's vision. We observed that staff were putting the principles into action and could give examples of how they did so.
- All staff we spoke with told us that trust and divisional leaders were highly visible.

We saw several areas of outstanding practice including:

- Good joint working between the wards and departments, the bereavement services, chaplaincy services and the mortuary services to ensure as little distress as possible to bereaved relatives.
- Caring staff throughout the hospital, who were seen to treat patients at the end of their lives and patients' relatives with dignity and respect.
- The trust had a proactive escalation procedure for dealing with surges in activity and managing capacity.
- The major incident procedures had been regularly tested internally and with external partners with reviews of learning being implemented.
- The trust had developed an Older People's Assessment and Liaison (OPAL) team which enhanced the care of the frail elderly by ensuring these patients were effectively managed by a specialist team early in their admission. Their interventions decreased the number of admissions of this group to speciality wards, and also contributed to fewer patients being readmitted. Patients and their supporters said they felt involved in care planning and discharge arrangements.
- The electronic patient record system in the intensive care unit (soon to be brought into the high dependency unit) was outstanding. Patients benefitted from comprehensive, detailed records in one place, where all appropriate staff could access and update them at all times.
- In critical care there was an outstanding handover session between the consultants going off duty and those coming onto shift. This included trainee doctors and made excellent use of the electronic patient record system.
- The dinosaur trail designed to distract children on their walk to the operating theatre had proven to be very successful. It meant children were not scared when they arrived at the operating theatre.
- The play therapy team who worked within the paediatric services were very enthusiastic about their work, were well-respected by children and their parents and staff. The team had won a £3,000 prize for innovative ways to brighten up the playroom.
- The children's ward staff worked hard, with the clinical nurse specialist to ensure patients with diabetes had a high standard of care and there was a well-established transition to adult services.
- The trust had a very detailed policy for use at times when patient safety needed to be maintained to enable treatment through applying 'mittens'. The policy provided staff with guidance on their use in line with the Mental Capacity Act 2005, from the assessment of the patient, recording the decisions and the continual review of decision and when to stop using them.
- The trauma and orthopaedic unit had set up an early discharge team to reduce the length of stay for patients with hip fractures. Patients had continuity of care from hospital into their own home as they had the same staff. This had reduced their length of stay in hospital.

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

Importantly, the trust must:

Summary of findings

- Take action to ensure medicines in medical care services are stored at temperatures that ensure they remain in optimum condition and provide effective treatment.
- Ensure that all trained paediatric nurses are up to date with medicines management training.
- Take action to ensure patient records are kept securely and can be located promptly when required.
- Take action to ensure the critical care department has sufficient numbers of suitably qualified, skilled and experienced nursing staff on the units and the outreach team to safeguard the health, safety and welfare of patients at all times.
- Take action to ensure staffing levels on Ash Ward are such that they are able to meet the needs of their patients at all times.
- Take action to ensure theatres, anaesthetics and surgical wards have sufficient numbers of suitably qualified, skilled and experienced nursing staff to safeguard the health, safety and welfare of patients at all times.
- Ensure in the critical care department that there is a full range of robust safety, quality and performance data collected, audited, examined, evaluated and reported. The trust must ensure it has sight of this data, which follows the standards of a national programme, at board level.

In addition the trust should:

- Ensure the security arrangements for accessing the paediatric area in the A&E department are adhered to in order to prevent unauthorised access.
- Ensure the layout of the A&E department waiting area enables sufficient visibility for staff to identify if a patient's condition deteriorated.
- Ensure the access/exit routes of the room used for psychiatric assessment in the A&E department are not obstructed to protect the safety of staff and patients.
- Follow up the recommendations from the maternity external review to provide an improved experience and outcomes for women and their babies from ethnic minorities and for families with greater social factors and stress.
- Ensure adherence to the trust policy on inappropriate movement of patients at night, in particular those receiving palliative care.
- Ensure those patients who receive palliative care and have complex needs do not have a protracted journey via several clinical areas on their admission to hospital.
- Report on and display in the critical care department incidents of all categories of patient harms. These should be reported in staff and clinical governance meetings and actions taken around any trends or performance improvement identified.
- Ensure in the critical care department that all investigations it carries out into serious incidents have action plans attributable to members of the team, and mechanisms for actions to be followed up and reported.
- Ensure in the critical care department that all clinical areas are able to be easily cleaned and free from dust and sticky tape on the walls in clinical areas. The critical care operational policy should set out what area is considered as the 'clinical area' and how staff should behave in relation to infection prevention and control in this area. This should follow the trust policy on infection control.
- Audit critical care recommendations for the Faculty of Intensive Care Medicine Core Standards and escalate areas where it does not meet the standards to the trust risk register. This should extend to: cover provided from allied health professionals, including the pharmacist, confidentiality of patient records in the high dependency unit (HDU), and the environment of the HDU.
- Ensure any secure areas, such as the clinical room in the HDU, are attended to immediately when security fails due to broken door locks.
- Ensure critical care has access to a practitioner skilled in advance airway techniques at all times.
- Monitor all critical care patients for delirium using a recognised tool.
- Look to provide patients in the critical care department with innovative services to contribute to their emotional support and wellbeing. Patients' and relatives' views should be sought to determine what patients want from critical care. Their views and opinions should be acted on and used to improve the service.

Summary of findings

- Ensure that any policy used in the critical care department be approved by the relevant party within the hospital trust. Operational policies should be written in accordance with trust policies. The critical care operational policy should ensure statements around patient consent are made in line with current legislation and the Mental Capacity Act 2005.
- Consider how to improve the dementia-friendly design of its facilities.
- Ensure that medical care services consider how it formulates and records its strategy.
- Ensure negotiations remain ongoing with the local clinical commissioning group around designation of high dependency beds on Ash Ward.
- Ensure the staff skill mix on Ash Ward is such that the needs of children and young people with mental health needs can be effectively cared for and managed at all times.
- Ensure that all parents and staff are aware of the hot drinks policy when on the paediatric wards.
- Ensure the inpatient observation charts include a section for ongoing pain assessment, including how a child is responding to pain relief given.
- Review the dispensing of medication on Wren Ward from their medication room directly to patients without the use of safe and secure storage facilities.
- Review the storage arrangements of the oxygen cylinders in the sluice area in recovery.
- Ensure that staff receive safeguarding training to meet their target.
- Review the use of the mobile privacy screen on Wren Ward to ensure privacy for patients.
- Ensure assistance is provided to visually impaired patients with their meals.
- Consider how they ensure that staff in A&E understand their responsibilities regarding the Mental Capacity Act 2005 and its associated Deprivation of Liberty Safeguards.

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	Good	The A&E services at St Peter's Hospital was not always able to achieve and sustain delivery on the expected targets, despite their best intentions. This impacted on patient flow and there were occurrences of patients staying in the department for excessive hours, awaiting ward beds. The paediatric area of the department was accessible through unsecured doors, which posed a risk to the safety of children using the department. The layout of the seating area in the main reception did not enable staff to identify patients whose condition may deteriorate. Activity levels in the department impacted on the staff's ability to undertake all the required training and development, and, as a result, there were gaps in some staff knowledge, such as around the requirements of the Mental Capacity Act 2005. The major incident procedures had been regularly tested internally and with external partners, with reviews and learning implemented. The department participated in a range of local and national audits designed to enhance patient treatment and care. There was a strong culture of incident reporting, which was recognised by staff as a valuable opportunity to learn from mistakes or omissions. Staffing arrangements included use of temporary or agency staff who had been provided with information which enabled them to support the delivery of safe and effective care. Staff were observed to be kind, caring and compassionate and the majority of feedback from patients and their relatives was favourable. Staff reported positively on the leadership of the department and were very aware of the values that underpinned the delivery of patient care.
Medical care	Good	We found that medical care services at St Peter's Hospital required improvement in some aspects of patient safety. This was because we identified some concerns with medicines management, nursing staffing levels and hand-washing to prevent

Summary of findings

infection. Otherwise, we found that there were good systems to report and investigate safety incidents and that there was learning from these to prevent recurrence.
We found that treatment generally followed current guidance, and that outcomes for patients were often better than average. We found that there were arrangements to ensure that staff had the necessary skills and competence to look after patients. Patients had access to services seven days a week and were cared for by a multidisciplinary team working in a coordinated way. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements.
Patients told us they received compassionate care that respected their privacy and dignity and we observed care being delivered in a kind and respectful way. Patients told us they felt involved in decision-making about their care.
We found services were developed to meet the needs of the local population. However, the service experienced difficulty meeting the demand for its services and this resulted in long waits for admission and disruption to the agreed patient pathways. There were arrangements, including for patient discharge, to help patients with complex needs.

Surgery

Good

While care was seen to be caring and compassionate across all areas, improvement was required to make the service safe.
Staff were encouraged to report any incidents on the trust's computer system. Where incidents had been repeated, it would suggest learning from these had not taken place.
Compliance with the WHO surgical safety checklist was not meeting the trust target.
There was a high number of qualified nurse vacancies across the division. Staff told us they were working extra bank (overtime) hours to cover, as well as using agency staff.
Storage on some wards for patient notes was not secure and this meant visitors to the hospital could have had access to these confidential records.

Summary of findings

The trust participated in local and national audits, for example, the hip fracture audit. There was good multidisciplinary working within the units and wards.
Patients and their relatives felt the care patients received was very good. Patients told us the staff respected their privacy and dignity.
The trust was not meeting the 18-week referral-to-treatment time (RTT) target for general surgery and trauma and orthopaedics.
A new urology unit had recently been opened to make the assessment of patients quicker and to provide their treatment at one location.
Staff told us they were aware of the trust's visions and values and they were very passionate about patients receiving good care. Staff on the wards told us they felt supported and listened to by their divisional management team. However, some staff in theatres told us they did not feel supported by or listened to by the divisional management team.

Critical care

Requires improvement

We have judged the overall performance of critical care as requiring improvement. This was due to the unit needing to improve safety and governance. The effectiveness, caring and responsiveness of the unit was good.
The most pressing issue for the safety of the unit was the shortage of substantive and experienced nursing staff on the units and the outreach team, and the significant use of agency nursing staff. Work on quality and performance safety audits, analysis of incidents, and responding to patient risk was not given the priority it required. There was a lack of good data available on patient harms. Patient records were outstanding in the intensive care unit (ICU), where the use of an electronic patient record system contributed to patient safety and quality.
The safety of the high dependency unit (HDU) environment and equipment had not been assessed since it was incorporated into critical care in October 2014.
The clinical effectiveness of the unit was good. Care and treatment was delivered by trained and experienced medical staff and committed nurses. The service followed national guidelines, practice and directives. The units were recording consistently low death rates. The unit was not able

to deliver as much teaching as required both internally and for the outreach nurses out on the wards. There was an insufficient number of nursing staff with post-registration qualifications in critical care.
The care given to patients and their relatives by staff was good. Patients and relatives were happy with the care provided. The care we observed from the nursing staff was kind, reassuring and supportive. Patients were treated with respect and their dignity was maintained.
The critical care service responded well to patient needs. Delayed discharges and discharges onto wards at night were below (better than) the national average rates. There was a very low rate of elective surgical operations cancelled due to unavailability of a critical care bed. The facilities in the ICU were good and met many of the modern critical care building standards. The HDU was, however, less fit for purpose and there were limited facilities for patients, staff and visitors.
We have judged the service as requiring improvement in terms of governance. There was no robust programme of governance, risk assessment, assurance and audit. The governance arrangements of the service were not providing feedback on incidents, audits, or results from those quality measures it had. There was a lack of accountability for implementing actions and improvements.
There was, however, a strong culture of teamwork and commitment in the critical care service. All the staff we met were dedicated and professional. Staff were supportive to their patients and to one another. All staff had similar worries about the unit, and these centred around the shortage, retention and recruitment of nursing staff.

Maternity and gynaecology

Good

We found that the maternity and gynaecology services provided at Ashford and St Peter's were good overall and improving; there was a sense of pride in the service and optimism for the future. Midwives and doctors collaborated well to achieve the best outcomes for women and their families. Feedback from women using the services was good, received through the NHS Friends and Family Test.

Summary of findings

The midwife-to-birth ratio was 1:31 which was just outside the recommended ratio of 1:29. Many of the managers worked as supernumery and in clinical capacity and there was a flexible system for the deployment of staff to deal with peaks in activity.
The recent opening of the Abbey Birth Centre which had enhanced the service by ensuring that women were cared for in the areas most appropriate to their needs.
There was a new, engaging and participative leadership style with clear standards for safety and quality and a greater empowerment of midwives to make decisions, as appropriate, and provide a normalised childbirth experience.
Introduction of the Perinatal Institute Growth Assessment Protocol had led to some duplication of postnatal records and gaps in information.
We found a considerable number of staff had been impacted by what had been acknowledged as inappropriate leadership behaviours. The current leadership team had developed a vision and were working on an action plan following the external review which focused on quality and team work.

Services for children and young people

Requires improvement

Services for children and young people were found to be good overall, with safety requiring some improvement. Children received good care from dedicated and caring staff who were skilled in working and communicating with children, young people and their families.
Children and their families were involved in their care and treatment and their feedback regularly sought and listened to. We had positive comments from all of the parents and children we spoke with. We observed positive, inclusive interactions with babies, children and their families.
The arrangements for safeguarding had recently been reviewed and new policies and procedures were in place. As a result, the systems were not yet embedded in practice. Staff told us about the developing culture that encouraged them to report issues as they arose.
Ash Ward told us they had not had any formal leadership for the last six months and it had been a very difficult period. We were told of a number of new appointments to senior posts that were just about to start, meaning that all of the wards and

departments would have their current designated senior posts filled. A Recent senior nursing staff appointment had been welcomed as there had been a period of time without leadership within the paediatric services. Staff reported, especially on Ash Ward, that they could see the new leadership taking effect and now felt supported and listened to.
Due to lack of beds regionally, Ash Ward sometimes provided high dependency care in the close observation bay. This put extra pressure on staff as the ward was not funded for this and did not have the resources to meet the needs of these children. Despite that, the staff provided good care to these children and their families.
The neonatal intensive care unit (NICU) and Oak Ward (day surgery and oncology day care) functioned well with appropriate systems and procedures.
Accommodation was available for parents who had babies in the NICU and letters and cards displayed in the unit showed how important that was so parents could be close to their babies at all times.
Separate areas for adolescents had been created on Ash Ward and those using the facilities during our visit appreciated the efforts that had been made.
The play therapy team was very active in supporting children and their families. They worked well together as a team and provided a six-days-a-week service; soon to be seven days a week once one person had completed their training. The team had won a £3,000 prize for innovative ways of improving the play room.

End of life care

Good

The specialist palliative care team were accessible, visible and supportive of all areas in the trust. Team working with all wards and departments was evident to promote safe and effective end of life care. Staff throughout the trust valued the skills and support of the specialist palliative care team. The review of patients took place within multidisciplinary meetings to promote coordinated, safe and effective care. Care records demonstrated that potential problems for patients were identified and planned for in advance. The team were piloting and reviewing a person-centred care plan to be used to improve the safe and effective delivery of care in line with current best practice.

Summary of findings

Staff throughout the trust were caring and treated end of life patients and their relatives with dignity and respect. Staff made every possible effort to ensure that patients and relatives had everything they needed to be comfortable and accommodated. The close working relationship between the nursing and medical staff, chaplaincy, bereavement, mortuary services and porter services was evident to support patients and relatives.

Outpatients and diagnostic imaging

Good

We found that a safe environment for patients was maintained and that the required safety checks were being completed and recorded. The outpatient waiting areas and clinic rooms were clean and hygienic.

Patients attending the outpatient clinics were positive about their treatments and consultations and the professionalism of the staff.

Clinical staff were caring and compassionate in their approach to patients. Staff were treated with respect.

The trust was taking action and implementing changes to respond to an increased demand in some clinic services. Some additional clinics were being run and action was being taken to improve the patient experience with regards to appointment booking.

There were consistent processes to monitor the performance of the different clinic services and identify risks and ongoing concerns. There was an ongoing transformation plan for the outpatient service that was being implemented with the engagement of staff.

Requires improvement

St Peter's Hospital

Detailed findings

Services we looked at
<Delete services if not inspected> 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

Contents

Detailed findings

Background to St Peter's Hospital

Ashford and St Peter's Hospitals NHS Foundation Trust was formed from the merger of Ashford and St Peter's hospitals in 1998 and became a foundation trust in 2010.

The trust had 636 beds, of which 553 were inpatient (overnight) beds and 83 were for day cases. Of the 553 inpatient beds, there were 55 maternity and nine critical care beds. The trust employed around 3,500 staff Ashford Hospital 618 (537 wte) and St Peters Hospital 3,067 (2,742 wte)–In the financial year 2013/14, the trust had a turnover of £246 million and reported a surplus of £1.4 million.

The trust provided district general hospital services to a population of around 410,000 people living in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow and Surrey Heath. There are variations within those areas in terms of the ethnic diversity of the local populations and also in deprivation. In Spelthorne and Runnymede, the average proportion of Black and minority ethnic residents was 12.7% and 11% respectively, both lower than the England average of 14.6%. The average proportion of Black and minority ethnic residents in Hounslow was 48.6%, significantly higher than England (14.6%). Deprivation in all three areas was the same as the England average, but with higher-than-the-England-average rates of children in poverty and statutory homelessness in Hounslow. The trust also provided some specialist services, including neonatal intensive care, bariatric and limb reconstruction surgery.

At the time of this inspection, there had been some recent changes within the executive team. The chief executive had been in post since September 2014, having previously been the chief nurse since 2010.The chief nurse had been in post since October 2014, having previously been the deputy chief nurse and associate director of quality. The chair had been in post since 2008.

We inspected both St Peter's and Ashford hospitals. The inspection did not include the BMI Healthcare Runnymede Hospital that provides services on the St Peter's Hospital site at Chertsey.

We inspected the trust as part of our in-depth inspection programme. The trust has been identified as a low-risk trust according to our 'intelligent monitoring' system between March and July 2014. Our inspection was carried out in two parts: the announced visit, which took place between 3 and 5 December 2014 and the unannounced visit which took place on 14 December 2014.

Our inspection team

Our inspection team was led by:

Chair: Gill Gaskin, Medical Director, University College London Hospitals NHS Foundation Trust

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team of 42 included CQC inspectors and a variety of specialists: a consultant intensivist, a consultant vascular surgeon, a consultant paediatric surgeon, a consultant obstetrician, a consultant in end of life care, two junior doctors in medicine, pharmacists, a director of nursing, an associate director of governance, specialist nurses in paediatrics, theatres, end of life care, surgery and accident and emergency (A&E), a midwife, a student nurse, an expert by experience, an occupational therapist and an associate director of nursing and safeguarding lead.

How we carried out this inspection

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These included the

Detailed findings

clinical commissioning group (CCG) at North West Surrey, Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Healthwatch.

We held a listening event in Chertsey on 27 November 2014 where 20 people shared their views and experiences of services provided by the trust. Some people who were unable to attend the listening event shared their experiences with us via email or telephone. We also met with a group of patient representatives from the Surrey Coalition of Disabled People who shared their experiences of using the trust.

We carried out an announced inspection visit between 3 and 5 December 2014 and an unannounced visit on 14 December 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, physiotherapists, occupational therapists, administrative staff, healthcare assistants and support workers. We also spoke with staff individually, as requested.

We talked with patients and staff from across the hospital, including in ward areas and outpatient services. We observed how people were being cared for, talked with carers and family members and reviewed patients' records of personal care and treatment. We interviewed the chair and the chief executive, and met with a number of executive and non-executive directors, a number of the trust governors, senior leaders from the clinical divisions and managers.

Facts and data about St Peter's Hospital

Ashford and St Peter's Hospitals NHS Foundation Trust had 636 beds and employed around 3,500 staff Ashford Hospital 618 (537 wte) and St Peters Hospital 3,067 (2,742 wte)The trust provided district general hospital services to a population of around 410,000 people living in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow and Surrey Heath. The trust also provided some specialist services, including neonatal intensive care, bariatric and limb reconstruction surgery.

In 2013/14 the Ashford and St Peters sites had approximately 38,948 elective admissions of which 32,356 were day cases. The Trust had a further 23, 906 emergency admissions and non-elective admissions and provided approximately 397,655 outpatient attendances. During the same year the emergency department dealt with 92,198 attendances.

The trust had consistently high bed occupancy. This regularly reached over 90% and was 90.7% between April and June 2014 (the latest figures available at the time of the inspection). It is generally accepted that when occupancy rates rise above 85% they can start to affect the quality of care provided to patients and the orderly running of the hospital.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Requires improvement	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	N/A	N/A	N/A	N/A	N/A	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

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

Information about the service

The urgent and emergency services at St Peter's Hospital provide a 24-hour, seven-day-a-week service to the local population of 380,000. Between April 2013 and March 2014, 91,638 people attended the department. The number of patients who were admitted to a ward was 23,906.

The department has provision for adult and children's emergency and urgent care assessment and treatment. The number of adult and paediatric attendances at the department between 4 April and 19 September 2014 was 42,029. Of these, the percentage of patients under the age of 17 attending the department was 24.1% between April and June 2014 and 21.4% between July and August 2014.

Patients either self-present to the department and book in at the reception area or arrive by ambulance. Where a patient arrives in the department on foot, after booking in they are seen by a triage nurse who prioritises or 'streams' them to the appropriate care area. Patients who arrive by ambulance are initially assessed by a senior nurse within the 'pit stop' area where they are handed over by ambulance staff, before being assessed. Emergency 'blue-light' patients are admitted to the major area or resuscitation room.

The Emergency Department consists of 20 cubicles in the major / trolley (Majors) area, 8 cubicles / examination rooms in the minor injuries (Minors sections) including a triage / streaming room, 7 beds in the PIT stop ambulance assessment area and 6 beds in the Clinical Decision Unit. In addition there are four resuscitation bays, one of which can be used by children. The children's area has seven cubicles, including one used for triage.

During the inspection, which took place across three days (3–5 December 2014), we looked at all areas of the department, including reception, triage (sorting) and areas for the provision of minor and major patient treatment and care. We looked at the resuscitation room, PIT stop area, the clinical decision unit and associated treatment rooms. We visited the children's area and reviewed all aspects of service provision there. We also undertook an unannounced inspection on Sunday 14 December, where we visited both adult and children's areas.

We spoke with nine patients and seven relatives and reviewed the care records for 14 patients. We spoke with more than 50 staff and made observations of activity in the department.

Urgent and emergency services

Summary of findings

The emergency and urgent care services at St Peter's Hospital required improvement in some aspects of patient safety. They were not always able to achieve and sustain delivery on the expected targets, despite their best intentions. This impacted on patient flow and there were occurrences of patients staying in the department for excessive hours, awaiting ward beds. The department's staff demonstrated that they were continually reviewing their processes and responded to the situation to ensure patients received appropriate care in a safe and timely manner.

The paediatric area of the department was accessible through unsecured doors, which posed a risk to the safety of children using the department. The layout of the seating area in the main reception did not enable staff to identify patients whose condition may deteriorate.

Activity levels in the department impacted on staff's ability to undertake all the required training and development. As a result, there were gaps in some staff's knowledge, such as about the Mental Capacity Act 2005.

The major incident procedures had been regularly tested internally and with external partners, with reviews of learning implemented.

The department participated in a range of local and national audits, designed to enhance patient treatment and care. There was a strong culture of incident reporting, which was recognised by staff as a valuable opportunity to learn from mistakes or omissions. Complaints were acknowledged and acted on in an open and transparent way.

Staffing arrangements included use of temporary or agency staff, who were provided with information, which enabled them to support the delivery of safe and effective care. Staff were observed to be kind, caring and compassionate. They took time to speak with patients and their relatives and the majority of feedback from patients and their relatives was favourable.

There were good arrangements to engage with the multidisciplinary team and to refer patients to associated expertise and support. Staff reported positively on the leadership of the department and were very aware of the values that underpinned the delivery of patient care.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

Emergency and urgent care services were judged as requiring Improvement. The secure arrangements for accessing the paediatric area of the department were not maintained at all times. The layout of the seating area in the main reception did not enable staff to identify patients whose condition may deteriorate. A number of seats in this area were damaged.

There was sufficient equipment available to support the delivery of patient care; however, some electrical items did not have up-to-date evidence of required safety checks.

The department experienced difficulties in recruiting sufficient nursing, medical and administrative staff; however, staffing levels were supported by regular agency, locums or bank (overtime) staff so that safe care was provided to patients.

Training records related to hand hygiene demonstrated 48% of staff did not meet the trust's competency requirement. Over the three days we undertook observations of staff's hand-washing practice. We observed varying levels of compliance with hand washing or use of hand decontamination gel in between seeing patients.

Safety of staff and patients using the room designated for assessment of patients with mental health issues was not assured. Whilst there were two doors in the room one was blocked by large metal cages on the outside. This presented a risk to staff of not being able to exit the room in the event of a patient incident or emergency.

Incident reporting was understood by the majority of staff and it was common practice to report incidents or near misses via the trust's reporting programme. There was evidence of staff learning from incidents, near misses and errors. Improvements were implemented where the review process identified the need to act.

There were systems to monitor patients at risk, to protect and maintain their safety. Safe systems and processes were used for infection prevention and control and for managing medicines.

The major incident procedures had been regularly tested internally and with external partners, with reviews of learning implemented.

The department had processes for assessing patients when they first presented to the department, and also for monitoring patients when they remained in the department for extended periods. Patients were escalated to the appropriate clinician as required to ensure they received timely care and treatment.

There were arrangements to ensure staff were suitably skilled and competent for their duties. Staff had access to relevant training and development, although high activity in the department often prevented them from attending.

Incidents

- Staff reported incidents, including near misses, via the trust's electronic reporting system. We were able to review a sample of 726 incidents reported for the period April to October 2014. Information reported by staff included the date and location, a description of the event and a grade of impact from low, moderate to high. The majority of events reported had been assigned a green low-risk rating. The one red, high-risk rating related to patient numbers in the department. We saw action taken by staff was described in the reporting process, including immediate action and referral to other relevant personnel.
- With the exception of one member of the medical staff, who had only recently commenced work at the hospital, staff were knowledgeable and confident in using the system to report incidents. We made a member of medical staff aware of the individual who was not familiar with the reporting process. We saw from training records supplied that incident management training had been completed by 94.6% of staff.
- A consultant said the department was developing a strong reporting culture, when previously it had used only informal discussions. They added there were monthly governance meetings where incidents were reviewed. From this a newsletter was produced, summarising lessons learned. The December newsletter advised staff about the measures to take in relation to managing patients at risk of falls. This included use of orange signage to alert staff and falls reduction equipment, such as sensor mats. We saw signage in use on our visit.

Urgent and emergency services

- We discussed the arrangements for reporting and investigating serious untoward incidents with staff. A member of nursing staff was able to tell us about six incidents which had been reviewed or were undergoing investigation. As a result of the findings of one of the investigations, changes had been made to the frequency of patient observations. Staff had been made aware of the requirements to record observations of patients' blood pressure, heart rate and respirations at least hourly when in the Majors section; in the trolley bay area, observations were to be checked at least two hourly. Anyone with a head injury was expected to have their neurological observations recorded in line with the National Institute for Health and Care Excellence (NICE). We saw that guidance on these actions was included in the agency induction checklist.
- We spoke with nursing staff about incident reporting and learning from the outcome of reviews. We were told by senior nursing staff the investigations may involve individual staff members and a representative from the department may lead on the incident review. The risk manager was said to help with the process, for example, in agreeing the terms of reference. Learning from incidents was said to be communicated at the handover between shifts. In addition, staff said they received emails or the clinical governance newsletter for the department. Staff commented on the slow process of investigating and reporting back on incidents, which they said could be improved. Less senior nursing staff told us they did not get feedback about serious incident investigations.
- Examples of action taken as a result of incident reviews and raising awareness were explained to us. This had included a two-week seizure awareness campaign, where staff were provided with pocket cards to use as an aide-memoire and a four-week sepsis care campaign. We looked at the pocket guides provided to staff and saw that they contained essential information to guide staff in responding to patients' needs.
- Consultants told us that all incidents were reviewed by the department consultant, who then disseminated learning through the board round, newsletters and teaching sessions. Junior doctors confirmed that there was good learning from incidents and lessons learned were covered in the weekly teaching session, although activity in the department sometimes meant they missed some training. Examples were provided to us of such discussion, including a missed lumber spine fracture and a missed ectopic pregnancy.
- The department provided information as part of the Quality Experience, Workforce and Safety (QEWS) monthly triangulation and predictor dashboard. We saw examples of the information produced, such as October 2014 figures. With reference to safety and quality, a downward trend was noted for serious incidents, although this still rated as a red level overall. Best Care accreditation, which encompassed a wide range of data sets, indicated the department to be at level one, with compliance in practice achieving 80% in the month. Level one was indicative of six to nine green ratings of between 93% and 100% achievement.
- We asked a senior member of nursing staff how open and transparent they were with individuals and those associated with them where an incident had occurred. They told us of an incident where a patient had fallen in the department and how the relative had been fully informed, told about the investigation and the outcome of this. A letter of apology was sent and relatives could request to see the incident report and discuss it in person with staff if required. .
- Medical staff of various grades were not familiar with the term, "duty of candour" but from their responses to our question they were aware of the process for acknowledging matters, the review process and the need to be open and transparent where incidents had occurred.
- Staff told us that mortality and morbidity meetings took place. We saw formal evidence of such reviews taking place. For example, in the minutes of the accident and emergency clinical governance group meeting notes from 30 October 2014, reference to a mortality and morbidity presentation was noted. This had included the review of 13 deaths between June and August 2014, two of which were referenced in the minutes. We saw also a formal presentation of review process for cases that had happened between January and June 2014, with discussion of lessons learned. We saw in separate minutes a discussion related to paediatric mortality and morbidity, with subsequent lessons learned in the A&E department.

- Prevalence rates per 100 patients were surveyed for three safety indicators: pressure ulcers, falls and catheter-related urinary tract infections were very small for the department.

Safety thermometer

- There were no trends identified from the information submitted as part of the NHS Safety Thermometer, a tool for surveying patient harms and monitoring and analysing local improvement and harm-free patient care over time.

Cleanliness, infection control and hygiene

- Generally we found the department to be suitably clean and observed designated domestic staff undertaking their duties in accordance with the displayed cleaning schedule. Staff were seen to undertake high and low cleaning and were constantly present in the department, keeping the area as clean and tidy as possible, considering the high activity levels. Equipment used by domestic staff reflected the recommended national colour-coding scheme; ensuring equipment was used for the right area.
- The standards of cleaning had been monitored on a monthly basis and we saw outcome scores displayed in the waiting area of the department. The target was set at 98% and we noted scores ranged from 96% for November 2014 to the highest level reported in September 2014 of 97%.
- Arrangements were present for the disposal and management of different types of waste, including sharp items. We noted there were two sharps bins which had been overfilled, one of which had an unsecured lid. This could have posed a risk of injury or exposure of contamination if the container had been knocked over.
- We saw, and were told about, the arrangements for dealing with possible Ebola patients, with very good guidelines for triaging potentially infected patients. A flowchart was used for staff to follow and training had been provided in regard to minimising risks to themselves and others within the department. Reception staff were clear about their role and responsibility if a possible Ebola patient presented. An Ebola walk-through exercise had been carried out on 24 October 2014 and we were provided with a copy of the key learning points and requirements as a result. Information demonstrated that consideration had been given to infection control measures and actions to be taken by staff to minimise risks.
- We were told that people who presented with a possible risk of infection could be assigned to a side room for isolation. We saw staff put this into practice, liaising with ward staff to ensure the patient would be admitted to a side room on the ward.
- Training records related to hand hygiene were provided to us and we saw 48% of staff did not meet the trust's competency requirement. Over the three days we undertook observations of staff's hand-washing practice. On the first day we did not observe many staff complying with the expected practice of either hand-washing or using hand decontamination gel in between seeing patients. On the subsequent two days we saw nursing staff adhering to best practice but, again, saw limited attention to this by medical staff. During our unannounced visit on 14 December, staff were seen to use hand sanitiser gel and hand-washing facilities.
- Throughout the department there was good access to hand-washing and drying facilities. We saw a good supply of personal protective equipment and staff used aprons and gloves during the course of their work. Hand hygiene audits were said to have been devolved to band 6 nurses and they reported back on a monthly basis. Omissions were entered onto the Best Care dashboard and reviewed at the infection control governance committee monthly meeting. Staff confirmed that hand hygiene audits took place each month, although it was acknowledged that a couple of months had been missed over the summer. We looked at hand-washing audits and saw compliance scores ranging from 95% in May to 98% in April. There had not been submissions in July and August.
- We reviewed infection control audits, including one carried out on 5 August 2014. This identified problems, the action to be taken, by whom and an expected timeframe. We were told about, and saw from documentary evidence, a mattress audit had been carried out to check the quality of those in use and to identify where replacements were required. As a result, a replacement had taken place and back-up stock made available in the bed store.
- We checked equipment used for the delivery of patient treatment and care, including commodes, and found all

items to be clean. Staff filled and signed an equipment log when items had been checked and cleaned. While we noted there were some gaps in the record, we did not identify any concerns or risks to patients as a result of this.

- In our discussion with the director for infection prevention and control (DIPC) and the lead nurse we were told there were link infection control nurses in the department. They were responsible for monitoring standards, attending meetings and cascading information back to the team. Nursing staff in the department were aware that there was a designated link nurse but did not necessarily know who this person was.
- There were no reported instances of Methicillin Resistant Staphylococcus Aureus (MRSA) in the emergency department year to date.

Environment and equipment

- The department had separate adult and children's emergency/urgent care areas. The children's area was accessed through an unsecured door directly from the main waiting are. A waiting area was provided, with a television and access to information leaflets and the NHS Friends and Family Test feedback forms. Seating space was limited and, when busy, soon became overcrowded, as we saw on our unannounced inspection.
- The children's area had seven cubicles, plus one designated for triage purposes. A number of cubicles were close to the waiting area and, although curtained off, it was not always easy for staff to afford privacy to individuals.
- We looked at equipment provision in the children's area and saw that, while equipment was clean, many items, (for example, syringe drivers, intravenous pumps, an ophthalmoscope and aurascope) were not up to date with evidence of yearly testing.
- A designated paediatric resuscitation bay was provided in the main resuscitation room. Equipment checks in this area identified one out of three syringe drivers (used for the controlled delivery of intravenous fluids) to be out of date for the electrical test. A number of blood sample bottles were out of date but were replaced as soon as we notified staff. The blood sugar monitoring equipment had been checked daily, in line with point-of-care testing requirements.
- Staff reported the main adult department layout as not being ideal for patient flow and access to other departments, such as the medical assessment unit and the computerised tomography (CT) scanner. Managers were said to be in the process of drawing up plans for a new department and work had commenced with the architects.
- The adult emergency department was accessed via two routes: one for walk-in patients and one for ambulance personnel only. The reception area was clearly visible and enabled walk-in patients to provide their details to staff. Seating was noted to be set out in an unsafe manner, with some seating around the outside of the area and two rows of chairs facing away from the reception. The majority of seats (19 out of 31) did not enable staff to identify if a patient's condition deteriorated. Further, three chairs had their arms missing, exposing a metal protrusion at the side which posed a risk of injury to people when seating or to young children.
- There was access to toilets and hand-washing facilities in the area, including disability access. A vending machine in the waiting area was seen to be well-stocked with healthy snacks. A wall-mounted television was identified in the waiting room but this was not on, and when we asked staff they said it provided a general loop of information only. There was no information in the form of electronic display or noticeboard to tell people how long they were likely to be waiting. The exception to this was a small, laminated A4 sheet of paper in triage with the time expected to see a doctor written on it.
- Access to the main emergency areas was through a secure, locked door. However, access to the paediatric area could be gained with ease, as the door was not locked, despite having a key pad. Staff advised when questioned that the door had never been locked as they felt this would delay access to patients.
- A triage area was located immediately adjoining the reception, which enabled reception staff to pass through records to the triage nurse to action. The triage area consisted of a designated room with all required equipment to undertake the initial assessment, such as electrocardiogram (ECG) and blood sampling. Additional rooms were also available to enable rapid assessment of patients by nursing or medical staff.
- The PITstop area received patients arriving by ambulance and those who self-present who are likely to require treatment in Trolleys/Majors, for initial

assessment, investigations and treatment. Once a cubicle becomes free in the Trolleys/Majors areas the staff are made aware of this and the patient is moved out of PIT stop.

- Other treatment areas within the department consisted of 15 bays all with oxygen and suction, five including cardiac monitoring. These were used for Minors and Majors patients, separated by a central hub. A four-bay resuscitation room, which included a bed for paediatric resuscitation had all required monitoring and interventional equipment readily available. There were areas set aside for treatment, including a plaster room and minor operations room. The latter was noted to be used for storage of hoists and was not kept solely for its intended purpose. Treatment cubicles were curtained off by disposable curtains for privacy.
- A six-bed clinical decision unit, which included one side room, was managed by emergency department staff. This was separated into gender-appropriate sides on each of the days we were present. Patients using this area were usually waiting for blood tests or other investigation results or were elderly and could not go home at night and may have needed an occupational assessment.
- We were informed by staff that the family room adjoining the bereavement room was used for patients with psychiatric problems. However, on inspection we noted this was not a suitably safe room, as it had two doors, one blocked by large metal cages on the outside. This presented a risk to staff of not being able to exit the room in the event of a patient incident or emergency.
- Resuscitation equipment was readily available and accessible to staff. This equipment was noted by us to have been checked to ensure all required items were available on the trolley and that equipment was ready and suitable for use.
- We found numerous items of electrical equipment with out-of-date portable appliance tests (PAT) stickers attached. Therefore it was not possible to determine whether the equipment was past the time period for electrical safety testing.

Medicines

- Medicines in the children's area were found to be managed safely, with good storage, checks and safe administration by the registered children nurses. On the whole, checks of controlled drugs were carried out regularly, although we noted a small number of days where checks had not been carried out.
- Staff had access to a small medicines room in the adult section of the department, which was accessible only via a secure key pad. We saw medicines in this room had been stored safely and in accordance with requirements. For example controlled drugs were stored in a locked, wall-mounted cupboard, accessible only by separate key. Items which required controlled temperature storage were placed in the fridge, with temperature checks carried out and recorded. Checking of controlled drugs was seen to be carried out by two qualified nurses prior to preparing and administration to patients. We saw that nursing staff undertook and recorded stock checks of these drugs.
- Staff told us the medicines room was overseen by the pharmacy and the sister or charge nurse. When stock arrived this was checked and put away by the charge nurse so they could ensure sufficient supplies. Intravenous fluids were kept in boxes for safety as there were limited storage facilities for these. Drawers were labelled for ease and staff had waste disposal receptacles and hand-washing facilities in the room. We saw staff used personal protective equipment appropriately.
- We saw that dates of opening and disposal dates on applicable items had been clearly displayed. Staff had access to guidance on injectable drugs in the medicines room and a current British National Formulary resource.
- Each patient record we reviewed included information about regular medicines they had been prescribed and, where relevant, prescription charts had been completed for patients who needed medicines while in the department. Where such medicines had been given, we saw that staff undertook relevant checks and signed the record once given to patients.
- Medicines management weekly audits had been undertaken and results we saw showed that monitoring included security of keys, controlled drugs storage, record-keeping and general storage and management. Action or recommendations required were stated.
- The training records we reviewed indicated that 61.9% of the required staff had undertaken medicines management training.

Records

Urgent and emergency services

- We reviewed two emergency records for children being cared for in the department and saw that these had been fully completed. There was evidence of full assessment and completion of a Paediatric Early Warning Score (PEWS) system. On our unannounced visit, we also tracked cases for two children who had been in the emergency department and had then been admitted to the ward. We found that both children had gone through the triage system and had been assigned a colour code for urgency. Pain assessment scores using the Wong Baker FACES Pain rating scale (a tool created with children to help them communicate their pain levels using a series of faces) had not been recorded in both cases, although there was reference to pain assessment in the nurse's notes.
- Each adult patient who arrived at the department had a record of assessment, treatment and care commenced by nursing staff, which was updated throughout their stay. We saw from the 12 records we reviewed entries for time of arrival, initial assessment and interventions from medical and nursing staff according to patients' individual needs. Records we reviewed were sufficiently detailed and provided an account of assessment, treatment and care and referral where required to other members of the multidisciplinary team. We saw written evidence that staff followed care pathways for conditions such as sepsis.
- Care records were kept in the central 'hub' for the main Majors and Minors areas of the emergency department and within the separate areas of resuscitation, clinical decision unit and the 'pit stop' area. Care records for patients in PITstop are kept in PITstop once they have been seen by a doctor or in the central 'hub' if they are waiting to be seen.
- Nursing staff were able to describe the range of risk assessments used for patient safety and we saw risk assessments were incorporated into patient assessment and care planning records. In each of the records we checked, we saw that assessments had been completed, for example, in relation to falls, skin integrity and pressure areas, malnutrition and venous thromboembolism (VTE or blood clots). Where required we saw recommended treatment had been taken to minimise risks. This included placement on a suitable mattress to minimise risk of excessive pressure on the skin.
- Training records provided to us indicated that 66.7% of staff in the A&E had undertaken information governance training.

Safeguarding

- Safeguarding training was provided to staff at different levels. The training records we saw showed that level 2 training had been completed by 89 emergency care staff. Four nursing staff were not up to date with this, including training that had been out of date since September 2012 and July 2013. Out of 58 medical staff listed, 20 were not up to date with either child or adult safeguarding training.
- The name and contact details of the safeguarding lead was visible in various parts of the department. Staff had access to formal guidance related to safeguarding vulnerable adults and children. We were able to witness staff acting swiftly on information provided by a patient, which related to their own safety and potentially that of their children. Nurses were able to describe the reporting process for safeguarding matters and one newer member of staff said they felt, "confident" to deal with matters, including reporting to senior staff.

Mandatory training

- Training information was provided to us in respect to mandatory subjects staff were expected to attend or complete. We saw that clinical staff were required to complete basic life support every two years and 67.7% of the staff were compliant with this. The frequency of other mandatory training was not stated in the information. However, we saw from the information provided that the department struggled to ensure that staff achieved the required mandatory training. For example, equality and diversity training had been completed by 62.8% of staff. Out of 129 staff, 17 had not undertaken their manual handling training. Conflict resolution had been completed by 95.3% and health and safety had been completed by 96.1%.

Assessing and responding to patient risk

- Patients attending emergency and urgent care services were expected to be assessed within 15 minutes of arrival, with a target of 95% compliance. The time to assessment at St Peter's was reported to be higher than the England average but was less than 15 minutes.
- We saw from our observations of nurse actions and the review of patient care records that staff used a five-point

triage system, known as Manchester triage system – used to manage patients in a methodical way. This was based on recommendations by the British Association for Emergency Medicine and the Emergency Care Association of the Royal College of Nursing. The staff aimed to see and triage people within target times. Immediate resuscitation assigned a 'red' flag and met by a team of staff who had been notified in advance by ambulance staff. Very urgent patients were assigned an 'orange' alert and were expected to be seen within 10 minutes. Patients with serious problems but identified as stable were classed as urgent and assigned a 'yellow' status and staff aimed to see them within 60 minutes. Standard situations, classed as not being in immediate danger or distress were assigned a 'green' status and were expected to be seen within two hours. Non-urgent patients, those who were not true accidents or emergencies or who had old injuries, were expected to be seen within four hours and were assigned a 'blue' status.

- Between the hours of 10am and 7pm a nurse was assigned to 'streaming', where they assessed people and streamed them to either Minors or Majors. We saw evidence of rapid assessment and treatment processes in the 'pit stop' area of the department. Designated nursing staff and medical staff were allocated to work in this area and were able to provide responsive assessment and initiate required treatment.
- An emergency services technician worked in triage and was able to perform blood tests and ECGs, subject to an identified assessment criteria.
- The department used a formalised care record, which incorporated an early warning tool based around the assessment of patient physiological indicators. For example, staff recorded patients' blood pressure, pulse and respirations, as well as their responsiveness. These indicators were then scored and, where required, urgent medical attention was sought. A separate early warning score tool – PEWS – was used for paediatrics.
- The trust had a patient flow and escalation plan, which outlined the purpose, principles and responsibilities to departments and staff. The aim of the escalation procedure was to deal with capacity issues and respective pressures. We observed a capacity meeting taking place in the department and heard how the escalation status was agreed, based on a combination of four triggers: green, amber, red and black. The latter status was agreed to be allocated following an extraordinary meeting which was called on the second day of our visit. Black status defined the trust as being in a critical position, which required business continuity processes to be put in place to support de-escalation. We heard and saw senior staff respond to the situation to reduce the status.

Nursing staffing

- The children's emergency and urgent care services were managed by the women and children's division and were not overseen by the main emergency department. However, the service was supported by staff from the adult section if required. The department was open 24 hours and was always staffed by paediatric trained nurses – two on duty 7.15am to 7.45pm and one from 1030am until 11pm. At night there were two nurses who started at 7.15pm and worked until 7.45am. Each day the service was allocated an A&E doctor and a paediatric senior house officer or registrar. On-call consultants were available to support the service at weekends and out of hours.
- We were told that the whole time equivalent (WTE) establishment of nursing staff in the adult emergency department was just over 80. Medical staff said the nurses were "stretched" and morale was low, with constant 'red' or 'black' levels of activity. This had an impact on nurse training, with sessions cancelled because staff were needed in the department.
- We had been made aware of the difficulties in filling vacancies in the nursing team, in part because of the close proximity to London and higher salaries for working in the capital. Vacancy levels were stated as being just over 11 posts, with a true vacancy of just over five WTE, including three band 6 registered nurses and two band 2 grade healthcare assistants. There were nearly six WTE posts going through the recruitment process, one band 7 and about five band 5 grades.
- Various measures had been tried to increase the nursing numbers, including overseas recruitment. As a result of this we found there was a multicultural clinical workforce, with recruitment from countries such as the Philippines and Portugal.
- We asked what the average sickness rate was and were given figures of 1.54% for qualified nursing staff. Nursing staff turnover rates viewed indicated the following: April 2013 to March 2014 – 23.11%; April to June 2014 – 36.31%; and July to August 2014 – 42.74%. We asked

staff if they knew the reasons for staff turnover and various explanations were given, such as family/ personal reasons, moves to other areas of practice, or being able to earn more as an agency nurse.

- The department did not use a formal acuity tool to identify and agree safe staffing levels. We were told that a tool had been used on one occasion and the results from this indicated the department to be significantly understaffed.
- Nursing staff said they had a formal handover between shifts, the start of which included a brief on any incidents or 'need-to-know' information. We observed handover taking place at our unannounced inspection and confirmed the arrangements described to us.
- We viewed duty rotas and saw that shifts were planned with a range of grades and skills mix, ensuring that there were 19 nurses and healthcare assistants on the day shift and 14 on nights. Day shifts were variable in length and with a number of different start and finish times. Night shifts tended to be a long shift starting at 7.15pm and ending at 7.45am and one shift from 5pm until midnight. We asked how many shifts between August and October 2014 did not get staffed to the required levels and saw the following: August had shortages on 11 shifts; in September 10 shifts were short and in October two shifts.
- Information supplied to us demonstrated the split of nursing staff across the previous six months as follows: substantive nursing staff – 55.66%; with overtime from substantive staff at 6.02%. Bank (regular temporary staff who are used from a pool of nurses) use was 2.05%; and nurses supplied through an agency, 16.14%. The agency usage was higher than would be desirable. However, the risk of using agency was mitigated through a thorough induction and regular agency staff who were familiar with the department. The split for healthcare assistants was as follows: substantive healthcare assistants – 15.18%; with overtime at 2.36%; bank, 2.49%; and agency – 0.10%. We saw from duty rotas, and staff confirmed, that there was regular agency staff supporting the service.
- Agency staff told us they had received a local induction to the department and they were part of team, rotating work across the various areas. We were told by senior nursing staff that there was a formal induction, including a checklist for temporary clinical staff, to be signed off in the department. We saw from information provided that the local induction was to be completed on the first day of work. Areas covered included: duties and responsibilities; safety matters related to equipment; reporting incidents; emergency numbers; and patient care. Supplementary information was also provided to temporary staff, which covered the expected frequency of patient observations and monitoring of their condition.

Medical staffing

- We compared the medical staffing arrangements by grade with those of the England average and found that there were 18% at consultant level, against England's average of 23%. Registrars made up 30% of the workforce, against an average of 39%. Middle-career doctors – three years as senior house officer – constituted 12%, with England's average of 13%. Junior foundation year 1 or 2 doctors made up 41% of medical staff, against an average of 25%.
- We reviewed duty rotas for medical staff and saw there was an identifiable consultant of the day, with overall responsibility for the department seven days a week. In addition we noted that consultants were assigned to oversee the clinical decision unit and 'pit stop' area Monday to Friday. On-call consultant cover was arranged between 8pm and 7am, seven days a week.
- Middle-grade doctors worked a range of shifts again with a number of different start and finish times varying There was a specialist registrar between the hours of 10pm and 8am seven days a week and an additional registrar between 10pm and 6am covering all seven nights. Junior doctors also had a range of varying start and finish times, which covered all hours day and night.
- We reviewed figures supplied to us which indicated varying percentages of agency use, from 20.5% in August to 26.4% in June 2014. Medical staff told us there was regular use of locum doctors but these individuals were regular attendees and so were aware of the role requirements and responsibilities. We reviewed medical staffing rotas, including the rota for October 2014. We identified use of regular locum or agency staff, which equated to 52% of the middle-grade workforce in that month.
- We were told that there were difficulties in converting agency staff to the hospital bank for overtime as a result of problems in delayed payment for working. This had a negative impact on budgetary controls, as agency staff costs were higher than bank staff.

- Locum doctors were provided with a local induction, which included the provision of a formal document titled Essential Information for Locums. This publication included detailed information covering essential rules and expectations, patient assessment and triage, priority patients, targets and incident reporting. We noted that the latter section was very limited and did not give sufficient detail to guide locums on the processes to follow.
- Medical staff said their induction had been "very good", with two dedicated days completed away from the department, in addition to local induction in the emergency area. We were told the induction covered patient care pathways and other useful subjects, such as microbiology.
- We observed handovers of patients and general activity within the department taking place at regular intervals. Staff had also developed a very useful and productive way of conveying information between medical staff and nurses using a small whiteboard kept at the nurses' station. Medical staff could make a request, for example, for nursing staff to take blood samples and this was written on the board for the respective patient. This enabled staff to continue their duties and keep on top of patient-related treatment and care needs.

Major incident awareness and training

- We saw the nursing staff induction and competency checks included major incident management, along with chemical, biological, nuclear and radiological incidents. A newly qualified nurse going through their preceptorship practical experience and training programme confirmed they had studied major incidents. Other senior nursing staff said they had also had this training and told us the clinical practice educator coordinated this. A porter confirmed they had undertaken this training and said it was part of their responsibilities to respond to major incidents. We asked for formal confirmation of training in respect to major incidents and were told that 29.16% of staff working in the department had completed this, which was significantly under what would be expected.
- As a category 1 responder, the trust had an Emergency Preparedness, Resilience and Response (EPRR) policy agreed in August 2014. We saw from the policy provided to us that the arrangements reflected the requirements outlined in the NHS England planning framework: Everyone Counts: Planning for Patients 2013/14.
- The trust had carried out a communication exercise on 19 August 2014 in respect to major, internal incidents, which involved the South East Coast Ambulance Service and various staff and departments. An action plan was developed, although we noted that specific dates had not been included to indicate expected resolution.
- A trauma network exercise had also taken place on 3 April 2014, in which major incident processes were tested out, including collaborative working with other services.
- Hazardous Material (HAZMAT) training had been provided in July 2012for material known to be flammable or poisonous and a danger to life or to the environment if released without precautions. We noted from the list of attendees that only a limited number of personnel had completed the theory (four attendees) and practical, (seven names listed, plus an unspecified number of nursing staff). The practical training included the use of a specialised suit in chemical or biological incidents. Chemical, Biological, Radiological, Nuclear and Explosives (CBRNE) training had also been provided to staff. We reviewed the content and saw that it included decontamination and disposal of waste.
- We reviewed minutes from a debrief, which related to a major incident which had occurred in February 2014. The debrief documented and outlined learning from the event, actions and responses. This demonstrated a multi-agency, joined-up approach to reviewing events in the best interests of all concerned.
- The department did not have any on-site security arrangements and we were told that, if required, staff would escalate a problem to the main security team who were trust-based and were bleeped when needed. Staff said they had training in relation to de-escalation but had not had training on restraint. The police were said to be called if needed and they would stay with patients who were thought to pose a risk.
- We saw the department had closed circuit monitoring, with a screen in the main hub area showing images of various parts of the department, including the reception and waiting area.

Are urgent and emergency services effective?

(for example, treatment is effective)

Urgent and emergency services

Good

There was an ongoing programme of auditing various aspects of the service, based on national and local schemes. The achievement and sustainability of expected targets was not always possible, despite best intentions.

Policies and procedures had been developed, taking into account national guidance and best practice evidence from professional bodies such as the College of Emergency Medicine (CEM), NICE and the Resuscitation Council UK.

The multidisciplinary team worked well together to provide effective service to patients. Of particular note was the Older People's Assessment and Liaison (OPAL) team, their links to the pain team and the fragility fracture liaison nurse. The OPAL services were seen to be fully integrated into the delivery of treatment and care pathways and resulted in positive outcomes for patients using the service.

Evidence-based care and treatment

- Medical staff had access to policies and procedures based on guidelines from the CEM and NICE. This included the guidance; acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. There were numerous care pathways to guide staff; however, these did not make reference to NICE or otherwise. For example, the care pathway for seizures did not reference the NICE clinical guideline 137 for epilepsy.
- We reviewed detailed information of the arrangements to manage patients with sepsis. We looked to see if staff practice reflected guidance by the CEM. We found that staff had guidance to follow for making assessments and acting on the results. Patients arriving in the department with a fractured neck of femur were cared for under the associated care pathway, which included provision of pain relief and request for x-ray and subsequent referral to trauma and orthopaedic team. Adherence with the local policy contributed to the national audit.
- We reviewed the ambulatory care pathway for stroke patients coming through the department. We checked to see if the plan reflected the recommendations of the Royal College of Physicians 2012 to admit patients directly to a specialist acute stroke unit. The plan for the A&E department included patient history, examination and assessment, investigations, including CT scan. Depending on the results, patients were either admitted to the ward via the stroke pathway or referred to the transient ischaemic attack pathway. We asked staff if patients were given blood-thinning treatment in the department and we received varying responses. Nursing staff told us patients came back from the CT scan and would at times receive this in the unit. Sometimes drug treatment was delivered by stroke ward staff, otherwise by emergency care staff. The clinical director told us treatment was given on the stroke ward. We could not identify from the care pathway where or who was responsible for administering blood-thinning medicines.

Pain relief

- Patients who spoke with us reported having their pain managed by either the ambulance staff prior to admission to the department or after arrival. We saw staff assessing people's level of pain and rapid response to the provision of pain relief where required. For example, a patient who had abdominal pain was assessed by nursing staff and they reported to the doctor who then prescribed intravenous Paracetamol. This was given straight away by a nurse.
- Our review of patient records demonstrated to us that patients had their pain levels assessed and recorded by nursing staff. Where pain relief was required, we saw the medicines had been prescribed by a doctor and staff signed for the subsequent administration of the medication. One relative told us her husband had been given morphine for pain and we saw this had been recorded in the care record. A patient told us the nurse was, "looking to see what they can give me".
- We were able to observe nursing staff prepare and administer pain relief in the form of controlled drugs as prescribed to patients. Their practice was noted to be safe and in accordance with expected guidance.
- We saw there was good access to the pain team and observed interaction of the pain team nurse within the department addressing the needs of a patient. For patients who had a cognitive impairment, such as dementia, staff used the Bolton Pain Assessment Scale to aid their assessment. The scale was developed for patients with communication difficulties and includes a

section for the family to be involved in the assessment and provide information specifically relating to the individual. Guidance on this was visible in the clinical decision unit.
- The department had not participated in the most recent 2011/12 CEM Pain in Children Audit. The last data reviewed related to the 2009/10 audit, which would not necessarily reflect current patient experiences.

Nutrition and hydration

- A pantry was located in the emergency department. These enabled staff to prepare and provide a limited range of food and drinks, particularly for people who had not been able to move to a ward bed or were awaiting arrangements for discharge. We found that the provision of food and drink was variable and depended on the patient situation. For example, we saw staff providing breakfast cereals for a number of patients who had experienced delays to ward admission on each of the days we were present in the department. In addition, we observed catering personnel providing drinks mid-morning and mid-afternoon to patients who were able and allowed to drink. A number of patients told us they had been provided with sandwiches while waiting. Hot meals were said to be provided to relevant patients twice per day.
- One patient who had arrived in the department at 8pm in the evening spoke with us at 1.45pm the following day and said they had to ask for a drink and that no breakfast was offered. They had been offered a sandwich. The relative of a patient in the clinical decision unit reported that their relative had not been given anything to eat until they requested something on the patient's behalf. No tea was offered but they did not like to ask as they could see the department was very busy.
- A patient waiting in the Majors area said they had not been given anything to eat but had been given a drink. They were unsure about the reasons why they could not eat. On checking with staff, the patient was told it was because staff were awaiting the outcome of an investigation which may have meant going to theatre. Another patient was unable to eat and drink and explained that they knew the reason for this and had been fully informed by staff that they may need to go to theatre.

Patient outcomes

- We reviewed the report of the department's participation in the fractured neck of femur audit, assessing outcomes based on clinical standards set by the CEM's clinical effectiveness committee. Areas where the service scored less than the lower England quartile related to: pain relief not being offered and no reasons for this recorded; and provision of pain relief within 20 or 30 minutes for patients with moderate pain.
- The emergency department had participated in the Paracetamol Overdose in Adults Audit and submitted data for 50 patients who came through the department between 5 December 2013 and 19 March 2014. Data we reviewed included a summary of treatment provided in line with the Medicines and Healthcare products Regulatory Agency (MHRA) and National Poisons Information Service (NPIS) guidelines. We saw that, out of the patients treated, 35 were rated as 'yes' in respect to receiving treatment as per guidelines and six as 'partially' having received treatment as per guidelines. Three patients were not treated in accordance with the guidelines and there were three serious omissions. In addition six patients declined treatment or left the department.
- We were provided with audit data which related to the department's participation in the Severe Sepsis and Septic Shock in Adults Audit. The audit had taken place between 17 September 2013 and 17 December 2013, reviewing 25 cases. Results indicated a number of areas where information was not recorded. For example: blood glucose levels on arrival, whether high flow oxygen was given in the department, if blood cultures were taken in the department and urine output measurements. A consultant said the current focus of patient outcomes was on sepsis and we saw there was a pathway for staff to follow and this was put in to practice.
- The department had participated in the 2012/13 audit for the Treatment of Feverish Children (under 5 years of age) who presented with a medical condition. The audit measured results against the clinical standards set by the CEM's clinical effectiveness committee and compared outcomes with 179 departments who submitted data. We saw from the report that performance was seen to have improved from 71% in 2010 to 81% in 2012.
- We were provided with a copy of the results for the CEM Renal Colic Audit which the trust had participated in for 2012/13. Areas where the trust scored less than the

lower England quartile included testing and recording results before discharge of: urine tests, consideration of the need for x-ray, full blood count, patient renal function and exclusion of abdominal aortic aneurism in patients over 60 years of age.

- Figures for unplanned re-attendance to A&E were provided to us. The target levels were set at an expected rate of less than 5% for the department. The CEM recommends that unplanned readmission rates should be between 1% and 5% and the national average is 7%. Results for the period April to the end of October 2014 indicated ranges from between 5.10% and 5.79%.
- The CEM sets the standards for emergency departments in respect to clinical care and audit. The standard includes three types of patient groups who should be reviewed by a consultant prior to discharge. This includes: adults with non-traumatic chest pain; febrile children aged less than one year of age; and patients making an unplanned return to the department with the same condition within 72 hours of discharge. Information provided to us indicated that the department performed less well than other services in England for: patients being seen by the consultant or associate specialist, (7% against England score of 14%); an ST4 specialty grade or more senior doctor seeing the patient (40% against a comparative score of 48%).

Competent staff

- Nursing staff working in the emergency department told us they had to achieve various competencies to deliver effective care. We saw that newly qualified staff were supported through a period of preceptorship practical experience and training with a designated mentor. New staff had also been supported through their development and had meetings to review progress. These were expected to take place at three-monthly intervals. We were able to review a competence assessment record in progress and saw competencies included: drug administration, limb splinting, application of plaster of Paris and wound closure. We saw a number of completed competency assessments, including venepuncture and blood sampling.
- The emergency support technician had been trained to undertake specific tasks, including blood sampling, cannulation (tube insertion) and ECGs.
- The triage nurses were suitably competent to be able to refer directly to other services, such as the department of sexual health, ophthalmology, mental health and ambulatory care. Flowcharts and protocols were in place to support this, although staff said they needed to be updated.
- The provision of care and treatment of children in the paediatric department was overseen by a dedicated paediatric consultant, supported by a senior house officer or registrar and paediatric nurses.

Training and personal development

- The emergency department had two part-time clinical practice educators, equivalent to a whole-time worker. They explained that they were responsible for all nurse education in the department.
- We noted in our review of medical staff duty rotas that there was cover to enable staff to attend training. In addition, medical staff said they had opportunities for local training within the department. Trainee registrars advised us that there were monthly training sessions available to them at a local level and they attended regional CEM days. They reported that they had “good hands-on” experience as registrars.
- Staff were asked about the arrangements for supervision. A newer member of nursing staff said they had been assigned a preceptor trainer and they had time to meet and discuss progress. They added that there was a formal agreement for learning and achievement of competencies. Specific training had also been identified and attended, such as a day on the Manchester triage system (used to manage patients in a methodical way). A member of the medical staff who had recently joined the team said they were assigned a supervisor but they had not had an opportunity to meet with them in their first few weeks. They were concerned that they did not have an understanding of some of the systems and processes. With their permission, we reported these concerns to a senior member of staff.
- We asked for information on the number of nursing staff who had yet to receive appraisals in the department and saw that 15 out of 46 staff were overdue a review. There were also a further 19 staff listed; we were unable to identify their employment commencement dates, or when they were due a performance reviews. We were told the appraisal process had recently changed so that it could be linked to salary reviews and, as a result, some had been completed early and some would be

later than expected. A newer member of nursing staff reported their appraisal was due in January and said they had already been sent documentation in preparation.
- We were told by medical staff that all the consultants had completed their annual performance appraisal. They informed us that there was no formal system of appraising regular locums and there was a reliance on the provider agency to do this. They added that this was not checked. We were advised that there were plans to undertake appraisals of locum staff once they had worked a year in the department.

Multidisciplinary working

- We witnessed a very strong and positive working relationship between ambulance personnel and the department staff. Ambulance staff told us they tried to join the bed capacity meetings to get oversight of the general activity and status of the hospital. We saw good handover of between ambulance staff and nurses of patient information.
- We were able to observe bed capacity meetings, with attendees from various areas in the hospital. These meetings enabled managers and staff to gain updated information on the activity in the emergency department and availability of beds on ward areas. The meeting concluded with a status update for the department and hospital.
- Staff had good access to the multidisciplinary team, which included the fragility fracture liaison nurse, the clinical lead for psychiatry and the liaison psychiatrist at Surrey and Borders Partnership NHS Foundation Trust. There was also the OPAL team who looked after patients over 75 years of age in line with a frailty care pathway. We saw there was access to physiotherapists, occupational therapy and dieticians.
- The specialist pain nurse explained how they tried to see patients as soon as possible after they were paged. They said they would try to help people with acute pain and would, if necessary, make suggestions to the doctor. A member of the pain team was also a nurse prescriber and was able to prescribe medicines, subject to a full assessment of the patient.
- Consultants reported having a good working relationship with surgeons, including having a direct line to the surgical clinical director. This was slightly more challenging out of hours, especially if the on-call team were occupied in theatres. They reported having a slightly more challenging relationship with the medical team and were currently engaging with the medical assessment unit to ensure that referred patients were moved promptly to ensure flow through the department.
- We were told that there were sometimes difficulties in getting patients accepted by the orthopaedic and trauma team, despite having care pathways for back pain and unstable spinal fractures. An incident was described to us where the team had refused to take an unstable spinal fracture for monitoring and wanted the patient to be kept in the emergency department. We witnessed a conversation between the consultant and an orthopaedic senior house officer (SHO), where a patient's diagnosis had been made by the consultant but the SHO was not happy to take the patient on. The consultant had to insist on the patient being admitted in accordance with the septic arthritis pathway.
- Children who were critically ill were transferred via the South Thames Retrieval Service and taken to wherever there was an available bed. There was a paediatric anaesthetic lead and equipment available to support the transfer.
- The trust worked closely with surrounding hospitals to manage escalation processes where bed capacity was full. This included transferring children to other hospitals.
- There was positive responsiveness from other integrated services across the hospital. This included accessing specialist teams such as palliative care, oncology or respiratory expertise.
- We asked staff about access to the alcohol/substance misuse liaison team but not all were aware of the process for this. We noted signage which indicated availability of the alcohol adviser being present on a Friday each week in the department.
- Staff said there was a referral process for psychiatric input and psychological support.
- Not all nursing staff were aware of the admission avoidance through a local care pathway; however, we were told by senior staff that the service worked closely with social services in partnership with the clinical commissioning group (CCG) to provide beds for respite care. Also, carers could be enlisted to look after people overnight in their own home, so they did not need to be admitted to A&E.

Seven-day services

- We observed effective x-ray arrangements for patients; with local provision within the Emergency department. The facilities included two x-ray rooms and a portable machine, accessible between 8am and 8pm by allocated staff. Outside of these hours there was on-call provision, including interventional radiology.
- The CT scan was accessible during weekdays between 8am and 8pm and on call outside of these hours and at weekends. CT scans are reported six days per week, with a limited range of reporting on the seventh day. We were told there were arrangements with another trust for reviewing CT scans, where decisions related to neurological problems.
- There were formal arrangements between surgeons and operating theatres for urgent referrals. The policy we reviewed outlined the criteria for referral, based on the National Confidential Enquiry into Perioperative Deaths (NCEPOD) recommendations.

Access to information

- For people with internet access, the trust had an informative website, providing information about services, patient information leaflets, details about infection control and consent. People were guided to seek support from the Patient Advice and Liaison Service for information in alternative languages or formats.
- The majority of patients and relatives who spoke with us reported that they had been given information about their presenting problem and results of tests and investigations. They told us information was clear and understandable. A patient who was using the service for the first time said everything had been explained to them and they were fully aware of what was happening.
- One patient who had previously used the department said their experience this time was "worse" because of delays and lack of information. They said they were "in limbo" and did not know what was going on. They said they had been seen by different doctors and "they all say different things". This person added, "I don't know what is going on and am thinking of discharging myself". We passed this on to the nurse who explained what was happening and informed the patient. Another patient reported to us a mixed understanding of what was happening. They said nursing staff had explained about an x-ray they had and that they may need to go to theatre, but they were not aware of how long they may have to wait for this. Despite this, they commented on their experience positively, telling us it had been a "better experience this time" and "brilliant today, happy and comfortable".
- The parent of a child told us they had been kept informed of delays when waiting to be seen, adding they had been treated very well.
- A range of informative leaflets were readily available to people in the department, for example, leaflets about head injury, care of plaster and casts and a general 'welcome to the department' leaflet containing detailed information about people's rights, the different areas of the department and the process of triage (sorting or prioritising patient care). There was an excellent range of leaflets in the children's department.
- All nursing and medical staff had easy access to information to support the delivery of treatment and care on the hospital intranet. We saw that staff were able to access care pathways guidance and hospital policies and procedures. For example, we saw pathways available to support the delivery of treatment and care for stroke patients, renal stones, pulmonary embolism, lower gastrointestinal tract bleed and seizures. Junior doctors reported that they could access relevant information and the major pathways of treatment had also been covered at their induction. We were told by a doctor there were "very useful" paediatric guidelines on the intranet. We were shown an orthopaedic online tutorial, developed by the orthopaedic department to assist in educating medical staff on common fractures, injuries and dangers to look out for.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with nursing staff about patient consent and were told that this was mainly sought informally prior to carrying out investigations, treatment or care. The exception to this was where an individual required sedation. Other examples described by staff indicated lack of good practice in respect to mental capacity assessments matters and refusal of treatment. For example, staff described a situation where an individual had been sedated without a formal assessment of their mental capacity or a best interest decision. We were also made aware that a recent Paracetamol Overdose Audit had indicated poor documentation of the assessment of mental capacity and refusal of treatment.

- Patients we spoke to confirmed that explanations were given by staff so they could agree to or decline tests or procedures.
- Training records supplied to us indicated that, with the exception of six, all staff working in the emergency staff were in date for receiving training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguarding. Despite this, when we asked staff about these issues, there was variable understanding from the medical staff, particularly junior doctors and registrars. For example, one junior doctor did not know what deprivation of liberty safeguarding was but described a situation where an individual with dementia became aggressive and wanted to leave the department. Another doctor had a good understanding of the safeguards and said this was because they had previously worked in a psychiatric role. They also confirmed that they had not seen the safeguards used in the department. Not all nursing staff had an understanding of deprivation of liberty safeguards and one staff member who had worked in the department for four years said they had not received the appropriate training.

Are urgent and emergency services caring?

Good

People attending the adult and children's emergency and urgent care service were provided with treatment and care in a compassionate manner. We observed staff responding to people's needs in a timely manner, with kindness and care, treating patients with dignity and respect for their choices, varying cultures, faith and background.

Patients and their relatives told us they had been given information, were well-informed and involved in the decisions and plans about their care. There was access to information and specialist staff to support people where needed.

Compassionate care

- During our observations across the three-day inspection, we found the department to be extremely busy, with high activity and associated demands on staff in all areas. Despite this, we saw staff were diligent in their attention to patients' needs. Staff were seen and heard to be kind, compassionate and caring in their administrations of treatment and care. Where emergency admissions came into the department, staff were seen to respond promptly to people's immediate needs, with reassurance and explanations delivered sensitively. We saw staff support patients with toileting and assisting in a calm and reassuring manner.
- We spoke with seven relatives, the majority of whom were satisfied with the service provided. One relative said that although the staff were very busy, the care had been very good. Another relative said it had been a better experience than another hospital they had used and commented specifically on the healthcare assistant for their "excellent caring manner".
- We were able to speak with nine patients. One patient who had arrived in the department at 8pm the previous evening said they were disappointed not to be offered a bowl to have a wash. They also reported that the curtains were kept closed around their bed area, despite telling staff they had claustrophobia. Another patient who was unhappy about delays and lack of information reported that the nurses "nice and caring". They also said the staff who performed a scan were "lovely." Patients told us that staff treated them with respect and dignity and with as much privacy as possible.
- A patient who had not previously used the service was awaiting admission to a ward and told us they had seen two doctors and "lots of nurses". They said the staff were, "so helpful and kind". They said, "after seeing how hard they work, I think they are amazing". This person said their dignity had been respected and staff had "definitely provided privacy" for them. Another patient using the service for the first time said the nurses were "cool" and overall the service so far had been "very good". This patient and their relative said they would recommend the department as "first class."
- Doctors gave us complimentary comments about the nursing staff, including that nursing staff were "very caring" and "always going the extra mile for patients". A consultant told us the nurses were caring and compassionate, saying "they come in every day wanting to do the best for their patients".
- Staff were heard introducing themselves to patients and explaining what they were going to do in a discreet manner. One patient was accompanied by a relative who staff used to translate information. We heard the

phlebotomist (a person who takes blood samples) explaining the procedure in a kind and informative manner, demonstrating respect and their competence to an elderly person.

- We observed that the majority of patients awaiting admission to wards who had been in the department for in excess of the four-hour waiting time had been placed in hospital beds. However, a patient who had a back problem had not been moved on to a more comfortable bed, despite having been in the department for more than eight hours.
- NHS Friends and Family Test cards were available in the waiting area; however, these were not very well displayed and so were not likely to be seen by all people. We did not see any prompts to remind people to comment on the service they had received. This may be one reason for the low response rates. The department did not display any results from the NHS Friends and Family Test and members of the public could not see how well (or otherwise) the department was doing. Also, we did not see information to indicate what action was taken where feedback from the public indicated a need to change.
- The emergency service newsletter for December 2014 indicated there had been 445 responses to the NHS Family and Friends Test in October 2014, of which 50 respondents scored the department poorly. Concerns shared in the newsletter were about waiting times, communication, staff behaviour and attitude, clinical care and pain relief.
- The trust scored about the same as other trusts on the two questions related to provision of information and privacy.

Understanding and involvement of patients and those close to them

- Patients' relatives who spoke with us reported that they had been involved in discussions about treatment and care where appropriate. They told us they had been kept informed by staff and were aware of the next steps in the patient's care. One relative said they could not fault the treatment and they had been, "well informed." Another relative said they too had been, "well informed", adding that the doctor was "very caring". A patient experiencing the department for the first time said they had been fully informed and were aware of the next stage of their ongoing treatment and care, for which they were awaiting a ward bed. Another patient told us their relative was not with them in the department but staff had informed them of their admission to the department, which they had found reassuring.

Emotional support

- Where patients required the interventions of specialist expertise, we saw that staff arranged this. For example, we saw a patient who had been referred to a psychiatric liaison nurse. We saw the clinical nurse specialist for respiratory care helping a patient understand their condition and how best to manage it. The orthopaedic trauma nurse was also seen reviewing a patient, providing information and details about their treatment.
- Staff told us there was no formal counselling service but people would be referred if necessary to the psychiatric liaison team. There was access to the bereavement team and chaplaincy.

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

(for example, to feedback?)

Good

The staff were able to demonstrate they could cope with routine activities and were able to respond to surges in patient presentations, despite the increasing demands and higher attendances. However, while patients' treatment and care was delivered responsively in the department, there were concerns about the flow of patients. This had an impact on the patient experience, and many waited excessive hours to be transferred to a ward bed for ongoing care.

The staff learned from complaints received and reviewed ways to improve their practice and the patient experience within the department.

Service planning and delivery to meet the needs of local people

- The trust recognised the need to develop the emergency department to improve the provision of services to the increasing population and subsequent demands. We were told about the proposed

development and initial working with architects to change the department. These were in the early stages of discussion and feedback from staff on proposed changes was currently being sought.

Meeting people's individual needs

- Staff advised us that the mental health liaison team at Surrey and Borders Partnership Foundation Trust were available between 7am and 3am. Outside these hours, the home team were expected to pick up patient concerns. The adult psychiatric lead nurse said they had a good working relationship with the department. Their only concern was the lack of a suitable area to see patients and the safety aspects of the relatives' room which was being used for this purpose.
- The staff had access to a translation service, either through the Patient Advice and Liaison Service or directly via Language Line. Information about this was clear on the department's intranet.
- We saw that staff had access to a hospital communication book. This contained information on Makaton signage, (the language programme that uses signs and symbols to help people communicate) and pictorial references to aid communication about the body parts. The contact details for the learning disability lead were accessible to staff.
- We reviewed the local policy for supporting people with learning disabilities. This had been developed and agreed by the learning disability steering group, a sub-section of Surrey Health Care Group and Surrey's Learning Disability Partnership Board. The policy included guidance on general consent, capacity and best interest decisions. In relation to urgent or emergency admissions, the policy made clear the need to obtain the individual's personal Hospital Passport (a document which contains key information about how the individual should be supported, the person's behaviours and likes and dislikes) either from a carer or place of residence. The liaison service was expected to be contacted at the first opportunity. When questioned, nursing staff said they used the Hospital Passport for information about the person and, in particular, their communication needs.
- The staff followed the Butterfly Scheme (a system for working with patients with dementia), although this was said to be mainly used in the clinical decision unit. Where individuals were placed in the Majors area, staff said they tried to use bay area's 11, 12 and 14. We noted a patient with needs associated with dementia trying to get off the trolley, which was not in direct view of nursing staff. We stayed with the patient until a member of staff was alerted and staff moved the patient to a more visible area.
- We reviewed a nurse-led training workshop on the Butterfly Scheme, which had been carried out in September 2014. Nursing staff who spoke with us were able to describe how they would look after people who had particular needs associated with a cognitive impairment, such as dementia.
- There were three Butterfly link nurses in the department, as well as two dementia specialist occupational therapists. In addition, a liaison nurse for patients of 65 years and over said they supported the department Monday to Friday between 9am and 5pm. Budget set aside for 'winter pressure' had been used since October to fund additional support at weekends.

Access and flow

- Information supplied by the trust indicated that between 30 September 2013 and 31 March 2014 there were 99 A&E ambulance black breaches. Between 7 April and 29 Sept 2014 they reported 29 A&E black breaches. The majority of these were attributed to amber or red escalations, with bed capacity impacting on the ability to move patients.
- Our Intelligent Monitoring which covered July to September 2014 compared the number of patients waiting more than four hours in A&E across all trusts and found that Ashford and St Peter's were within expected limits when compared to other trusts.
- Monthly analysis of the average time spent in accident and emergency between January 2014 and September 2014 showed that figures at the trust were persistently higher than those seen nationally, ranging from 7 minutes to 25 minutes longer spent in department when compared to the England average.
- Without exception, the main problem reported by staff was patient flow, with particular concerns about the flow of patients to inpatient beds. Throughout our time in the department we saw evidence of significant numbers of patients who were waiting in excess of four hours for transfer to a ward bed. For example, on the morning of 3 December, six patients had been waiting in

excess of seven hours. At 10.30am we noted a patient had been waiting in excess of 14 hours. At 2pm of the 60 patients in the department, 13 had waited more than four hours. One patient had waited in excess of 12 hours.

- On 4 December at 2pm, three patients were awaiting the medical team and had been waiting for between six and just over 16 hours. A capacity meeting was held at 3pm on as a result of the sudden increase demands on the service. At that time, 19 patients were waiting to be seen, nine of them were priorities. There was an estimated two-and-a-half-hour wait for minor problems and three patients were waiting in ambulances. Patients were also present in the department on 5 December who had been there in excess of 20 hours.
- On our unannounced inspection on 14 December we noted that patients were still in the department awaiting beds, although the maximum wait was just over seven hours.
- Monthly figures from the Health and Social Care Information Centre for the period January to September 2014 indicated that 1,481 patients left the department before treatment or having refused treatment. Monthly analysis of the percentage of people leaving the A&E department before being seen or having refused treatment showed that this was the case for between 0.5% and 1.1% of patients at the trust between January and September 2014. This was consistently lower than was seen nationally, where figures ranged between 1.9% and 2.9% over the same period.
- We reviewed information provided to us which indicated that the overall referral-to-treatment time experienced by patients was usually less than an hour for the period April 2013 to March 2014.
- Weekly trend analysis of the percentage of emergency admissions in the department waiting four to 12 hours from the decision to admit to admission showed that the trust figures were higher than the national percentage for the vast majority of weeks over 2014; this was the case for 40 out of 52 weeks over the year, ranging from less than 1% higher to 15.2% higher. In ten weeks of the year the percentage of patents waiting between four to 12 hours from the decision to admit to admission at the trust was higher than the national figure by 10% or more.
- The department had undertaken a paediatric survey in conjunction with the CCG in September 2014. This looked at ways of reducing unnecessary visits to the department, when children could have been better helped by using other services, such as walk-in centres. The findings showed that attendance times and age of children presenting were the key problems. We saw that 92% of respondents considered their child's condition to be an emergency and 45% had been advised to come to the department by another healthcare professional. The report did not contain any indication of possible actions they would take with the CCG to address the findings.
- The number of ambulance handovers delayed by more than 30 minutes was 401 between November 2013 and March 2014 which was low when compared to the national data for delayed handovers for this period which ranged from none to 4,779, with a national average of 549. This does not however take into account differences in trust size.
- Consultants reported to us that out-of-hours referral to surgical specialties could be a concern, especially when the on-call team was occupied in theatres. This resulted in delays to patients being referred and being reviewed out of hours.

Learning from complaints and concerns

- Learning from complaints was shared with the department's staff to improve the patient experience. A member of senior nursing staff said the department received a few complaints and there was always a complaint open and under investigation, usually related to communication, which sometimes included the attitude of staff. They told us that recent complaints related to a missed fracture and a patient fall.
- We saw that information was available directing people to raise concerns through the Patient Advice and Liaison Service. A patient who spoke with us said, "If I needed to complain, I know how to".
- Senior nursing staff in the department reviewed all formal complaints received and concerns raised and these were investigated accordingly. A centralised system was used to identify any emerging trends.

Are urgent and emergency services well-led?

Good

Staff across all grades were proud to work for the service and felt supported in their efforts to provide a high-quality patient experience. Staff worked well as a

team, even when under pressure. They demonstrated a passion for their work, enthusiasm and commitment. The staff we spoke with were aware of the trust's values and expected behaviours and worked hard to achieve these.

There were clear governance structures and risk management systems designed to deliver and improve patient outcomes.

There was a culture of being open and honest where adverse events had occurred or when complaints arose. Staff tried to be innovative and make improvements to the delivery of their services as far as they were able.

Vision and strategy for this service

- In our discussion with the divisional managers they reported that there was no overarching strategy for the emergency and urgent care department. We were told that a lot of time was spent supporting operationally, coming up with improvements and there was, "emerging thinking about how it should be functioning" in respect to the department.
- We found there were emergency care strategic priorities outlined in the trust's strategic plan for 2014/15–2018/19. This included enhancing general hospital urgent care services, ensuring patients have access to the care they need seven days a week and 24 hours a day where appropriate. In addition, the priorities described working with local partners to realise a vision of joined-up healthcare. Both these points alluded to the potential merger with Royal Surrey County Hospital.
- Staff spoke confidently about the values of the trust, the provision of best care, regardless of the situation and as safely as possible. A newer member of staff commented on the responsibilities to ensure people were safe and kept informed. They said, "I believe we are good at this." This person also said they felt respected and valued and they would be listened to if there was a problem.
- Staff told us the vision and values were communicated well and were understood. Also, staff expectations were built in to appraisals and they were required to show evidence of how they had applied the values to their working practice. Staff spoke about the "four Ps": Putting patients first; having a Passion for excellence; Pride in their teams; and taking Personal responsibility. We reviewed the Best Care accreditation level for the department and saw there were various actions to be taken to improve accreditation, with various end dates stated.

Governance, risk management and quality measurement

- The governance arrangements were described to us by the senior managerial team for emergency and urgent services. Meetings included a divisional management meeting, in which the risk register was reviewed along with incidents. This was a relatively new meeting but information from this was reported on a monthly basis to the performance review committee, the patient experience group and the trust governance group. We reviewed the department's clinical governance meeting notes for 30 October 2014 and saw action points discussed and agreed, including a Chest Pain Audit against NICE guidance, as a result of a serious incident.
- There was evidence of good governance arrangements in place, which supported the department to deliver on the required areas of practice. The divisional director said they took the lead on risk and scrutiny, the associate director of nursing led on patient experience and the associate director of operations reported to the quality monitoring group. The emergency clinical governance group and acute phase trauma group was led by a designated member of medical team and they reported to acute and emergency medicine lead and then the trust-wide quality and governance committee.
- We found from minutes reviewed and discussions with staff that the urgent and emergency care services had effective governance arrangements. The overall governance was led by a responsible person, who completed an exception report to be tabled on the agenda for the divisional clinical governance meeting. This meeting was attended by the clinical director, associate directors of nursing and operations and representatives from finance and human resources. Information from this meeting was reported to the trust-wide quality and governance committee. We saw the division presented periodic exception reports and an annual governance report.
- We asked senior nursing staff about the departmental risk register and were told about a number of risks identified on this. For example, the absence of checking of the condition of trolley mattresses, and not having a CT scan facility in the department. Nursing staff confirmed the risk register was discussed at monthly clinical governance meetings and said, "intermediate meetings took place to cover missed items".

- We reviewed the risk register and identified the examples provided to us. In addition, we saw risks associated with medical staffing and delays in psychiatric assessment. In all respects, the date of the risk being opened was noted, along with the review and close date. We saw that risk levels had been identified, action plans developed to address the risk, and progress on action noted. We saw there were four open risks with review dates set between 1 December, 2014 and 7 January, 2015.
- There was effective monitoring of the progress of action plans arising from clinical incidents. So the division could be assured that the response to incidents and actions taken was resulting in improvement, a test of effectiveness, developed by the governance lead, was applied. As a result, incidents were not closed until the 'test of effectiveness' was demonstrated. A final sign-off by an executive member of the Trust Board would then follow.
- According to nursing staff, the QEWS quality dashboard was discussed at monthly performance review meetings, which were attended by members of the executive board, the chief nurse and head of patient safety. Areas discussed and reviewed included: Best Care, sickness, appraisals, hand hygiene, NHS Friends and Family Test results. We saw evidence of such reports which included evidence that performance was continuously monitored.
- We found medical staff attended quality and safety half-days where mortality and morbidity data was discussed along with feedback from incidents. Minutes indicated that audit information was also discussed.

Leadership of service

- With the exception of children's emergency and urgent services, the adult A&E department sat under the leadership of the divisional director, the associate director of nursing and the associate director of operations. All three also oversaw the division of medicine. The three leaders said they saw each other on a daily basis, although the divisional director had clinical responsibilities on two days per week. They told us that formal meetings took place every other week between them and less formal meetings were held for the division on a monthly basis with managers. They also met every two weeks to consider and act on divisional improvement projects, for example, improvements around the emergency care programme.
- We observed the associate director of nursing to be visible in the department. They took proactive decisions around arrangements to support the escalation of capacity issues, including telephoning wards to aid the transfer of patients delayed in the department. In addition, they liaised with other hospitals at the weekend when capacity was full and beds were needed for child admissions.
- A senior nurse said the three managers worked well together, supported one another and worked in a similar way. This staff member said there had been a change in the organisation and the chief executive knew how departments worked, which was viewed positively.
- In our discussions with staff they reported the associate director of nursing to be visible and approachable. Staff, including some medical personnel, did not know who the divisional director was. We did not see the divisional director in attendance, other than one brief visit at a board meeting, where patients were under review by the team.
- A member of medical staff reported that they were not involved in making suggestions or decisions around improvements to the flow of patients through the department.
- Leadership at departmental levels was commented on favourably by staff, with positive mentions of support, accessibility and hands-on help. One long-serving member of nursing staff reported improvements in the department over the previous five years, particularly in relation to quality and leadership. They said there had been improved stability, strong team work and supportive senior staff who, although long-serving, were open to new ideas.
- We saw minutes of the consultant and sister meeting held on 2 October 2014 had discussed and agreed actions around 'shop floor' leadership, with a need for delegated personnel to hold pagers at night, including the registrar.

Culture within the service

- It was very evident to us that the culture within the children's and adult's departments was focused on delivering the best care possible to people in a timely and responsive manner. There was very strong evidence of a supportive team approach and staff worked collaboratively and in a professional, organised and unflustered way, despite the pressures they were under.

- There was a culture of openness and staff were not afraid to report matters or incidents which concerned them. The 'Being Open' policy provided a mechanism to assure staff that any matter raised would be listened to and addressed without fear of reprisal. Awareness of reporting was also raised through the staff newsletter Aspire.
- Staff, including student nurses, agency and housekeeping, spoke passionately about their work and of being part of the team. Comments to us included, "fantastic, fast-paced, friendly and knowledgeable". Although a porter said they did not feel part of the team and had not been invited to any meetings, they loved their role, liked meeting people and chatting with patients.
- One member of nursing staff reported that there were occasions where staff, including junior doctors, were disrespectful to consultants and gave an example where a junior doctor had challenged the need for a surgical assessment. This had made the staff member feel that there was a culture of "either your patient or ours" and that it did not feel like there was "equal responsibility". They added that, at night and out of hours, they felt particularly isolated and felt disheartened at times regarding the ability to provide good care.

Public and staff engagement

- Senior nursing staff were asked how the public were engaged with and we were told they were not really involved. They added that they took the views from the NHS Friends and Family Test into account and looked to see if they could make any improvements. There was patient representative at the patient panel meetings and we reviewed minutes for 16 September 2014. We saw that discussions had taken place about future legislation around separate, secure psychiatric provision in emergency/urgent care services.
- With regard to staff engagement, we were told that senior sisters had been involved in departmental planning meetings and plans were available in the staff room for discussion. Band 5–7 staff had been involved in discussions around patient streaming and had put forward good ideas. This included designing a name board with pictures of staff to assist medical staff in identifying personnel. Other ideas had included improving the use of the minor operations theatre around stocking and inappropriate use of equipment.
- We reviewed the staff survey results from 2013. Four questions scored significantly less than the trust average for the department. These related to: physical violence from patients or others; harassment and bullying from patients, relatives or others; discrimination from patients, service users or members of the public; and errors, near misses and incidents that could hurt staff. There were significantly better scores than the trust average for 13 questions. This included lower scores for managers asking for staff opinions and giving clear feedback.

Innovation, improvement and sustainability

- Nursing staff spoke to us about improvements made to patient care, for example, regarding the sepsis care pathway, the provision of pain relief before being seen by a doctor and improved checking of patient skin for pressure damage.
- We were told that a patient information poster was being designed to educate the public about the walk-in centre. A briefing paper had also been written on the Butterfly Scheme.

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

Information about the service

At St Peter's Hospital medical care services are managed by the division of medicine and emergency services. Specialties include acute medicine, gastroenterology, respiratory medicine, cardiology, endocrinology, elderly care and stroke care. There were 25,547 admissions to medical care services at St Peter's Hospital in 2013/14. Medical care services had a bed complement of about 235 inpatient beds in nine wards. The division also managed the endoscopy service and the discharge lounge. During our announced inspection we visited all the medical care areas and wards managed by the division.

To help us understand and judge the quality of care in medical care services at St Peter's Hospital we used a variety of methods to gather evidence. We spoke with 13 doctors (including consultants) about 30 registered nurses (including ward managers) and healthcare assistants. We also spoke with about 12 allied health professions and other support staff. We also spoke with about 12 patients and six patient's relatives. We interviewed the divisional management teams. 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. We carried out an unannounced visit to Aspen and Maple wards on a Sunday afternoon.

Summary of findings

Overall, we found that that medical care services at St Peter's Hospital were good although they required improvement in some aspects of patient safety. This was because we identified some concerns with medicines management, nursing staffing levels and hand-washing to prevent infection. Otherwise, we found that there were good systems to report and investigate safety incidents and learning from these to prevent recurrence.

We found that treatment generally followed current guidance and that outcomes for patients were often better than average. There were arrangements to ensure that staff had the necessary skills and competence to look after patients. Patients had access to services seven days a week and were cared for by a multidisciplinary team working in a coordinated way. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements.

Patients told us they received compassionate care that respected their privacy and dignity and we observed care being delivered in a kind and respectful way. Patients told us they felt involved in decision-making about their care.

We found services were developed to meet the needs of the local population. However, the service experienced

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difficulty meeting the demand and this resulted in long waits for admission and disruption to the agreed patient care pathways. There were arrangements, including for patient discharge, to help patients with complex needs.

There were robust and effective governance systems. Staff expressed confidence in their leaders and said they felt supported to do their job well. All staff were aware of the trust's vision and strove to demonstrate this through their daily work. Arrangements ensured that staff were engaged in the running and development of the service. We observed a caring and positive culture.

Are medical care services safe?

Requires improvement

Overall we judged that safety in medical care services required improvement. This was because we found that medicines were not stored in conditions that ensured they remained in optimum condition. Also, when patients did not receive their medicines, including critical ones, the reasons were not always recorded. We found that nursing staffing levels did not meet current guidance from the National Institute for Health and Care Excellence (NICE) and the service's own agreed nursing staffing levels were not always maintained. We also observed that confidential patient records were not securely stored to prevent unauthorised access and some staff did not adhere to the World Health Organization (WHO) guidelines on hand-washing to prevent the spread of infection.

Generally, there were sufficient medical staff to treat and care for patients and there were arrangements to ensure that appropriately experienced and skilled doctors were available at all times and that patients received timely reviews of their condition and treatment.

Mandatory training rates were variable, and trust targets for completion were not met in 60% of topics.

We found that staff knew how to report clinical incidents, that these were investigated and learning from them shared to mitigate against recurrence. Rates of harm-free care were better than the England average. Staff were able to identify potential abuse in children and adults in vulnerable circumstances and acted in accordance with local procedures when required. There was a culture of openness and transparency and patients were involved in the management of any safety issues. Although staff understood the principles of the Duty of Candour, they were not yet familiar with the specific requirements of the new regulations which had just come into force in November 2014.

We observed that the care environment was clean and hygienic. There was adequate equipment, appropriately maintained to meet patients' needs.

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There were processes that were generally followed to ensure the condition of patients was monitored to identify any potential deterioration and that early escalation of problems occurred. There were arrangements to manage any major incidents.

Incidents

- Twenty incidents were reported via Strategic Executive Information System (STEIS) March 2013 to November 2014. All of these were categorised as grade 1. Slips, trips and fall accounted for 35% (7) of these incidents, delays in diagnosis 25% (5) and grade 3 or 4 pressure ulcers 20% (4). In September 2014 there were two serious incidents requiring investigation.
- Training records indicated that 97.8% of staff in medical care services had received incident management training. All relevant staff had received training in investigatory skills.
- There was a system for reviewing mortality and morbidity at directorate meetings. We saw examples of the presentations used at these meetings and noted that the format encouraged discussion and the exploration of learning points. In July and August 2014, 39% of patient deaths were formally reviewed.
- Safety incidents were reported using an electronic system. All staff we spoke with were aware of the system and could describe its use. In a "Compliance in Practice" audit carried out by the trust in November 2014; 85% of staff indicated they knew how to report an incident; 82% said they felt comfortable to escalate or discuss risks with their manager; and 79% said they had reported an incident.
- Managers demonstrated to us how they used the system to monitor safety incidents in their area, both in real time and for identifying emerging themes and trends. We saw an example on the Medical Short Stay Ward where an increasing number of falls had been identified. A programme of interventions had been instigated that included input from the trust's falls specialist nurse. Monitoring demonstrated that the programme was proving effective.
- Staff told us that they rarely received individual feedback when they completed an incident report. However, we looked at minutes from directorate governance meetings, and ward meetings and noted that discussion of incidents was a standing agenda item. We noted that, at these fora, there was discussion about safety incidents, learning was shared and actions to mitigate recurrence were formulated. Data from the "Compliance in Practice" audit indicated that 82% of staff shared learning from concerns, incidents, good practice, complaints, patient experience and other reported alerts with their teams.
- We saw that root cause analysis (RCA) investigations were carried out in the case of serious incidents. We saw examples of completed RCA's which were comprehensive and detailed. We also observed that learning points and clear plans with mitigating actions were included.
- We reviewed a medication error where a nurse gave the wrong medication to a patient. We saw there had been an appropriate response, with the nurse removed from drug administration and their competency in this area had been reassessed.
- We looked at an RCA in detail. We saw that the patient's family had been involved with approving the terms of reference for the investigation, had been involved in the investigation itself, and had been provided with a copy of the report. This demonstrated that patients and their supporters were informed when things went wrong and that investigations were transparent.
- Staff we spoke with were familiar with the concepts of openness and transparency and could give us examples of how these were actualised when managing safety incidents. However, they were unaware of the requirements of the newly introduced Duty of Candour regulations and the management team had yet to review their processes to ensure they met the regulations.

Safety thermometer

- Medical care services participated in the national Safety Thermometer programme. The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results to allow measurement and monitor local improvement and harm-free care over time. Results were disseminated to clinical areas and we noted that these results were displayed for the staff and public to view. However, the information was not in a format readily understandable to the general public. Information relating to falls and pressure damage was displayed using the safety crosses format, which enabled patients and their supporters to identify the days such events occurred on.

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- In October 2014 medical care services achieved a rate of 98% harm-free care, better than the national target of 95%.
- Data since July 2013 showed a higher than average prevalence of pressure ulcers, although there was no clear trend over time. In October 2014 wards in medical care had an average of one instance of pressure damage in that month with a range of 0 – 3.
- Data since July 2013 may indicate a recent rise in falls. The most recent available data for October 2014 showed that there were no falls with harm reported that month.
- Incidence rates of 3.7% and 3.3% reported on two out of 10 wards for new catheter associated urinary tract infections. For new pressure ulcers, two wards reported rates of 3.7 and 4.2%.
- Data since July 2013 showed a high prevalence of catheter associated urinary tract infections with no clear trend identified. In October 2014 wards in medical care services reported two new infections.

Cleanliness, infection control and hygiene

- Overall, we found that the requirements of the Department of Health's "Code of Practice on the Prevention and Control of Infections and Related Guidance" were being followed in medical care services.
- Medical care services had reported no MRSA bloodstream infections or outbreaks of Norovirus. The provider reported lower than England averages for Clostridium difficile (C. difficile) infection with the exception of one month since March 2013. We were unable to access data concerning the C. difficile infection rates in medical care services. However, data for the Trust was supplied and there were 7 C.diff cases August 2014 year to date against an annual target of 9.
- Staff received appropriate training in infection prevention and control, although training rates did not meet the trust's targets. We saw training records that indicated 65.4% of staff in medical care services had attended mandatory training in infection prevention and control and hand hygiene, less than the set target of 90%.
- There were adequate facilities for the isolation of patients, both with and at risk of an infection. However, we saw some examples of patients in isolation rooms with doors left open. In one case there was confusion among staff as to whether the patient required isolation or not. This presented a risk that infections may not be adequately prevented.
- Clinical areas appeared clean and hygienic. We saw that cleaning schedules were displayed. We were told that cleaning audits were carried out.
- Equipment and sanitary ware shared between patients was cleaned between each patient use. We observed this happening and saw that distinctive green labels were affixed to indicate the item was ready for use. Staff told us that if this was missing they would re-clean the equipment before they used it. We saw that single-use items were not re-used and that items designated for single patient use were not shared.
- There was a programme of audit carried out by infection control specialist nurses. We saw results of these audits and the feedback and actions given to ward staff.
- We saw audit results that showed 88% compliance with clinical care bundles that were developed as part of the Department of Health's Saving Lives guidance. However, we looked at records for the Visual Infusion Phlebitis (VIP) score on three wards which this guidance requires. The trust policy was that these scores should be recorded on each shift, and although nurses were calculating them and showed an awareness of them, we found they were inconsistently completed.
- We saw that hand hygiene was audited against the WHO's 'Five Moments for Hand Hygiene'. The October 2014 audit results showed compliance rates ranging from 60% to100% (average 93%). However, during our observations across medical care services, we noted that this guidance was not always followed and that hand hygiene opportunities were missed, especially after contact with the patient's surroundings.
- We observed that there were adequate supplies of personal protective equipment and staff used it when required.
- There were suitable arrangements for the safe disposal of waste. We saw that used linen that presented an infection risk was segregated and managed appropriately. Clinical and domestic waste was segregated in colour-coded bags and managed appropriately in clinical areas. Sharps such as needles and blades were disposed of in approved receptacles and their management met the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

Medical care (including older people's care)

Environment and equipment

- We saw training records that showed 97.7% of staff in medical care services had undertaken training in health and safety, exceeding a target of 90%, and 72.7% of staff had completed their statutory fire training.
- We looked at the reports for medical care services generated after the last patient-led assessment of the care environment (known as PLACE). We noted that concerns were raised about the general décor and maintenance of ward areas. However, we saw from the action plan that some minor works that had been identified, such as updating fire signage, had been completed. Other more major works, such as replacing damaged floors, were in progress, and some wards had been identified as needing to be included in the capital ward refurbishment programme within the next two to three years. This showed that the safety of the physical environment was reviewed and actions taken to remedy any deficiencies.
- We did not observe any immediate safety hazards in the clinical environment. Staff could describe how they reported any defects to the estates department and told us they received a satisfactory response when they did so.
- Staff told us they had access to adequate manual handling equipment. We saw a range of such equipment in clinical areas. We noted that the equipment had labels attached indicating it had been maintained.
- We found that there was adequate equipment for the management of medical emergencies, including resuscitation equipment. We looked at records that showed this equipment was checked at least daily to ensure it remained ready for immediate use.
- Electrical medical equipment was kept in an equipment library. Staff told us the system worked well and they always had access to this equipment when they needed it. We visited the library and found that there were arrangements to ensure that all equipment was decontaminated and checked to ensure it was working properly before being made available for use. Equipment was stored plugged in so that batteries remained charged. Staff in the library demonstrated the tracking systems which noted when equipment was used and when it was due for routine servicing. The system prevented the issuing of equipment beyond its service date. We also saw that equipment was linked specifically to the patient using it via the tracking system, allowing for traceability although some departments had standby items for emergency use where this was not possible. This meant that electrical medical equipment was managed to ensure it was always safe to use.
- We saw that some ward areas had access to point-of-care testing, including blood gas analysers and urinalysis machines. These were managed by a dedicated pathology team. The team demonstrated to us the electronic systems used to monitor these pieces of equipment to ensure they were properly maintained and displaying reliable results. We also saw the systems where only staff who have been trained and deemed competent to use this equipment could access it via a swipe card. This meant that point-of-care testing equipment was fit for purpose and the quality of results obtained was monitored.
- However, point-of-care glucose monitoring machines were not part of this system and were operated as standalone systems. These systems should have had a calibration test done daily but, when we looked at the tests on two wards, we found they were inconsistently performed. On some occasions the gaps between tests was as long as a week. Additionally there was some confusion over the frequency of testing, with one senior nurse informing it should be done weekly. This presented a risk that these machines, which guide patient treatment, may not be giving reliable results. We discussed this with the point-of-care team who showed us evidence that this risk had been recognised, and that a tender process was underway for the provision of new glucose monitoring machines. The specification stated that these machines have the same safety features as other point-of-care testing equipment, such as remote monitoring, user restrictions and mandatory calibration that cannot be omitted.

Medicines

- Medical care services had access to a ward-based pharmacy service, with dedicated support from pharmacists and technicians. Pharmacy staff visited the wards to check the appropriateness of prescribing and to ensure adequate supplies of medicines were available. They confirmed what medicines the patient

had been taking before admission and made sure there were no omissions. They also worked with nursing staff to identify patients in need of pharmacy support and resolve medicine problems before discharge.

- We saw training records that indicated that an average of 58.8% (the range was 25% – 100%) of relevant staff had completed medicines management training, less than the trust target of 90%.
- We found medicines storage was secure. We saw medicine cupboards in treatment rooms were locked on all wards, and medicine trolleys secured to walls when not in use. Keys to medicine cupboards were kept with the nurse in charge. We saw examples of digital locks securing drug trolleys rather than traditional keys, and staff explained how the number was known only to authorised staff and was periodically changed to improve security. Access to treatment rooms where medicines were stored was also secure.
- Medicines were not stored at temperatures that ensured they remained in optimum condition. Dedicated medicine refrigerators had temperature checks. However, there was a poor response to maximum refrigerator temperatures being out of range. The medical assessment unit (MAU) recorded a maximum temperature of 100C on three occasions and 110C on three occasions in July 2014 and 160C on 14 July 2014 with no actions taken. On Aspen Ward, maximum temperatures of 10.50 C were recorded. Maple Ward had a reading of 140C between 19 to 22 November and on 1 December, and 180C on 29 November, 30 November and 2 December with no action taken.
- We saw that medicine storage cupboards had been located directly above radiators in the MAU and within ambulatory care, meaning that temperatures for safe storage would be exceeded.
- Treatment rooms where medicines were stored were too warm. On the MAU, the temperature was 29.60C, exceeding the maximum recommended temperature of 250C. An air-conditioning unit was in place but not working properly. The temperature had been consistently above 250C since June 2014. We saw that a portable air-conditioning unit had also been installed in the treatment room on Maple Ward. The chief pharmacist told us they had identified 12 areas where 250C was exceeded on a regular basis and a business case for wall-mounted air-conditioning was being prepared.
- Actions had been taken to minimise errors with infusion solutions by using a different supplier for those infusion solutions containing potassium.
- On Maple Ward we found an instance where different strengths of an injectable medicine in pre-loaded syringes were stored together in a box. This increased the risk of a wrong dose being administered.
- We looked at controlled drug registers and found there were no stock discrepancies. However, on Maple Ward there was no indication that a three-monthly check by pharmacy had taken place. We checked the expiry dates of stock medicines and found all were in-date.
- Prescriptions that could be used at a community pharmacy (FP10 forms) were kept safely and their issue was recorded. In the MAU we saw there was a clear audit trail of the prescriptions issued. This meant the potential for misuse was minimised.
- Most oral liquids had 'date-opened' stickers on them, applied by the pharmacy, but not all wards were filling them in, especially on Aspen Ward. On Maple Ward, one bottle of a liquid medicine was found with no indication of how long it had been open. This meant there was a risk patients may be given medicines that had passed their use-by date.
- There was good access to medicines out of hours through an emergency cupboard. A list on the department's intranet ensured that staff knew which wards keep specific medicines so they could be located if needed urgently. There was an on-call service provided by the pharmacy team. We were told about a situation where there was an emergency discharge for a dying patient. The pharmacist came in and dispensed medicines and was very efficient and helpful.
- We found poor documentation around the recording administration codes on Aspen Ward. These codes explain why medicine doses have been missed or withheld. We saw examples of code for "nurses' decision to withhold (needs justification)" recorded but no justification included. This meant there was no record to demonstrate why a patient's medicine was not given as prescribed.
- We found examples where critical medicines (as defined by the National Patient Safety Agency (NPSA) in "Reducing harm from omitted and delayed medicines in hospital") were missed. We found that the relevant sections on the treatment charts had not been signed and there was no indication why the medicines had not been given. One patient had been prescribed

Rivaroxaban (an oral anticoagulant) 20mg daily and we found missed doses on two consecutive dates in December. Another patient was prescribed Enoxaparin (an anticoagulant to prevent the formation of blood clots) 20mg daily and we found a missed dose on 25 November. It was unclear if these incidents had been reported.

- In an evaluation of missing and delayed medicines dated July 2014, 12% of medicines in medical care services had been omitted, with patients being 'nil by mouth' and refusing medication accounting for 25% of these omissions. Unavailable medicines caused 15% of omissions, although some were available as stock in other wards, and 1% of medicine doses were delayed.
- There were systems to prevent patients being given medicines to which they were allergic. Allergies were recorded on treatment charts. We saw there was a system of yellow stickers identifying products containing soya or peanut oil.
- We observed that oxygen was prescribed, in line with the NPSA regulations when it was required by patients.
- On the MAU we saw good recording of discharge packs of medicines when they were issued from wards, with a double check by nurses. This was supported with a clear audit trail that enabled staff to respond easily to any queries about what medicines a patient had taken home. Unfortunately, although it met the legal requirements, some of the labelling on the packs of medicines did not fit the discharge requirements and staff were having to hand write instructions on the boxes for pharmacy-only medicines. We saw evidence of this for Aspirin 75mg where the patient had to take 300mg daily for two weeks and for a laxative where there was no space on the label to write how many to take per day.
- We saw there were adequate resources, such as up-to-date British National Formulary and intravenous treatment guides that staff could reference when they needed to. However, staff were unaware of whether there was a medicines information service for them to use for information queries or advice. The chief pharmacist told us the medicines information service was provided by another local NHS provider.
- We found there was some confusion around the supply of information booklets for patients who needed to start using the anticoagulant Warfarin outside of the anticoagulant clinic. Supplies of starter pack booklets were not available at ward level. The ward nurses told us that they came from pharmacy, but pharmacy told us that they did not supply them. This meant that patients commencing a high-risk treatment may not have access to the information needed to use it safely.

Records

- We looked at training records which showed that 73.3% of staff had received training in information governance, less than the trust target of 90%.
- We found that confidential nursing records were not stored securely in some ward areas, for example, the MAU and Aspen Ward. They were situated in patient bays and not locked away, meaning they could be accessed by unauthorised personnel.
- We looked at nursing records and found that they were not always consistently completed. For example, repositioning charts, food charts and personal care round records were not completed on every occasion. Overall, however, nursing care records were comprehensive, current and easy to navigate. We judged that they contained all the information required to support the delivery of safe care.
- Core care plans were in use and we found that patients in medical care services also had a personalised care plan based on an assessment of their needs. The 'Best Care' audit report dated September 2014 showed that 84% of patients in medical care services had a relevant care plan, and 98% had had their care plan evaluated.
- Nursing documentation contained a range of risk assessments covering the major risks for patients. The standardised risk assessments covered risk of pressure damage, risks of falls and use of bed rails. We noted that these were updated when required. The latest best care audit reported: 93% of patients in medical care services had their risk of pressure damage assessed within 24 hours of admission and this was reassessed in 100% of cases; 99% of patients had a falls assessment; and 96% a risk assessment for the use of bed-rails.
- Risk assessments for venous thromboembolism (VTE or blood clots) were completed on patient admission and appropriate risk-reducing measures, such as the use of anticoagulants, were implemented.
- We reviewed patients' medical records and found that these were maintained every day. They were comprehensive, current and complete.
- Other records relevant to the running of the service were maintained, and could be produced when requested. These records were current and fit for purpose.

Medical care (including older people's care)

Safeguarding

- Safeguarding training formed part of the mandatory programme but training rates were less than the trust target. Training records showed that 82.8% of staff had completed training in child protection, and 73.3% in safeguarding adults at risk. This was less that the target rate of 90%.
- Staff knew where they could access the relevant safeguarding policies. Staff could articulate situations that would alert them to potential abuse and could tell the correct course of action to follow. In the September 2014 "Best Care" audit report, 95% of staff could name the trust safeguarding lead. Staff we spoke with were aware of the trust safeguarding lead and how to contact them.
- On Aspen Ward we were told of an example of a child safeguarding referral that had been made the previous day as a result of a patient's concerns to provide appropriate care for their child. The nurse was very clear about the rationale for their actions. We also saw an example of an incident report completed that day regarding the admission of a patient from a care home with advanced pressure damage which had generated a safeguarding referral.
- Medical care services had made 105 safeguarding referrals since April 2014. Referrals for neglect constituted the greatest proportion of these at 35% and domestic violence accounted for 17%. We noted that all forms of potential abuse, including psychological abuse and sexual abuse, had been recognised and referred to the appropriate body.

Mandatory training

- There was a programme of mandatory training. We looked at the topics covered and noted it contained training on the key risks and safety issues expected.
- We looked at training records. All mandatory training had a compliance target of 90%. Of 10 topics, we saw that in medical care services, six topics did not achieve this target. Compliance rates ranged from 65.4% (for infection prevention and control) to 98.1% (for Mental Capacity Act 2005/Deprivation of Liberty Safeguards).
- In a "Compliance in Practice" audit in November 2014, 77.9% of staff in medical care services indicated they were up to date with their mandatory training.

Assessing and responding to patient risk

- Training records showed that training rates for basic life support were 75% against a target of 90%.
- We looked at patient records and judged that, in general, patient observations were completed at appropriate frequencies. The "Best Care" audit report showed that 81% of patients in medical care services had their physiological observations taken at the appropriate frequency.
- Medical care services used the National Early Warning Score (NEWS) for acutely ill patients, a scoring system that identifies patients at risk of deterioration or needing urgent review. We found that NEWS scores were consistently and accurately completed with each set of physiological measurements. On some occasions we found the specified escalation processes were not followed when the score was low but this could be explained – for example, respiratory patients sometimes had an elevated score because of their usual raised respiratory rate. However, the patients' records were not clear on why this judgement was made, and observation charts did not always specify the target range or acceptable tolerances.
- Staff we spoke with were aware of how and when to contact the critical care outreach team and gave us examples of situations where they had done this. They spoke positively of the advice and support this team provided in the care of very sick patients.

Nursing staffing

- In October 2014 the vacancy rate for nursing posts was 14.9% – worse than the trust target of less than 10%. The stability of the workforce was quantified as 80.8% – less than the target of greater than 85%. This indicated that there recruitment and retention of staff represented a risk to medical care services.
- All staff we spoke with – from the management team to healthcare assistants – recognised nursing recruitment as a major safety risk to the service. We saw that it was reported on the directorate risk register. The management team told of various measures, such as open recruitment evenings and overseas recruitment initiatives, they had put in place in an effort to decrease vacancies. All ward-based staff were aware of these initiatives and were supportive of them. There was general agreement that recruitment and retention of nursing staff was seen as a priority
- Where shortfalls in nursing numbers were identified we saw that temporary staff from the hospitals own bank of

staff or from an agency were used to ensure that there were adequate numbers of nurses to meet patients' needs. Agency staff accounted for an average of 2.2 whole time equivalent (WTE) per ward worse than the trust target of zero. However, records showed that nursing shortfalls occurred as a result of these shifts being unfilled. For example, in November 2014 six shifts on the MAU were unfilled, and 10 shifts on Maple Ward.

- There was a checklist system for ensuring that agency nurses received orientation to a ward area which were to be completed at least every six months for each ward the nurse was assigned to. We saw some examples of completed checklists but also found staff on duty who had not completed them. Two ward managers commented that they were aware that these checklists were not being routinely and consistently completed. This meant there was a risk that temporary staff may not be able to function safely.
- The trust had devised a red/amber/green (RAG) rating criteria on which to make judgements of shift safety based on the number of shortfalls per shift. In November 2014, 84.93% of individual shifts achieved the staffing levels rated 'green'. We found that 22 (0.27%) shifts were RAG rated as 'red' and 124 (14.8%) were rated as 'amber'.
- There were shortfalls in registered nurses, and these spaces in the rota were filled with healthcare assistants. In November 2014 on Swift Ward we noted that this occurred on 41 occasions.
- Senior ward staff told us that shifts where they were supernumery and not allocated a patient caseload were frequently cancelled. We saw that few supernumery shifts were recorded on the staffing monitoring sheets. Senior nurses told us this impacted on the time they had available to concentrate on management tasks and work that helped to develop the staff and the service.
- Staff and managers told us, and we observed, that staff were frequently moved to other wards to cover shortfalls. Staff appreciated why this was necessary but also perceived this as an added stress and voiced concerns about negative impacts on team work and continuity of care for patients.
- On the morning of our inspection, the discharge lounge had no registered nurse on duty, although the hospital's approach was to have been one, supported by two healthcare assistants. This meant there was no registered nurse to manage the discharge process or to monitor recently discharged patients. The adjacent Medical Short Stay Ward was covering nursing tasks, such as arranging discharge medication and discharge documentation. A staff member in the discharge lounge told us, "We are down a staff member reasonably often". This also placed an additional workload on the staff in the Medical Short Stay Ward.
- We saw that, to safely staff an extra-capacity area, a system of rotating staff from surgical and orthopaedic care areas for whole weeks or months was in place. While this ensured that there was a core of the trust's own staff responsible for the ward, staff told us that it did not provide continuity of care and they found this stressful.
- NICE guidance – (Safe staffing for nursing in adult inpatient wards in acute hospitals) was not being met. This guidance recommends minimum registered nurse to patient ratios of 1:8 during the day and 1:10 at night. In four out of eight wards the night nursing establishments did not meet these ratios. On Holly Ward the ratio was 1:15. Staffing shortfalls also meant this ratio was not maintained. For example, in November 2014, the 1:8 daytime ratio on Holly Ward was achieved only on a single shift, and on Swift Ward the recommended ratio was only achieved on 78% of day shifts. The management team were aware of this shortfall when we discussed this with them.
- Nursing establishments were reviewed to take account of patient dependency using a nationally recognised methodology developed by the Association of UK University Hospitals. We saw data collection in progress for this review and observed that it had been completed on Aspen Ward. This review identified that an increase in staffing numbers was recommended and we saw how this was being progressed through the business planning process.
- Records indicated that when patients required one-to-one care, additional staff were employed. This was confirmed by staff we spoke to.
- In a "Compliance in Practice" audit in November 2014, 75.6% of staff in medical care services responded positively to the item "Today, do you feel that the ward has safe staffing levels to deliver optimum patient care?" This meant that although the majority of staff felt there safe staffing levels, a significant minority disagreed.
- We visited Aspen Ward as part of our unannounced visit and found there were no vacant beds, with three registered nurses and two healthcare assistants on duty plus a student nurse covering for two staff who were off

sick. The agreed staffing template was for five registered nurses. The staff were very busy and told us they had not had any meal breaks. Staff reported they had stayed late over the weekend to support their colleagues. This demonstrated that, on this occasion, there were insufficient staff to meet the needs of patients while ensuring staff could take scheduled breaks and leave on time.

Medical staffing

- Consultants accounted for 30% of the medical workforce in the medical care service, slightly below the England average of 33%. Doctors described as 'middle career' accounted for 11% of the workforce (average 6%); registrar grades 32% (average 39%); and junior doctors 26% (average 22%). This meant that the medical workforce was, in general, more junior than the England average.
- Consultant locum use for February to August 2014 was confined to the MAU and represented 8.9%, however, these were long-term locum appointments.
- On the MAU, we observed that patients were reviewed by a consultant on a ward round. There was a consultant present on the unit 12 hours daily from 8am to 8pm. Outside of these times a consultant was on call. Guidance from the Society for Acute Medicine and the West Midlands Quality Review Service (2012) suggests that a consultant should be on site or be able to reach the unit within 30 minutes. When we spoke to the directorate management team they indicated that they had not checked how quickly on-call consultants could attend the MAU, and a consultant we spoke with told us they were about 35 minutes away. This meant the service could not be sure that this guidance was met.
- One doctor was trained in the specialty of general internal medicine or acute internal medicine at specialist level ST3 or above (or equivalent Specialty and Associate Specialist grade) and was available at all times on the MAU, in line with the guidance.
- We saw that arrangements had been made to ensure there was consultant cover for an extra-capacity escalation ward that had been opened in September 2014.
- Patients on the MAU were cared for by the medical team on call for the day. A member of the directorate management team told us that if patients did not stay beyond the 24 hours set out by the hospital's medical care pathway this would not present any issues. However, patients frequently stayed longer and junior doctors described the situation where some patients would be cared for by a different team of doctors each day. Although, some specialties cared for their patients on MAU while they awaited transfer to a ward. The junior doctors felt this lack of continuity presented a risk of poorly coordinated care, and said it created difficulties for nursing staff in knowing which team of doctors to approach for support in caring for patients. Patients commented to us about their perceptions, with many saying that they saw many doctors, and one describing their care as "disjointed" as a consequence.
- There were arrangements to ensure medical cover out of hours. A rota covered the acute medical unit and ward areas. Junior doctors felt that the rotas provided adequate cover as long as the hospital was not under pressure. However, they felt that as the hospital was busy the majority of the time, the workload demanded of them was excessive. Ward staff we spoke with did not raise any concerns about the availability of out-of-hours medical input.
- A junior doctor told us they felt they spent too much time on call. They gave an example that, on a four-month rotation, only three weeks were spent on the ward. This situation did not ensure continuity of care for patients and presented a risk that the doctor's on-the-job training needs might not be fully met.

Major incident awareness and training

- Staff were aware of the trust's major incident and business continuity plans and knew how to access them on the intranet. They were unaware of the detail of these plans but could articulate the principles they would follow in the event of a major incident or business continuity event.
- A nurse on the MAU described a major incident simulation exercise they had participated in, and felt this had helped them understand the process more clearly.

Are medical care services effective?

Good

Overall, we judged that medical care services were effective.

This was because we found that care and treatment reflected current guidance. We found that patient outcomes, as measured by national audits, were generally better than England averages. We saw that stroke services were improving. Patients received adequate pain relief and there were arrangements to ensure their nutritional needs were met and they had sufficient to drink.

There were processes to ensure that staff were registered with the appropriate professional bodies and there were appraisal systems, although we noted that appraisal rates were below the trust's targets. Staff had access to a range of educational activities to develop their skills. We saw that nurses' competency in key skills was assessed. However, we found that there was a shortfall in the number of nurses assessed as competent to administer medicines.

Patients could access services seven days a week, although service levels were reduced at the weekends. Patients received care from multidisciplinary teams of doctors, nurses, therapists and social care staff who had access to the information they needed to provide effective care.

Where patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements.

Evidence-based care and treatment

- The endoscopy department had recently been awarded Joint Advisory Group (JAG) accreditation. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. This meant that the endoscopy department was operating within this guidance.
- Generally the requirements of NICE guidance were being followed. For example, we specifically looked at the requirements of the guidance Acutely Ill Patients in Hospital (QS6), Falls: assessment and prevention of falls in older people (CG161) and Intravenous fluid therapy in adults in hospital (CG174) and found that policies and practice met the guidance.
- We saw that the diagnostic guidance published by NICE for acute myocardial infarction was being followed.
- We found that patients with heart failure were not receiving a follow-up consultation within the timescales recommended by NICE guidance (Acute Heart Failure CG187). We were shown an audit of cardiac rehabilitation and noted that 81% of patients did not receive the attention of a cardiac rehabilitation nurse. This meant that patients with heart failure were not receiving after-care in line with national guidance.
- The Directorate of Acute and Emergency Medicine was participating in 11 national audits, and monitoring reports showed that nine of these were progressing to plan.
- We looked at specialty clinical governance meeting minutes and noted that new national guidance from NICE and learned societies was discussed, including implications for practice.
- In a "Compliance in Practice" audit in November 2014, 81% of staff demonstrated that they had "used relevant external data (for example, NICE, Department of Health research, CQC, Monitor, the Health and Safety Executive and other NHS trusts) to improve, innovate and to transform service provision".

Pain relief

- Patients told us that they received adequate pain relief when they required it. We looked at medication records and saw that people were prescribed suitable analgesia and that it was administered as needed.
- In the "Best Care" audit report dated September 2014, 99% of patients received a pain assessment on admission to medical care services. We saw that pain scores were routinely completed with each set of patient observations and that, during patient care rounds, staff indicated that the comfort of patients was considered.
- We saw that staff had access to specialist assessment tools to help them manage the pain of people with learning disabilities or living with dementia. During our unannounced visit, the Bolton Pain Assessment Scale was carried out for a patient with cognitive impairment.

Nutrition and hydration

- We saw records showing that patients received a nutritional assessment using the malnutrition universal screening tool (MUST). This was reviewed at least weekly at interviews and appropriate care interventions were put in place. The "Best Care" audit report showed that 99% of patients in medical care services had a MUST assessment and that 97% had this assessment repeated

and reviewed appropriately. In 95% of cases, correct actions were taken following this assessment, including 100% referral rate to the dietician when this was needed.

- Staff said they could access dietetic advice and we observed a dietician involved with patient care on the wards. We witnessed a dietician session with a patient and saw the interaction was very caring and appropriate. The agreed referral-to-response time was three days, but internal monitoring suggested that, in most cases, a response time of two days was achieved.
- We saw that, when patients were fed artificially via feeding tubes, they received this in accordance with the prescription formulated by the dietician. However, we found the recording of the administration was confusing. We were told feed administration should to be documented on fluid balance charts, but it was difficult to confirm if the patient was receiving what has been prescribed from these.
- The "Best Care" audit report showed evidence of appropriate mouth care in 100% of patients surveyed. We did not see examples of poor oral hygiene and noted that equipment, such as foam sponges, were available for staff to perform mouth care.
- Patients reported that they received food and drink in sufficient quantities to meet their needs and they were offered an appropriate choice. There were arrangements to provide therapeutic diets and food that met people's religious and ethnic requirements.
- We observed that patients were given encouragement to take adequate oral fluids, and that drinks were left within people's reach. Where it was needed, patients were given help at meal times.

The "Best Care" audit report showed that there was 100% compliance for observing protected meal times, in line with the trust's policy.

- In the November 2014 "Compliance in Practice" audit, 83.4% of patients responded positively to the question, "Do you believe the meals you receive are of good quality?"

Patient outcomes

- The crude mortality rate for September 2013 in medical care services was 2.35% and represented a downward trend.
- In the Sentinel Stroke National Audit Programme (SSNAP) for January to March 2014, the trust's stroke services attained an overall score of 'D' on a scale of A to E, with A being the best. Since then the trust's overall score has steadily improved; data for April to June 2014 showed a score of 'C', while data for July to September 2014 showed a score of 'B'. Monitoring of stroke performance by the service shows that the proportion of patients admitted directly to a stroke unit from April to November 2014 was 55%, below the target of 90%. However, 83% of patients spent at least 90% of their stay on a stroke ward, better than the target of 80%. Also, 68% of stroke patients were scanned within one hour of arrival, exceeding the target of 50%. All patients eligible for thrombolysis treatment received this, and 90% of high-risk transient ischaemic attack referrals were treated within 24 hours of first contact with a health professional (the target was 60%). Of low-risk transient ischaemic attack referrals, 98% were seen within seven days.
- In the Myocardial Ischaemia National Audit Project (MINAP) the trust achieved a significantly better performance than England averages.
- In the National Diabetes Inpatient Audit (NaDIA) September 2013 the trust performed better than the England median averages in 16 out of 20 indicators which indicated that patients were receiving care that was better than the national average.
- We looked at the Enhancing Quality report for quarters 3 and 4 of the last financial year and noted that the trust had achieved a rating of "moderate achievement" against targets for the care and treatment of heart failure and community-acquired pneumonia.
- The average length of stay for elective and non-elective admissions to medical care services mirrored the England averages at four and seven days respectively. In geriatric medicine the average length of stay was longer than average for non-elective admissions at 14 days against an average of 10 days. This meant that patients were treated and discharged within expected timescales.
- The standardised relative risk of readmission for patients admitted as an emergency was 113. This is +13, which is greater than average. The risk for elective patients was 89 (-11, better than average). During our inspections, we saw examples of rapid readmission of patients and heard anecdotal evidence from staff that,

due to bed pressures, they felt that patients' discharge could be rushed which resulted in readmission. This meant that, for non-elective admissions, patients in medical care services were more likely to be readmitted.

- We saw evaluation data that demonstrated the effectiveness of the Older People's Assessment and Liaison (OPAL) team. For example, for this specific patient group, the number of readmissions within 30 days decreased from 20.4% in October 2013 to 11.3% in January 2014, and the number of patients admitted to a ward from the MAU fell by 3%. The data showed that 94% of patients and 100% of relatives felt involved in care planning and discharge arrangements. This showed that the initiative was delivering effective care to patients.

Competent staff

- We saw records which showed there was a system to ensure that staff registered with the General Medical Council and the Nursing and Midwifery Council and maintained active registration entitling them to practice.
- We found that nursing staff were engaged in the appraisal process. However, appraisal rates in October 2014 for medical care services stood at 74.8% against a trust target of 98%. Nursing staff we spoke with told us they had found their reviews useful, that they had a development plan and were supported to meet their objectives. In the 2013 staff survey, medical care services received positive feedback about appraisal and staff development. For example, in acute medicine, only 4% of staff felt they were not supported by their manager to receive training, learning or development identified in appraisal (average 19%), and in cardiology 8% agreed with the statement that training, learning or development needs were not identified in the appraisal (average 26%). In care of the elderly, only 5% agreed that they had received no other job-relevant training, learning or development (average 26%).
- We found that consultant medical staff were engaged with the revalidation processes.
- There were no current arrangements for nursing staff to receive ongoing clinical supervision. Staff told us that there had been systems in the past but these were no longer being used. However, on the MAU we saw records that showed the ward manager was meeting regularly with individuals to discuss managerial and professional issues.
- We saw that new nursing staff were required to undergo a corporate induction programme. This was supplemented by local induction which included completion of initial competency assessments in key skills to be completed in the first three months. This was followed by a further tranche of competency assessments to be completed in the first year. We saw examples of these competency assessment frameworks in the process of completion and staff spoke to us about them. This meant there was a system for the medical services to be assured of the competence of its staff, and for staff to gain and demonstrate that they had the knowledge, skills and experience to do their jobs.
- Nursing staff were required to undergo a competency assessment before they could administer medicines, and this included bank (overtime) and agency staff. We found staff on duty awaiting completion of this assessment. This meant that not all staff on duty could administer medicines and this resulted in staff from other wards being moved to perform this task. Discussions with staff confirmed that non-availability of staff to administer medicines was an ongoing problem and a source of frustration for them, although all acknowledged the importance of staff competency in this high-risk activity. This appeared to be a particular problem on Aspen Ward.
- Nursing staff and managers told us that training days were often cancelled at short notice due to staffing pressures. This meant staff were experiencing difficulty accessing the training and development they required to undertake their roles.
- Junior medical staff described the system of teaching and other learning opportunities open to them. They told us they received sufficient teaching and that the quality of the teaching and experience was good.
- We saw examples of nurses being supported to undertake further qualifications and training as part of their personal development plans. For example, we spoke with a healthcare assistant who was being supported to complete a foundation degree. This showed that the service supported the development of its workforce's skills.
- On Cedar Ward we saw that specific competencies and a training programme had been developed to ensure staff working on the stroke unit had the training and skills appropriate to their role to enable them to deliver high-quality, specialised care.

Medical care (including older people's care)

Multidisciplinary working

- Patients could access care and treatment from the full range of health and social care professionals. Therapists made 38,859 contacts for inpatient medical care services from April to November 2014.
- We saw that there were a range of specialist nurses to support patients and their families. Staff were aware of how to contact these specialists, who also visited wards to identify patients they may need to see.
- The response times for therapists' standards for stroke patients were monitored. Outside of stroke these standards had not been audited or the current financial year. Performance indicators including therapy response times are currently being reviewed. The SSNAP data for April to June showed that the median time between clock start and being assessed by a physiotherapist was just over 24 and a half hours, occupational therapy was just over 23 hours, and speech and language therapy was about 23 hours.
- We saw that medical care wards held daily 'board rounds' (multidisciplinary team meetings to prioritise bedside reviews and discuss patients' current care and treatment and future plans). We attended a meeting on Aspen Ward which was attended by consultants and junior doctors, nursing staff, therapists and a representative from adult social care. We observed that each patient's needs and plans were discussed in detail and that discharge plans and dates were given appropriate consideration. We noted that there was good communication from all attendees and that their opinions were actively sought and not dismissed by senior staff.
- Nursing and medical staff told us they could access mental health assessment and support for patients. Mental health services were provided Surrey and Borders Partnerhship NHS Foundation Trust. Referrals were initially screened by a mental health liaison nurse, who we were told provided thorough assessments and comprehensive reports. This contact was followed up by input from a psychiatrist if indicated. Staff told us they felt they received an excellent service and felt supported to meet the mental health needs of patients. Staff told us that mental health services responded promptly to referrals, and we heard examples of immediate responses in crisis situations.

Seven-day services

- Medical specialties had a consultant presence seven days per week. We saw that acutely ill patients received a daily consultant review, although in endocrinology, weekend reviews were carried out via an internet link in the first instance.
- There was an endoscopy on-call rota at the weekends to deal with any urgent cases, usually gastrointestinal bleeding, that required urgent investigation. In discussion with junior doctors and endoscopy staff, we found that, although theoretically there was a rota for evenings and nights, in practice this rota was not functioning and was poorly understood. However, in the event of an urgent endoscope being required, a suitably skilled consultant could be contacted to perform it. This meant there was a risk that there could be delays in performing urgent investigations while a suitable practitioner was found.
- Pharmacy support was available every day with opening hours at weekends of 10am to 3pm on Saturdays and 11am to 3pm on Sundays.
- There was physiotherapist on call to manage urgent referrals, including chest conditions.
- There were arrangements for patients to be assessed by a therapist at the weekend to facilitate discharge, but routine ongoing treatment was not provided.
- Nursing staff and junior doctors told us that accessing diagnostic services at weekends was possible and did not present any issues for them. Diagnostic imaging services, including computerised tomography (CT) and magnetic resonance imaging (MRI) scans were available every day, although MRI scans were prioritised. Pathology services could be accessed at any time, as well as point-of-care testing and blood gas estimations.

Access to information

- We saw that, when patients were transferred between clinical areas, there was a nurse-to-nurse handover. Initial details were given to the ward the by the site management team which enabled them to ensure that any relevant risk factors were taken into account and planned for before the patient arrived – for example, the siting of a patient at risk of falls in an observable bed. We saw the handover of a patient from A&E to the MAU and noted that it was comprehensive and thorough and covered all aspects of the patient's history, treatment plans and care needs. The nurse receiving the patient was given ample opportunity to ask questions and clarify any points.

- Medical staff told us that they were able to access old medical records within 24 hours. Imaging and pathology investigation results were accessible via electronic systems.
- There were systems to keep all ward staff informed of the current hospital bed situation via screens at the nurses' station. These contained information about the number of patients awaiting discharge and admission in real time and assisted staff to prioritise workload.
- The screens also kept track of outstanding actions for patients on the ward, such as the completion of key risk assessments and screening activities.
- Patients reported that they felt their care was coordinated. One said, "It's a huge medical team looking after me. They are all coordinating with each other".
- We reviewed the discharge summaries electronically sent to GPs on Holly Ward. We found they contained all the key information about the patients' care and treatment that would allow this to continue in the community setting.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Of relevant staff in medical care services, 98.1% had completed training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Nursing staff we spoke with were able to explain their responsibilities under the Act. Junior doctors understood the Act, but were less clear about DoLS but we were assured they knew how to recognise when an application should be considered and where to obtain support and advice.
- We saw numerous documented examples of the best interest decision-making process, followed in line with the Department of Health's "Mental Capacity Act (2005) Code of Practice".
- In a "Compliance in Practice" audit carried out by the trust in November 2014, 60.5% of staff indicated that they knew the process to escalate Deprivation of Liberty Safeguard concerns.
- We were told that no current DoLS applications had been made. We did not observe any instances in medical care services where an application should have been considered. However, the department's database showed that five applications by medical care services had been made in the past year. It contained information that suggested the applications were appropriate and that their progress was monitored.
- The location made 20 referrals to an independent mental capacity advocate in the period October 2013 to September 2014, indicating that staff were identifying patients who should be given this support and were fulfilling their statutory obligations.
- In a "Compliance in Practice" audit in November 2014, 89% of staff were aware of the need to obtain verbal or written consent and knew how to do so.
- We saw documents in patients' records showing that they had consented to the care planned. Where they lacked capacity to give their consent, this had been signed by a relative.

Are medical care services caring?

Good

Overall we judged medical care services to be caring.

This was because patients told us they received compassionate care that took account of their privacy and dignity. We observed care being delivered in a kind and respectful way. Patients and their families told us that they were kept up to date about plans for their care and treatment.

There were arrangements to provide emotional support to patients and their families, although we noted that a specialised stroke psychologist had been identified as a need, but had not been funded.

Compassionate care

- Overall, patients and their supporters told us they felt they were treated with kindness, and that staff were friendly and approachable. We observed staff interactions which demonstrated a compassionate ethos. We saw patients being spoken with respectfully and that their privacy was maintained. We saw that patients asked before interventions were given and staff communicated with them throughout procedures. We saw that there were systems to ascertain patients' preferred form of address, and with one exception, this was the form used.
- In a "Compliance in Practice" audit in November 2014, 95.6% of patients (or their next of kin) responded positively to the question "Overall, do you feel the ward is caring?"

Medical care (including older people's care)

- Patients and relatives told us they felt they were treated with dignity. A typical comment received was, "I feel respected, even if they come to wash your hands and face, the blinds go round".
- The trust had a higher response rate to the NHS Friends and Family Test than the England average. Most medical care services wards scored higher than England average in the test, except Aspen Ward which scored lower than the average for most of the previous year. In October 2014, the test results ranged from 69.2% to100% (average 83.5%).

Understanding and involvement of patients and those close to them

- Overall, patients and their families told us that they were kept up to date about plans for their care and treatment. A typical comment was, "They have told me exactly what was going on". However, some patients and their families reported that they received mixed or conflicting messages. One patient told us, "Sometimes one person tells you one thing and another something else". A family member reported, "We're told one thing and then another. It's not consistent and it's distressing for the family. The main thing is inconsistency. There are four of us and we have all been told something different. Everyone needs to read the information and give the right answer".
- In a "Compliance in Practice" audit in November 2014, 89% of staff demonstrated involvement of patients in the decisions about their care and any changes. In the same audit, 89% of patients, or their next of kin, said they had been involved in planning and making decisions about their care.

Emotional support

- Staff spoke enthusiastically about the chaplaincy service and valued the emotional support it provided. There were arrangements for visits by spiritual advisers from all major faiths.
- The stroke service had identified the need for a specialist psychology services to support patients and their families through the life-changing consequences of a stroke. This would assist in achieving NICE guidance which states, "All patients after stoke are screened within six weeks of diagnosis, using a validated tool, to identify mood disturbance and cognitive impairment". A business case had been developed and presented but funding was not made available for specialised psychological input.

Are medical care services responsive?

Good

Overall we judged that medical care services were responsive to the needs of patients and their families.

This was because services had been developed to ensure the local population could access care and treatment as close to home as possible. However, we found that the service experienced difficulty meeting the demand for its services and this resulted in long waits for admission and disruption to the agreed patient care pathways. Although we saw that the requirements of mixed-sex accommodation guidance was followed in ward areas, we found that there were a small number of breaches of the guidance in the discharge lounge which the divisional management team and staff did not recognise.

There were arrangements to meet the specific needs of patients, including those with learning disabilities. We found some weaknesses in the care of people living with dementia but saw there was an organisation-wide action plan to address this.

Patients were informed of how they could raise a concern or complaint. We saw that complaints were investigated and that agreed timescales were met most of the time. We found there were systems to ensure that learning from complaints was shared within the service.

Service planning and delivery to meet the needs of local people

- The hospital had an Older People's Assessment and Liaison team (OPAL), consisting of medical staff, nurses and therapists who assessed patients in the assessment areas to avoid unnecessary admissions to hospital and to support older people in their homes and communities.
- We found that plans were well advanced to offer internet-based consultations with hospital staff to patients in local care homes to avoid attendance at hospital.

- There were systems using telemedicine technologies that enabled patients who had suffered a stroke to be rapidly assessed by a specialist any time, meaning care that met current NICE guidance could be delivered locally out of hours.
- In the "Compliance in Practice" audit, all applicable staff said they had developed outreach services to provide community-based services where appropriate, such as off-site specialist clinics. In the same audit, 71.4% of staff were judged to demonstrate an understanding of community chronic disease, including the local population's predominant health needs.

Access and flow

- There were 25,547 admissions to medical care services at St Peter's Hospital in 2013/14: 48% were in the general medicine specialty; and 21% in gastroenterology.
- Bed occupancy in the trust overall has exceeded 91% since October 2013, in excess of the 85% target figure. In October 2014, bed occupancy in medical care services was at 100.11%.
- Admissions to medical care services showed an increasing trend, and staff told us that there were continuous efforts in the service to meet the demand. Swift Ward had opened initially as an extra-capacity ward to meet this demand but the management team confirmed that this area was now considered a permanent clinical area.
- During our visit, the trust identified its escalation status as 'black' – the highest level, meaning that there was insufficient bed capacity to meet demand.
- From May to August 2014, the average number of medical patients cared for in non-medical clinical areas (commonly called outliers) was 42 per month.
- In August 2014, 46% of patients were moved to different wards during their stay: 32% were moved once; 10% twice; and 4% three times or more. Full year data from 2013/14 shows that these percentages were fairly constant.
- Medical care services performed consistently better in the 18-week referral-to-treatment times set by government as a national target. The expected compliance was 90% but in cardiology the compliance rate was 95.9%, in gastroenterology 98.4% and 100% in general medicine.
- Patients and families we spoke with told us of long waits for admission to a ward bed, often in inappropriate circumstances. One told us that they had waited 10 hours in a waiting room where the TV was not working. They also told us that there were only biscuits to eat and the unit had run out of sandwiches. Another reported that they had waited in the A&E department overnight, that they were allocated a bed at 3.30pm and arrived on the ward around 7pm. However, this patient was understanding of the situation and said, "There's been a bit of waiting around but I'm only one of many; it's unavoidable".
- We found that bed pressures meant that the service's admission pathways could not always be implemented. Emergency admissions to medical care services represented the majority of admissions. These were primarily via the A&E department, or via GPs. Patients were initially admitted to the MAU for assessment and diagnosis of their condition with a maximum stay of 24 hours. If a longer stay was required, patients were transferred to the relevant specialty ward, or to the Medical Short Stay Ward. However, due to bed pressures, patients were frequently cared for in the MAU for longer periods. Patients admitted with a stroke were seen on arrival by a specialist team and received a brain scan within an hour. If treatment with thrombolytic medicines was required, this was commenced in the scanning department and the patient transferred to the acute stroke unit. However, staff told us that often an acute stoke unit bed was not available and stroke patients had to return to A&E to complete their thrombolysis.
- The flow of patients in medical care services was disrupted as patients were discharged later in the day. The directorate was focusing on discharges early in the day to address the issue. Ward staff told us that waiting for medicines to take home and transport delays frustrated their attempts to discharge patients in a timely way. In October 2014, 44.6% of patients were discharged before 3pm, and 68.4% before 4pm, indicating that a large number of discharges occurred later in the afternoon which had a negative impact on the capacity available to manage the new day's admissions.
- There was a discharge lounge where patients could await transport or final discharge arrangements such as medicines. The discharge lounge was staffed by registered nurses and supported by healthcare assistants. It was open 8am to 9pm weekdays and 9am to 5pm at weekends. Patients had to be medically fit

and not confused to wait in the discharge lounge. Staff told us that, during periods of peak bed demand – such as we experienced during our visit – the lounge became very busy and there was pressure to take patients before arrangements were completed. For example, medicines to take home should have been prescribed before the patient went to the lounge, but a staff member told us, "To take home medicines are meant to be done, but are not always. Especially when we are on black alert – they want the bed space so we can be waiting a while for that. Transport is often late. It happens multiple times a week. There is a lot of pressure down here, especially on black alert". This confirmed that, although there was a discharge lounge to aid timely discharge, bed capacity issues placed a strain on the facility.

- We saw that discharge plans were commenced on admission and that patients had estimated dates of discharge documented in their records. We saw that discharge coordinators supported ward staff in planning complex discharges and carried out specialist assessments such as those for NHS-funded continuing care. Discharge arrangements were discussed at the daily board rounds.
- Bed pressures were compounded by high numbers of delayed transfers of care. For the week previous to 20 November 2014, it was reported that a total of 242 bed days were lost due to delayed transfers of care across the trust. We were told that the main cause of delays was the provision of community services, especially care home places, to meet patients' ongoing needs. However, the most commonly cited reason for delay was awaiting completion of assessment. While many of these delays were outside the direct control of medical care services, they remained within their influence. Medical care services were engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall.

Meeting people's individual needs

- We saw that, where assessments identified a risk, control measures and care interventions were in place. We saw examples of care being delivered in accordance with moving and handling assessments and noted that appropriate pressure-relieving equipment was used; this was confirmed by the latest "Best Care" audit which demonstrated that all relevant patients were cared for using appropriate pressure-relieving equipment
- All patients over 75 years were screened for dementia using a recognised methodology. This was performed by a specialist occupational therapist and we saw these assessments in patients' records. We saw examples of further assessment and referral being undertaken as a consequence of these screenings.
- Medical care services used the Butterfly Scheme, a national project which identifies those with dementia to staff and describes a range of approaches to help staff meet their needs. We saw that the butterfly symbols were used to identify relevant patients. However, in our discussions with staff, we found that there was a poor understanding of the care and communication approaches that follow the identification phase. On Holly Ward, we saw an example of two patients with butterfly symbols displayed, but there was no assessment of their cognitive function recorded in their case notes. This meant that a system designed to identify and promote the support of people living with dementia had been introduced but was not fully embedded, increasing the risk of not meeting the needs of this patient group.
- Dementia training was not part of the mandatory programme. However, the dementia action plan contained a strategy to ensure that all trust staff received dementia training appropriate to their role.
- We saw that some elements of dementia-friendly design were incorporated into the ward areas, for example, toilet seats in contrasting colours. However, other aspects such as pictorial signage were not present. Environmental assessment of ward environments was undertaken in the PLACE survey 2014 and this included remedying dementia friendliness. The findings were that generally all wards had a lack of Dementia friendly aspects such as: no calendars, Décor in most areas did not have a distinct colour for the toilets/bathrooms, light switches, handles, floor and paintwork were not all contrasting in colour. Actions were for all future ward refurbishments to factor in a dementia friendly environment which has been allocated to the Associate Director Estates.
- There was an arrangement with Surrey and Borders Partnership NHS Foundation Trust, the local NHS mental health trust, to provide a liaison service for people with learning disabilities. We met the liaison nurse touring the wards to find patients that needed a referral. They told us they did this twice weekly and accepted telephone referrals at other times. We noted

that staff appeared to be familiar with her role and observed a discussion about a patient who, although not formally diagnosed with a learning disability, was assessed by the ward team as warranting specialist assessment. Staff told us about, and demonstrated an awareness of the Hospital Passport scheme where patients with a learning disability held a document outlining their care needs, preferences and other useful information for staff to reference. There were no patients who needed to use these passports during our visit.

- Wards had systems for identifying people with hearing or visual impairments. Some wards highlighted these on their handover sheets, and others used discreet symbols on patient status whiteboards. On Maple Ward we were shown the symbols used, and were told that no patients required them at present. We looked at one set of patient records clearly identifying that the patient was profoundly deaf, yet no symbol had been used on the whiteboard. This means that, although there was a system, it was not always effective.
- We observed that patient call bells and requests for help were responded to appropriately. In the "Compliance in Practice" audit, 83.3% of patients, or their next of kin, said if they used the call bell, staff responded promptly.
- There were arrangements to meet the communication needs of people for whom English was not their first language, or who used British Sign Language. We saw posters advising that interpreting services were available for patients. Staff we spoke with were aware of how to arrange these. One staff member told us that she had been used to translate in an urgent situation. We saw records that showed that professional interpreting services (Language Line) were used on 161 occasions between July and November 2014. We noted that patient information leaflets were displayed in languages other than English.
- The hospital provided a range of refreshment facilities and shops on the campus. However, one patient told us that the only way to obtain a newspaper was to go to the shop, but this was difficult as they had very limited mobility.
- We saw that there was much relevant patient literature displayed in clinical areas covering information about specific diseases and procedures, health advice and general information relating to health, and social care and other services available locally.
- Medical care services had not reported any breaches of the mixed-sex accommodation guidance issued by the Department of Health. However, in the discharge lounge, there were two beds separated by curtains where patients of the opposite sex, dressed in their nightclothes were accommodated. This constituted a breach in the guidance and had the potential to compromise patients' dignity, which was unrecognised and unreported.

Learning from complaints and concerns

- From April to October 2014, medical care services received 165 formal complaints. In the same period there were 375 enquiries to the Patient Advice and Liaison Service. We found that complaints relating to treatment and communication problems were the main issues raised. The managers we spoke with were all aware that these issues were the main causes of dissatisfaction.
- In the same period, 84% of complaints were responded to within the agreed timescales.
- We saw literature and posters were displayed advising patients and their supporters how they could raise a concern or complaint formally or informally.
- We saw meeting minutes showing that the learning from complaints was shared at staff meetings and clinical governance forums. Staff told us they found this useful. In the "Compliance in Practice" audit, 89% of staff in medical care services could demonstrate learning and change in practices following complaints or concerns raised.

Are medical care services well-led?

Good

Overall, we judged that medical care services were well-led.

This was because all staff were aware of the vision of the trust and local services and strove to put this in to action as part of their daily work. We found that staff and managers were working on various projects and initiatives and that staff were well-informed about these. However, we found that the division and individual clinical areas did not have overarching strategies or plans that identified priorities, timescales, outcome measures, enablers and barriers to success and the inter-relationships between the various strands.

Medical care (including older people's care)

We found there was a strong system of clinical governance that had proved effective in identifying risks and underperformance. The governance system used comprehensive metrics presented as dashboards to ensure that quality issues and trends could be readily identified.

Staff expressed confidence in their leaders and told us they were visible and approachable, and supported staff to do their jobs well. We noted that staff showed a positive attitude to their work and spoke well of the organisation and their colleagues. We saw that staff were offered opportunities to develop their leadership skills. We found that staff were engaged with the running of the service and, in stroke services, there were initiatives to involve the local community.

Vision and strategy for this service

- All staff we spoke with were aware of the trust's vision. We observed that staff were putting the principles in to action and during discussion could give examples of how they did so.
- Individual wards had local visions or philosophies of care. Staff described to us how these had been developed during a collaborative project involving the care team.
- In medical care services, at both directorate and ward level, we found that staff had developed strategies and projects to address various issues and challenges. For example, on Aspen Ward, there were initiatives to improve the team dynamics and develop the specialist skills of nursing staff in respiratory nursing. On Cedar Ward we saw that the training needs of staff were being assessed and appropriate plans made. Most ward areas had plans to improve recruitment and retention of staff. Staff could speak confidently about these and were aware and supportive these initiatives.
- However, neither individual wards nor the directorate had a comprehensive strategy drawing these strands together into a coherent plan which identified priorities, timescales, outcome measures, enablers and barriers to success and the inter-relationships between the various strands. For example, we found that training was cancelled as part of the strategy to ensure adequate nursing staff were on duty to meet patients' needs, but that the development of staff skills was acknowledged as being an important part of retaining staff and developing services. Therefore, the two approaches were contradictory. This meant that the approach to achieving the strategic aims was uncoordinated. However, we did see a comprehensive plan for stroke services.

Governance, risk management and quality measurement

- Medical care services had a robust governance structure. Governance activity was coordinated by a dedicated post-holder. Each specialty held clinical governance meetings, attended by the lead and other consultants, Clinical Nurse Leaders, ward managers and the governance lead. We saw minutes of these meetings and saw they contained standing agenda items such as discussion of critical incidents and changes to practice guidance. An exception report was prepared by the governance lead. These were considered at the divisional clinical governance meeting as part of the overall agenda. This meeting was attended by the clinical director, associate directors of nursing and operations, and representatives from finance and human resources. We saw minutes of these meetings. In turn these meetings reported to trust-wide governance forums such as the quality governance committee. An annual governance report and periodic exception reports were prepared by the directorate and we saw examples of these.
- Each specialty was subject to a performance review by the divisional management team and an executive member of the trust board. Dashboards of key performance metrics were prepared for these reviews and we were supplied with these. At these reviews specialty leads, service managers, Clinical Nurse Leaders (occasionally ward managers) were required to account for their performance in the key metrics and provide assurance on any remedial work in progress to rectify areas of underperformance.
- Following "Best Care" reviews where care was judged against a comprehensive set of criteria by an assessor external to the department, managers were required to present their findings and any associated action plans to the chief nurse and head of patient safety. Levels of performance in this initiative formed part of the key clinical governance metrics and therefore concerns and their progress were monitored.
- Monitoring of metrics performed under this governance structure identified a particular ward that was not achieving the required levels of performance. We saw

that the division had taken action in this instance. Arrangements were made to provide a ward manager with a proven track record of service improvement, additional support in terms of input from specialist staff, and new posts – for example, a post where the remit was to develop the quality of documentation. We received very positive feedback from all grades of staff about the perceived improvements achieved in this ward over only a few weeks. This showed that the governance processes were effective and that the divisional leadership took action when issues emerged.

- Medical staff attended quality and safety half-days where mortality and morbidity data was discussed, and feedback from incidents and any audits was reviewed. We saw the minutes of these meetings and noted that all relevant agenda items were covered in detail.
- The associate director of nursing held weekly informal meeting with ward managers and Clinical Nurse Leaders, in addition to formal monthly meetings which were minuted. Each ward manager held a brief, informal meeting with the associate director of nursing to discuss the past week's operational issues and to plan for the predicted challenges of the coming week.
- We saw copies of the monthly divisional governance newsletter issued by the governance lead in ward areas. This contained information on new guidance, recent audits and learning from critical events. Staff reported that they found the newsletter informative and useful.
- There was a system for maintaining an accurate and current risk register for the division. Any member of staff could raise an issue for inclusion with the governance lead. After discussion, the risk was formally assessed and any control measures identified. Subject to thresholds being met, the risk was then approved by the divisional management team for inclusion on the register. There was a facility to escalate risks to the corporate risk register via an executive sponsor. All managers we spoke with knew the risks contained on the register and their status, showing a high level of understanding of the process. We looked at the register and noted that all the risks we had identified or had been informed of were included. We also saw that targets had been set with regards to actions planned to reduce risk, and that progress against these was recorded, demonstrating active management of identified risks.
- The progress and effectiveness of action plans following clinical incidents was monitored. As part of the action planning process, the governance lead developed tests of effectiveness. The incident could not be considered closed until these tests had been completed and the incident signed off by an executive member of the trust board. This meant the division could be assured that its response to clinical incidents was appropriate and generated improvements in patient safety.
- We found that some services provided by an external contractor in cardiology were governed by a service level agreement that was reviewed annually.

Leadership of service

- All staff we spoke with told us that trust and divisional leaders were highly visible. However, in the November 2014 "Compliance in Practice" audit, only 46.2% of staff knew the trust's chief nurse and their role and responsibilities, and 49.8% knew the medical director and were aware of their role and responsibilities.
- Ward managers told us that Clinical Nurse Leaders and the associate director of nursing could be seen on the ward daily and were approachable and helpful. Staff told us that they felt supported by their line-manager to do their jobs well despite the challenges, especially of capacity and recruitment. Staff of all grades were aware of the challenges faced by the service and were aware of, and engaged with, actions to mitigate the effects of quality and safety of care.
- The "Compliance in Practice" audit revealed that 88% of staff in medical care services said they felt positive about the trust leadership and the same percentage felt supported by both their team and line manager.
- We found that medical care services provided leadership development opportunities for its ward leaders. We were told that ward-based band 6 and 7 staff had attended the directorate leadership programme. Staff we spoke with felt that they had received support with developing their leadership and managerial skills within the directorate. We spoke with two staff members who had been supported to enrol on the Edward Jenner development programme via the NHS Leadership Academy, and a third who was undertaking the Prince Edward Leadership Scheme.
- Patients reported that they felt the service was well-run. One patient told us, "I get the impression it is well-run, with people getting quietly on with it".

Culture within the service

- We observed that staff were positive about working for the trust and understood the contribution they made personally to the care and treatment of patients.
- Patients acknowledged this positive and caring ethos. One remarked, "As far as I can see they do everything they have to and they are cheerful".
- The workforce was ethnically diverse. We saw that staff were enabled to observe their cultural identity, for instance, we saw nurses with covered heads. One manager from a non-British background told us they had not encountered any discrimination in the workplace and had been encouraged and supported by their managers to achieve their full potential.
- Staff sickness levels were 2.3% in October 2014, better than the trust target of less than 3%. Seven out of 11 areas achieved rates of less than 2%.

Public and staff engagement

- We saw that individual wards and departments held ward meetings, and issued newsletters to staff to keep them informed. In the latest "Best Care" audit report, 94% of ward staff were aware of ward-based improvements.
- We found through our discussions with all grades of staff that they felt informed and involved with the day-to-day running of the service and its strategic direction.
- We found that the consultant geriatrician working with the Older People's Assessment and Liaison (OPAL) team was attending meetings with the local care home providers group to better understand the challenges faced by community services.
- On Cedar Ward we found that staff had become involved in community-based health education initiatives such as 'Know Your Blood Pressure Day'.
- Stroke services had developed strong community links. A stroke club met every six to eight weeks and utilised past patients to support those undergoing their initial care and treatment. The local stroke advancement group consisted of interested parties, including past patients, who campaigned for improvements within the hospital and across the wider health economy. We were told that they helped with the business case for the hyper-acute stroke unit. The unit also had a productive relationship with the stroke association who provided a support worker who was considered part of the multidisciplinary team.

Innovation, improvement and sustainability

- The division had identified a range of cost improvement plans. Appropriate risk assessments had been carried out to understand their potential risks to quality and safety. We saw that some cost improvement plans relating to staffing had been identified as a 0% likelihood of achievement because implementing these plans would mean reducing staff which would not be appropriate and would have detrimental effects on patient care. This meant that matters of quality and safety were not subordinate to financial considerations.
- The governance system used comprehensive system of metrics presented as dashboards to ensure that quality issues and trends could be readily identified. Through its clinical governance and performance review structures and processes, the divisional management team were well-placed to ensure that improvements were identified and that performance across a wide range of metrics was sustained.
- Staff told us that they had used the Department of Health's 'Productive Ward' programme to become more efficient. We saw elements of this approach in practice, such as the use of 'patient status at-a-glance' whiteboards and the use of tabards to indicate that a nurse was administering medicines and should not be disturbed unless in an emergency. On Cedar Ward and the MAU, we saw that modules from the programme were being revisited to ensure that any efficiency gains were sustained and maximised.
- We saw examples of innovative practice, such as the use of internet-based ward rounds, and development of the stroke education programme.
- The OPAL team provided an innovative approach to the care of frail elderly people and aimed to enhance the quality of care by ensuring these patients were effectively managed by a specialist team early in their admission. The team focused on patients who met a set of frailty criteria and was based in the 'acute hub' consisting of A&E, the MAU and Medical Short Stay Ward. Patients were followed up on speciality wards to ensure their care plans were being implemented appropriately. The team also followed up patients on discharge with a community nurse from a partner organisation. The service aimed to improve patient care to support a reduction in the length of stay, facilitate safe, effective discharge and prevent readmissions for this patient group. We saw evidence of data being collected that demonstrated that these aims were being met and that patients and their supporters valued this service.

Surgery

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

Information about the service

Ashford and St Peter's Hospitals NHS Foundation Trust provides surgical services at both Ashford and St Peter's hospitals. This report is about the surgical services provided at St Peter's Hospital, which provides both elective and emergency surgery. The surgical specialities include: general surgery, trauma and orthopaedics, vascular, urology and colorectal. St Peter's Hospital is the tertiary centre for limb reconstruction.

The operating department at St Peter's Hospital has eight theatres (two laminar flow – or streamline flow –theatres and one hybrid theatre).The laminar flow theatres is used, for example, for certain types of orthopaedic surgery and the hybrid theatre is used for surgery with interventional radiology. Seven theatres are based in the main theatres department and one theatre is based in the urology day surgery unit. There is a 10-bed recovery room located in main theatres (two bays allocated to paediatrics) and a three-bed recovery room located in the urology day surgery unit. St Peter's has five surgical wards and an admissions lounge.

All of these areas are run by the theatres, anaesthetics, surgery and critical care (TASCC) division that operate trust-wide.

Swan Ward has beds for emergency and elective patients requiring an inpatient stay after orthopaedic surgery and is run by the trauma and orthopaedic trust-wide division.

We visited Swan, Wren, Falcon and Heron wards, surgical admissions unit, pre-admission clinic, admissions lounge and central sterile stores department (CSSD). We spoke with 70 staff, including: theatre managers, head of nursing, Clinical Nurse Leaders, ward sisters, consultants, anaesthetists, doctors, junior doctors and nurses. We also talked with ward clerks, housekeepers, healthcare assistants, pharmacy staff, physiotherapists and occupational therapists and members of the hotel services staff. We spoke with 16 patients and five of their friends and relatives. We observed care and looked at 10 sets of patient records. We reviewed data provided in advance of the inspection.

St Peter's Hospital had around 18,609 admissions in 2013/14. Of these, 34% were emergency, 20% were elective and 46% were day cases.

Surgery

Summary of findings

While services was seen to be caring and compassionate across all areas, improvement was required to make surgery safe.

Staff were encouraged to report any incidents on the trust's computer system. Where incidents had recurred, it would suggest learning had not taken place.

Compliance with the World Health Organization (WHO) surgical safety checklist was not meeting the trust's target.

There was a high number of qualified nurse vacancies across the division. Staff told us they were working extra bank (overtime) hours to cover, as well as using agency staff.

Storage on some wards for patient notes was not secure and this meant visitors to the hospital could have had access to these confidential records.

The trust participated in local and national audits, for example, the Hip Fracture Audit.

There was good multidisciplinary working within the units and wards.

Patients and their relatives felt the care they received was very good. Patients told us the staff respected their privacy and dignity.

The trust was not meeting the18-week target for referral-to-treatment time for general surgery and trauma and orthopaedics.

A new urology unit had recently been opened to make the assessment of patients quicker and to provide their treatment at one location.

Staff told us they were aware of the trust's visions and values and they were very passionate about patients receiving good care. Staff on the wards told us they felt supported and listened to by their divisional management team. However, some staff in theatres told us they felt unsupported and not listened to by the divisional management team.

Are surgery services safe?

Requires improvement

Staff were encouraged to report incidents on the trust's computer system. Staff told us there was a "no blame" culture and incidents were viewed as learning opportunities by the trust. We saw that some incidents recurred, suggesting that learning had not taken place to minimise the risks to patients. Two Never Events (serious, largely preventable patient safety incidents that should not occur with the proper preventative measures) had taken place at St Peter's Hospital in theatres in 2014. These were investigated and staff told us about the learning that had happened following one of these events.

The surgical and theatres division had not met the trust's target for mandatory training.

There was a high number of nursing vacancies across the divisions. Bank and agency staff were used to fill these. Staff told us they also worked bank shifts to cover the vacancies. There were enough staff on duty out of hours for one operating theatre. Staff in theatre told us they were able to call in other staff from home to run the second operating theatre if needed. However, some of the surgical staff raised concerns with us about the trust's ability to run a second emergency operating theatre out of hours if required due to an emergency that was not able to wait.

We observed in two wards that patient notes were not stored securely and were in public areas where visitors to the hospital could have gained access.

Incidents

- Staff told us they were encouraged to report incidents on the computer system. However, not all staff said they received feedback after reporting incidents and they were aware of some staff not completing incident forms because they did not receive any useful learning as a result.
- Incident management training was provided to all staff in the surgical and theatres division. We saw the training records for this division and a large number of staff had completed this training.
- We asked the divisional management team about how staff received feedback about incidents they had reported. They told us staff had to indicate this on the

computer system when completing an incident form. We asked who would provide the feedback to the staff member and they were unable to tell us who this would be.

- All ward or unit managers, lead nurses and assistant directors of nursing for each division reviewed all reported incidents. They then fed back any learning to the ward or unit staff at ward meetings or the monthly, half-day quality and safety meetings. Incidents were also discussed at the monthly clinical governance meetings for each division.
- The CSSD had two incidents that were recorded via the trust's reporting system. The CSSD management told us they were notified of incidents that involved their department. They confirmed that both recorded incidents had been fully investigated, but only one had related solely to their department. They said learning from this was shared with the staff at their meetings.
- We reviewed the reporting of incidents relating to medication for surgery for the four months up until October 2014. The level of reporting for some incidents from Swan Ward was higher than other wards. This may have been due to diligent reporting of some incident categories compared to other wards. There were no trends in the data across surgery. There was a robust policy for staff to follow if a medication error had occurred, including incident reporting, investigation, retraining and competency of the member of staff being checked. We saw learning and feedback from incidents discussed at ward meetings and information put on to staff noticeboards.
- The trust had reported two Never Events in 2014 for the theatre division at St Peter's hospital. Never Events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. All incidents had been thoroughly investigated. We saw minutes of the division's governance meeting where these incidents were discussed along with the learning that was required.
- A Never Event evening was held by the trust and all staff were invited to attend to share learning. The divisional management team told us that, after this event, a quality presentation was undertaken for staff who were not able to attend.
- Staff in recovery told us about the learning that had taken place since the Never Event involving the use of a specific medication. All staff were invited to a debriefing session and a new protocol was devised about the use of this medication. Changes to the storage arrangements had also taken place. We saw a poster on the medication cupboard door explaining the new guidance. Staff told us they were aware of the new protocol for its use.
- We were shown the investigation into a near-miss incident where the wrong patient was taken to theatre. Fortunately the error was picked up and the patient received the correct surgery. The investigation had highlighted the areas of concern which led to the incident. It also stated a similar incident had happened about six months previously. There were some suggested areas for improvement.
- Staff were able to tell us about the principles of the new Duty of Candour regulations. They told us it was about being open and transparent with patients following incidents and apologising to them.
- Senior staff in the divisional management team were aware of the Duty of Candour principles but were not aware of what the regulations stated. They told us that training had been booked for January 2015.
- Within the surgical and theatres division there were a total of 16 incidents reported to the Strategic Executive Information System (STEIS) for the year 2013/14. These incidents were, for example, pressure ulcers, slips/trips/falls and delayed diagnosis. We saw that these were discussed in the division's governance meetings and learning was shared with staff in ward or unit meetings.
- We saw records of the morbidity and mortality meetings. These were held for each of the surgical specialities, for example, vascular and trauma and orthopaedics. We saw presentations where each speciality discussed individual cases and the learning required.
- Interventional radiology monitored the mortality rates. They only recorded any mortality if it was directly a result of the procedure and within 30 days of it taking place.

Safety thermometer

- NHS Safety Thermometer information was not routinely displayed in the ward areas. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. This tool enabled wards and units to measure harm and the proportion of patients that were

harm-free from pressure ulcers, falls with harm, urinary tract infection with catheters and venous thromboembolism (VTE or blood clots) during their working shifts.

- Trust-wide information relating to harm-free care was recorded on the Quality Experience, Workforce and Safety (QEWS) monthly triangulation and predictor dashboard. This covered a number of areas – for example, nursing workforce, NHS harm and patient experience. The information for August, September and October 2014 had only short-term trends and no longer-term trends to see whether harm-free care had improved, deteriorated or was stable.
- Each ward and theatre had been accredited for the Best Care Dashboards. This looked at a number of areas and included hand-hygiene audits, complaints, consent and leadership. Three wards and theatres had achieved the top accreditation.

Cleanliness, infection control and hygiene

- We observed all the wards and theatre areas to be clean.
- Staff in the theatres area were wearing surgical 'scrubs'.
- The QEWS dashboard contained results of the hand-hygiene audits. The results for October 2014 showed all but one surgical ward was rated a 'green' level 3 top rating, with compliance of over 95%.
- All staff were bare below the elbows in wards and theatre areas, in line with hygiene recommendations.
- A cleaning audit for theatres for November 2014 showed they were 100% compliant.
- Monthly cleaning audit results were on display in the majority of wards. These indicated their compliance with the audits. The CSSD adhered to high infection control standards and guidance. Staff were observed wearing 'scrubs' and protective clothing which included face masks, gloves and gowns. Certain parts of the department were not able to be accessed unless staff were wearing scrubs and protective equipment.
- The trust's policy for Methicillin Resistant Staphylococcus Aureus (MRSA) detailed when patients needed to be screened prior to their surgery. Staff told us that, for all elective patients, this was done at the pre-admission clinic and for emergency surgical patients this was done on admission. The audit results showed screening for elective patients was 99% and 90% for emergency patients. These results were monitored by the infection control team monthly and the trust's target was 100%. These results cover both St Peter's and Ashford hospitals.
- The surgical and theatres directorate had two cases of Clostridium difficile (C. difficile) in 2014. Both were on the same surgical ward, one in March and the other in September. We saw this was reported in the annual report for the control of infection for 2013/14.
- We observed staff wearing protective clothing when required, for example, when caring for patients who were being nursed in isolation due to infections. Information was displayed outside the room, informing staff and visitors about the precautions that were needed before entering the room.
- The trust's annual report of the control of infection for 2013/14 stated that the surgical site infection rate for colorectal surgery had decreased from 16.2% in December 2012 to 8.3% for surveillance period April 2014 to June 2014.
- For fractured neck of femur, the most recent surgical site infection rate was from 2013 and was 3.2% compared to the national England average of 1.8%.

Environment and equipment

- St Peter's had eight theatres: two were laminar – or streamline – flow (this was where certain types of surgery took place, for example orthopaedics) and one was a hybrid theatre (this was where surgery and interventional radiology worked together). Seven theatres were based in the main theatres department and one theatre was based in the urology day surgery unit.
- The recovery area in the main theatre area was one room. Male and female patients were allocated to different areas and a specific area was also dedicated for children. Two trolley areas were combined into one and these were used for patients who would be going to the critical care unit (CCU). Staff told us they had an issue with storage of equipment due to the size of the room. For example, oxygen cylinders were stored in the dirty sluice area which could be a risk of cross-infection and infection control.
- Resuscitation equipment on each ward and in theatres was checked, with records in place showing completion.

- Surgical equipment was tracked and traced. We saw records of this in patients' notes. This was important in case any issues with patients or the equipment after surgery were identified and needed to be followed up.
- Equipment provided by CSSD was also traceable. We saw the tracking stickers from this equipment in patient notes.
- All scopes were cleaned by CSSD in line with the trust procedure for their cleaning and storage – for example, scopes used for endoscopic retrograde cholangiopancreatography (ERCP) and cystoscopy. Staff showed us how they cleaned the scopes and the safety checks they had in place. Records of cleaning and safety checks on machines used as part of the process were kept. A system was used to track which scope was used for individual patients in case an issue arose and needed to be investigated.
- Staff told us about the specialist equipment they had for bariatric surgery (weight loss) patients. This included larger beds, chairs and hoists. In theatre they used a specialist mattress to transfer patients who were not able to move themselves. Specialist anaesthetic equipment was available to support these patients.
- We saw the records for equipment used in theatres and this documented which company was responsible for equipment maintenance and when it was due.
- The trust had an external maintenance contract with the providers of the interventional radiology equipment. Staff told us this meant they were able to have the latest equipment and the provider maintained and replaced the equipment as required.

Medicines

- On Wren Ward the medication room was locked and medications were stored in locked cupboards. Staff told us they dispensed medication from this room and took it directly to patients as they had no medication trolley or secured boxes by patients' beds. This could potentially be unsafe as a member of staff could be interrupted while delivering a patient's medication and they did not have a secure place to store it.
- We reviewed the medication systems on Swan ward. Medicines storage lockers for storing individually dispensed items and a patient's own medicines in the bays were being replaced as some had broken locks and could not be used. Medicine trolleys were used for commonly used stock items (one per bay).This enabled nursing staff to have timely access to stock medications for patients.
- There was secure access to the treatment room and medicine keys. Trolleys were secured to walls when not in use. Medicine cupboards in treatment rooms were all locked.
- The room temperatures of treatment rooms where medication was stored were recorded daily and were below the recommended 250C. The medication refrigerator temperature was also recorded daily and was within the required safe range.
- The controlled drug registers and balances were all correct and checked daily by two nurses. The pharmacy undertook three-monthly controlled drugs checks.
- There was good recording of patients' take-home medications when they were issued from wards, and they were double-checked by nurses. A clear audit trail was used which would enable staff to respond easily to any queries about what medications the patient was discharged with.
- No out-of-date medicines were found.
- Staff had good access to medicines out of hours as there was an emergency cupboard and a list on the intranet about which wards kept certain medicines. Staff also had access to medicines resources including current British National Formulary and intravenous guide.
- Patient allergies were recorded on treatment charts and oxygen was prescribed when needed.
- We found no missed doses or gaps in the recording of medications administered on prescription charts. There was a ward-based pharmacy service. We saw very good documentation of medicines reconciliation (from a snapshot audit, about 80% of charts reviewed had medicines reconciliations completed). An electronic tracking system was used to inform wards about progress of items in the pharmacy.
- We were told there was yearly medicines management update training, either face-to-face or through e-learning, but we did not see figures for the number of staff completing updates. We were informed that nurses could not administer medicines for the first three months on the ward unless they had evidence of experience from their previous employment.

Records

- Nursing records were held at the end of patients' beds, at the nursing station and on the computer system. Medical records accompanied patients to and from theatre. We spoke with a ward clerk who told us they never had any problems with obtaining patient notes.
- Records were comprehensive and included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms.
- We found that not all patient risk assessments had been reviewed following surgery. For example, one patient's notes documented that they were 'nil by mouth' but the nurse told us they were eating and drinking. Nurses told us they did not always have time to update nursing records. This could have meant patients didn't receive the correct care.
- On Wren Ward we found that patient notes were not stored in a secure trolley and they were positioned in the main corridor area where they were easily accessible to visitors.
- We observed that some patient's notes were also not stored securely on the SAU. They were in a trolley close to the main entrance to the ward and this was not locked.

Surgical Safety

- We observed use of the WHO surgical safety checklist in all theatres. The National Patient Safety Agency recommended that this process be used for every patient undergoing any surgical procedure. It involved a number of safety checks designed to ensure that staff avoided errors. We observed the process being completed effectively and in line with trust policy and best practice.
- We saw the trust's results of their WHO audit for September 2014. These were listed according to individual surgeons, with each given a percentage overall for their completion against the WHO checklist. The trust had an overall compliance percentage of 94%, against their internal target of 100%. The divisional management team told us they had re-launched the WHO checklist in to the theatre division. The checklist had been renamed 'How to WHO' and its importance had been communicated to staff. This had only taken place a few weeks prior to our visit and the results were not completed at the time of our inspection.
- We were shown the report of an external review of the use of the WHO checklist. The report detailed several areas for improvement and these were going to be discussed as part of the re-launch of the WHO checklist.
- Interventional radiology also used the WHO checklist for procedures. We saw audits of these and, where results were not at 100%, consultants told us they had actions in place to address this.

Safeguarding

- Staff told us they knew when and how to make a safeguarding referral. Contact details for the trust leads for adult and children's safeguarding were displayed in the wards and in the theatre areas.
- Safeguarding training records for nursing staff for the surgical wards and theatres showed that Heron Ward was the highest with 92% of staff having done the training, and surgical high dependency ward with the lowest at 63%. We were told that line managers were responsible for checking the training records and encouraging staff to book on to safeguarding training.
- The main entrance to the SAU displayed a copy of the safeguarding adult's care pathway. This provided patients and visitors with information on the process that would be taken by the trust if a referral was made.

Mandatory training

- Staff in recovery told us they had completed their mandatory training. This included infection control and moving and handling.
- Staff who worked inside the theatre told us they had to complete mandatory training in their own time as they didn't have time at work. They said the training was provided on their computer system.
- The trust provided us with a breakdown of all staff training in the surgical and theatre directorate. We saw some staff were up to date with their mandatory training and we were told that it was the responsibility of their line manager to chase them to complete this training. We saw that the division's rate for take-up of mandatory training was 85%, below the trust's target of 90%.
- Staff in interventional radiology told us they were up to date with their mandatory training; however, we didn't see records to support this.

Assessing and responding to patient risk

Surgery

- Patients for elective surgery attended a preoperative assessment clinic where all the required tests were undertaken, for example, MRSA screening and any blood tests. If the patient was found to be suitable for Ashford Hospital they were referred; if the patient was medically unfit or at high risk due to existing medical conditions, they had their surgery at St Peter's Hospital.
- On admission, patients had an assessment for the risk of venous thromboembolism (VTE or blood clots). Evidence of the actions taken where risks were identified was recorded. For example, we saw patients had been prescribed anticoagulants or were wearing anti-embolism stockings.
- We observed patients being seen by the anaesthetist and surgeon/registrar before their surgery to assess their risk score for anaesthesia and to confirm the planned surgery.
- The trust used Modified Early Warning Scores (MEWS) to monitor patients. This is a tool used to aid recognition of deteriorating patients, based on scored observations including temperature, pulse, blood pressure and respiratory rate. A high total score activated an escalation pathway outlining actions required for timely review to ensure appropriate interventions for patients. These were clearly documented on the form and included the contact numbers staff needed to obtain medical support.
- In recovery they used an assessment and management tool to monitor patients' condition. For example, the tool included advice on the management of breathing, airway and circulation and alerted staff when to call for further advice and support.
- The divisional management team told us that any medical outliers on the surgical wards were reviewed as early as possible by the medical team to see if they could be discharged. They said a 'buddy' ward system was used where each surgical ward was paired with a medical ward to help ensure that any outliers were reviewed quickly.

Nursing staffing

- In the recovery area there were seven vacancies for qualified nurses. Agency staff were not able to be used to cover shifts because this was a specialist area. Staff were working bank shifts to cover the vacancies. Guidance for staffing in recovery was met as there was one-to-one care for adult patients and two-to-one care for children. Staff in recovery were also involved in an on-call rota. Staff told us they were able to get their time back if they were called in. Staff told us there was a consultation process taking place at the time of our inspection to remove the on-call duties for recovery staff.
- The anaesthetic team also had six vacancies for qualified staff. Bank and agency staff covered these vacancies.
- The duty rotas for theatre staff showed they were using high number of bank and agency staff to fill vacancies. We did not see any shifts that were not covered on the duty rotas; however, some of these were covered by permanent staff undertaking bank shifts in their own time. Staff told us the issue with staffing levels was putting them under extra stress and some staff were leaving because of this.
- On Wren Ward there were two vacancies for qualified nurses. Staff told us that, at times, they could not fill the vacant qualified nurse post so they had a healthcare assistant to cover that shift. On the SAU there were vacancies for qualified staff, as two qualified nurses had been sent to other wards for an extended period of time. One had gone to the escalation winter pressure ward. On the day of our visit there should have been five qualified nurses but one had gone to help out at the admissions lounge as they were short-staffed and required cover. This meant the SAU was working under their required numbers for qualified staff and this could have put patients at risk.
- Some staff raised concerns about the operating department practitioners who they felt were leaving the department due to lack of career progression. One practitioner told us they enjoyed their job as they had been there for a number of years but felt staff shortages were impacting on the workforce.

Surgical staffing

- The majority of theatre lists we observed were consultant-led.
- Some of the surgical staff raised concerns with us about the trust's ability to run a second emergency operating theatre out of hours in an emergency. There were enough staff on duty out of hours for one operating theatre. Staff in theatre told us they were able to call in other staff from home to run the second operating theatre if required. Staff did not tell us how often this had taken place and we did not see any recorded incidents of this.

- At our unannounced inspection the out-of-hours theatre had just completed an operation and were waiting for the next patient. We asked how they would manage if another theatre needed to be set up for another urgent case that could not wait. Staff told us they would do their best to call in other staff and the staff available would have to manage both theatres. They said they would then have to stagger the start times of all the staff who were called in the next day to allow them time to recover.
- On the surgical assessment unit a junior doctor was present on the ward at all times. A senior house officer was on call. The staff told us a registrar and consultant were available to support the other doctors, including out of hours. Ward rounds took place daily and also a 'board round' where patients were discussed between the medical and nursing staff.
- We saw the out-of-hours rota for general surgery, urology and for vascular consultants, registrars and junior doctors. A consultant was on call at all times for each of the specialities alongside a registrar and junior doctors.
- A consultant told us they had daily ward rounds Monday to Friday and all these were also attended by junior doctors.
- A patient who was under the care of the urology team told us they were not sure who their consultant was, but they had seen a consultant and team of doctors every day.
- At weekends the consultant on call would undertake ward rounds for their speciality.
- We observed several consultants completing ward rounds on the surgical units during our inspection. The nurses also attended the ward rounds and, if they weren't able to attend, the junior doctors fed back the outcome.
- We observed an early morning handover between a consultant and their medical team. They discussed all their patients and treatments. We were told that they hoped to develop these handovers between all surgical specialities to improve patient care and communication between the surgical team.
- The trust was just above the England average for the number of consultants in post.
- We saw records that locums had been used to fill any vacancies, for example, consultant's posts.

Major incident awareness and training

- The trust had a major incident operational plan, which had been issued in January 2012 and updated most recently in October 2014. Staff told us they were aware of the actions they needed to take, both at ward and theatre level. The plan was available to all staff on the trust's intranet.

Are surgery services effective?

Good

Staff had access to policies and procedures that were based on national recognised guidance, for example, National Institute for Health and Care Excellence (NICE).

The orthopaedic early supported discharge team had reduced the length of stay for some patients with hip fractures.

The trust participated in national and local audits – for example, Hip Fracture Audit. They performed better than the England average in this audit for surgery within 36 hours and 48 hours, preoperative assessment by a geriatrician, and patients admitted into orthopaedic care within four hours.

There was good multidisciplinary working within the units and wards. We saw physiotherapists and occupational therapists on the wards liaising with the nursing and medical staff. The interventional radiology consultants also attended the multidisciplinary meetings where patients were discussed.

Evidence-based care and treatment

- Medical and nursing staff had access to policies and procedures based on NICE guidelines. This included guidance for acutely ill patients in hospital. There were other care pathways to guide staff, but it was unclear if they met national guidance.
- The staff who worked with the bariatric (weight-loss) patients told us they worked in line with NICE guidance. For example, Obesity: Guidance on the prevention of overweight and obesity in adults and children (CG43)
- International radiology worked in line with NICE guidance, for example, Carotid artery stent placement for asymptomatic extracranial carotid stenosis (IPG388).
- The early supported discharge team worked in line with NICE guidance Quality standard for hip fracture (QS16).

- On the surgical admissions unit they had pathways for staff to follow, including peri-anal abscess and urology.
- Interventional radiology had care pathways for staff to follow, for example, in biopsy for liver and lungs.
- The surgical and theatre division took part in local audits, for example, surgical site infection rates. They had plans to undertake a surgical site infection audit on vascular patients and an audit was ongoing at the time of our inspection into the fasting of patients. This had been planned due to a patient being made to fast for longer than required.
- Swan Ward showed us they were undertaking an audit into VTE assessments and they were randomly choosing 10 patients to see if this had been completed.

Pain relief

- A preoperative pain assessment tool was used. We also saw an ongoing pain management form where the level of pain relief was monitored to ensure an appropriate level of effectiveness.A dedicated acute pain team routinely visited some patients post operation to offer guidance and support about pain control.
- Patients we spoke with about their pain told us it was well-controlled and they would ask the nurses if they needed more pain relief.

Nutrition and hydration

- We were told that patients were offered water up to two hours before surgery in the majority of cases. One patient told us they had been 'nil by mouth' for almost a day while waiting for their operation. This was because their operation had been cancelled and re-booked for another day. They said it was because of an emergency. Another patient told us they were told about when to fast prior to their operation.
- Each patient was assessed on admission to identify any specific nutrition and hydration needs. This was recorded in the patient's notes. One patient's care plan said they required encouragement with diet and fluids and this needed monitoring. We saw their food and fluid charts had been completed.
- The vast majority of patients told us they enjoyed the food and there was a good choice.
- One patient who was visually impaired told us that the staff did not always offer them assistance with their meal, for example, help using the salt and pepper or opening the butter pack. They did say the staff always read out the menu to them so they could choose their meal.
- Patients told us they had access to hot drinks at regular intervals and they were provided with a jug of cold water.

Patient outcomes

- Performance in national audits produced varied results. In the Hip Fracture Audit 2013, 100% of patients were given a falls assessment.
- The trust performed above the national average for surgery being performed within 36 hours and 48 hours; preoperative assessment by a geriatrician; and patients admitted into orthopaedic care within four hours. The trust fell below the England average rate for patients who developed pressure ulcers.
- The trust participated in the National Emergency Laparotomy Audit for 2014. This found that the trust had a fully staffed operating theatre available to for patients at all times who required an emergency laparotomy along with a formal rota for out-of-hours, on-site interventional radiology.

Competent staff

- Staff who worked in the operating theatre told us they had only about 30% experienced staff and the others were all junior staff. They felt this impacted on the team as the experienced staff had to support the less-experienced staff.
- Staff in the theatre area told us they were able to request specific training. For example, staff in the recovery area told us could apply for advanced life support training.
- The staff in the CSSD had to complete competency assessments to make sure they were able to safely work in this area. New staff had a five-week induction period. The management told us they had completed the new appraisals training and they were due to start their staff appraisals shortly.
- The wards' QEWS dashboard reported the appraisals percentage for each ward/division. For Swan Ward, the trauma and orthopaedic ward, in the October 2014 QEWS, their percentage of completed appraisals was 74 %. This was indicated as 'red' because it was under the trust's target of 90%. However, the trust informed us that a new procedure for appraisal had been introduced and

training of managers was underway. We saw the results for the other surgical wards and theatres and these were either rated as 'red' or 'amber'. However, Heron Ward had achieved 100% in their appraisals.
- The consultants we spoke with told us they had received their appraisals and had gone through the revalidation process.

Multidisciplinary working

- Surgical consultants told us they worked well with other members of the multidisciplinary team, for example, clinical nurse specialists, physiotherapists and occupation therapists. They felt they were a very important part of the team.
- The consultants in interventional radiology attended multidisciplinary meetings where patients were discussed, for example, colorectal meetings.
- On the trauma unit they had devised an 'early discharge team' for hip fracture patients. The team met the patient on the ward and completed an assessment to see if they met the criteria for early discharge. The team consisted of a physiotherapist, occupational therapists, qualified nurses and therapy assistants. Once a patient had been assessed as being suitable, a home visit would take place. The patient would be visited by the same staff at their home for up to two weeks. The service had access to consultants and outpatient clinics, for example fracture clinic, in case any issues arised. The patient's GP was also involved in the process. The team were able to refer patients to other services outside of this scheme, for example, community physiotherapy and occupational therapy.

Seven-day services

- Staff told us they had access to out-of-hours pharmacy and imaging. Pharmacy opening hours at weekends was 10am to 3pm on Saturdays and 11am to 3pm on Sundays. There was also an on-call service provided by the pharmacy team for outside of these hours.
- We saw the out-of-hours rota for general surgery, urology and vascular consultants, registrars and junior doctors. A consultant was on call at all times for each of the specialities alongside a registrar and junior doctors. Junior doctors told us they felt well-supported by the senior doctors.
- Interventional radiology had a consultant-led, out of-hours service.
- Staff told us out-of-hours cover for physiotherapists was available and they saw patients who were first-day post operation or had specific medical problems.
- The acute pain team provided cover six days a week.
- The early discharge team worked seven days per week and patients were given contact numbers of staff to call if they needed advice or assistance.
- The CSSD operated a seven-day service.
- The new urology unit was opened Monday to Friday 7am to 8pm.

Access to information

- When patients were transferred between wards, all their nursing and medical records were transferred with them. Staff told us they always provided a verbal handover as well as the written records.
- We observed handovers between theatres and the ward staff. Staff in theatres told us they needed to make sure they handed over all relevant information. For example, the last time the patient had pain relief, how the operation had gone and whether the recovery time had been satisfactory.
- We saw one patient who had been transferred from the CCU had a comprehensive transfer letter which detailed all the interventions they had received during their time there. Staff told us they also had a verbal handover of the patient's needs from the staff on CCU.
- Staff told us that when a patient was discharged to other services, they completed a letter that included details of the patient's needs and what support and treatment was needed from the new service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they were aware of the Mental Capacity Act 2005 and their responsibilities. The patient assessment tool provided staff with details about the Act and its associated Deprivation of Liberty Safeguards. There was also a mini-assessment for staff to complete to help ascertain if patients had the capacity to make decisions about their care.
- The hospital used four different types of consent forms. For example, one for children and one for patients who lacked capacity to consent for their procedure/ operation. The consent forms we saw were for patients

who were able to consent. We found these were completed in full and included details about the procedure/operation and any possible risks or side effects.

- One patient who was visually impaired told us their consent form had been read to them by the staff and had included details about the procedure and any risk associated with it.
- The trust had a consent policy which provided staff with guidance, including details about when patients lacked capacity and where to obtain more specialist information. There was also a section for staff about how to obtain consent from patients whose first language was not English and about the reasons for not using family members as interpreters.
- No patients on the surgical wards were subject to deprivation of liberty during our inspection.
- Staff told us that if a patient was confused and was, for example, removing essential intravenous lines, they were able to follow the trust's 'mittens policy'. The policy contained detailed guidance on for staff on how to assess patients for the use of hand mittens. Mittens are a type of glove that was placed over the hands of a patient to prevent them from being able to grab hold of and remove essential intravenous lines. This included staff undertaking capacity assessments under the Mental Health Act, recording of the decision in the patient's notes and discussions with the clinical team and family/representatives involved. It also mentioned how staff must continually review their use of mittens and discontinue them once they were no longer required.

Are surgery services caring?

Good

Patients and their relatives told us they received a good standard of care. They felt well looked after by nursing, medical and allied professional staff.

Patients felt that staff maintained their privacy and dignity. However, we did see on Wren Ward that a portable privacy screen was used in one of the bays when the escalation bed was being used. Staff told us they had to use the screen as curtains could not be used due to the overhead hoisting. Staff were very aware of the limitations of the screen and took patients to the bathroom when able to maintain their privacy. Patients had access to support from specialist nurses and teams, for example, stoma nurses and a pain team.

Compassionate care

- Patients and their relatives told us they received a good standard of care. Four patients on the SAU told us they were well looked after and the staff were very good.
- On SAU the NHS Friends and Family Test responses were on display. The results were one of the highest in the surgical directorate with a 75.5% response rate.
- We observed that staff maintained patients' privacy and dignity – for example, using the curtain around their bed, knocking on doors before entering. Patients told us they had no concerns about how staff maintained their privacy and dignity.
- On Wren Ward we observed a portable privacy screen being used in the bariatric bay when the escalation bed was in use. This screen did not provide total privacy. Staff told us they were aware of this and, where able, they took patients into the bathroom. However, because of the overhead hoist system, they were not able to have curtains between the beds when the escalation bed was in use. Staff said they did not mix genders in this or other bays.
- Another patient told us they were very happy with the care received. They mentioned that the staff came around before lunch to help patients refresh their hands which they appreciated.

Understanding and involvement of patients and those close to them

- A visitor told us they had been involved in their care of their relative. They also said they were able to visit outside of visiting hours if they were not able to make the allocated visiting times.
- We saw in one patient's medical records that they had been referred to another hospital for specialist treatment. The doctors had written that they had discussed the decision with the patient and their views had been documented. For example, this patient had made certain requests about their proposed treatment and their preferred location and doctor.
- For patients who were undergoing interventional radiology procedures, we saw information leaflets had been devised to provide them with details about what

to expect, recovery period and possible side effects. We observed a procedure taking place and the consultant leading the case and other staff kept the patient up to date on the progress of the procedure.
- We spoke with a patient waiting for surgery. The patient and their relative confirmed that they had been given details about the operation and what to expect on the day.

Emotional support

- We spoke with the specialist nurse for the bariatric service who told us they provided emotional support for patients who were referred to their service. Patients had access to counselling services and support groups.
- One patient was under the care of the stoma nurse following their operation. Staff told us they visited the patients to provide emotional support and help to teach them how to manage their stoma.
- In interventional radiology the staff told us the consultants counselled patients who were undergoing uterine artery fibroid embolisation. This was a minimally invasive procedure where small particles are injected into the uterine arteries that supply fibroids to help them to shrink in size. They also provided the follow-up appointments and gave information to the patient and their GP about the outcomes and possible side effects.

Are surgery services responsive?

Good

During our inspection the trust was experiencing a high number of admissions and this had resulted in elective operations being cancelled. The trust was meeting its targets for re-booking patients within the 28-days timescale. The trust had looked at ways of improving the patient flow through the hospital and they had opened an admission lounge for elective patients to attend pre-operatively rather than attending the wards on admission.

The trust was not meeting the 18-week referral-to-treatment time target for general surgery and trauma and orthopaedics. The divisional management team told us they were working hard to address this. The trust was meeting the target for urology. A new urology unit had been opened to speed up the assessment of patients and to provide their treatment at one location.

Patients told us they had no concerns about their care. We saw posters on display informing patients and visitors about how to make a complaint.

Service planning and delivery to meet the needs of local people

- The specialist nurse for the bariatric service told us the commissioning guidelines for obesity patients had changed and, to reflect this, they now provided a weight management programme. They were the only hospital in the area to do this. They were now taking referrals from the whole of the Surrey area to meet demand and, as a result, their referrals had tripled within a year.
- The early discharge scheme for patients with fractured hips had reduced their length of stay in hospital and provided continuity of care.
- A new urology unit had been opened about two months before our inspection. The purpose was to provide a self-contained department to enable a quicker assessment process for patients. The centre had a theatre and recovery area. Specialist nurses and consultants worked together in the unit to deliver a patient-centred service.

Access and flow

- The SAU had a seated area for patients who were referred from GPs, A&E minor injuries (Minors) area and outpatient clinics. These patients were offered treatments including pain relief and intravenous antibiotics if required. The staff told us that if patients were assessed and treated quickly they may not need to be admitted to hospital.
- Staff in recovery told us they have had to close the unit at times as they could not support patients after their operations because the unit was full. We did not see any incident forms for this as staff said they did not always complete them. This had an impact on the operations that were taking place, as patients had to wait in theatre until a space in recovery became available.
- The early discharge team for hip fractures discharged patients to their own home with their support. They told us that, since they had been operating, they had reduced the length of stay for patients from 18.1 days to 15.9 days.
- The new admissions lounge had been opened for about a month at the time of our inspection. This was where

elective patients for surgery came to be prepared for theatre and were then taken to a ward post-operation. The divisional management team told us this was to help improve patient flow through the hospital.

- During our inspection, elective operations were cancelled due to high admissions and pressure with beds. On one day, about five operations were cancelled. The divisional management team told us they had a system to make sure these patients were reviewed quickly and re-booked with in the 28-day timescale.
- The trust was not meeting its referral-to-treatment time18-week target for general surgery which was at 85%, 78% for trauma and orthopaedics and 88% for oral surgery. It was meeting the target for urology.
- The average length of stay for elective patients for trauma and orthopaedics, vascular and colorectal surgery was better than the England average for two out of the three specialities.
- During our inspection, the trust had a high number of surgical admissions and this had resulted in a number of outliers. Staff told us they tried to move the patients to the correct wards once beds had become available and they ensured that outlier patients were reviewed by the surgical team.

Meeting people's individual needs

- Staff on one of the surgical wards told us that, when a patient with mental health needs had been on the ward, the trust provided a one-to-one mental health trained nurse to care for them during their stay.
- The staff had access to an instant telephone translation service and on-site interpreters with 24 hours' notice.
- The trust told us that all emergency patients aged over 75 who had a length of stay longer than 72 hours would be screened for dementia. Patients identified through the screening were then referred to the specialist team for full assessment.
- Some staff was not aware of the specialist nurse for patients with dementia. However, one nurse told us about a specialist occupational therapist who visited patients on the wards with dementia for assessment to offer them support and any equipment that may have been required.
- A patient who was wheelchair user said they were not able to bring the wheelchair in to hospital with them because they had to use hospital transport and there was not room for it. They felt the ward should have had a wheelchair so they could use it to retain their independence.

Learning from complaints and concerns

- All patients we spoke with were happy with the care they had received and didn't feel they needed to make a complaint. Patients told us that if they wanted to make a complaint they would speak with a member of the nursing staff.
- We saw the trust's complaints procedure was displayed on noticeboards around some of the surgical wards.
- The surgical and theatre division had received 19 complaints for October 2014. We saw these were discussed at the trust board quality report and at divisional management level. The divisional management team told us they shared the learning from complaints at staff meetings and supervision meetings.

Are surgery services well-led?

Good

Staff told us they were aware of the trust's visions and values and they were very passionate about ensuring that patients received good care. Staff told us they always apologised to patients if incidents took place and they wanted to be open and transparent with them about any failings.

The divisional management team had plans to develop the surgical and theatres division.

Staff on the wards told us they felt supported and listened to by their divisional management team. This was not the same for staff in theatres.

The culture of learning from incidents was promoted with staff and they told us they were encouraged to report incidents.

Risks were identified and discussed at divisional level and these were recorded on the risk register and shared with the executive team.

Vision and strategy for this service

- Staff were aware of the trust's visions in relation to the 'four Ps' values: Putting patients first; having a Passion for excellence; Pride in their teams; and taking Personal responsibility. The divisional management team told us that staff were asked at their interview about these values and they were also included in staff appraisals.
- The divisional management team told us their visions for surgery and this included ways to improve the length of stay for patients. This had happened for patients who were on the early discharge scheme for hip fractures.
- The trust planned to move the vast majority of elective surgery to Ashford Hospital and to increase the amount of day surgery undertaken there. They wanted to develop St Peter's as an emergency surgery "hot site". They said that staff in the theatres division across both sites were aware of this.
- Other plans included increasing bariatric surgery and becoming a tertiary centre for colorectal surgery. Further development of some of these plans were dependant on the proposed merger with the Royal Surrey County Hospital NHS Foundation Trust.

Governance, risk management and quality measurement

- The divisional management team told us that their top risks were staffing in anaesthesia and Never Events across the surgical division at St Peter's and Ashford Hospitals NHS Foundation Trust. We also asked about the most serious incidents that had taken place. They told us there had been two incidents of the wrong patient being taken to theatre, two diathermy burns to patients (diathermy is a surgical technique that produces heat using high-frequency electric currents) and a minor fire in one of the theatres in November 2014 where a patient sustained burns to their abdomen. We examined the risk register and found that all of their top risks were included on it.
- Speciality governance meetings were reported monthly and the division undertook quarterly governance meetings which reported into the trust quality governance meetings. These meetings included a number of topics, for example, review of all serious incidents, complaints received and patient experience.
- Interventional radiology had completed audits of their service, for example, the WHO checklist and audits on patient consent. The audit for consent took place in 2012 and we were told it was due to be repeated.
- Monthly interventional radiology meetings took place and these fed in to the departmental radiology meetings.

Leadership of service

- Staff spoke highly of the new chief executive and told us they felt the chief executive would make the necessary changes to the trust to improve patient care.
- Not all staff felt the executive team were visible around the hospital. Theatre staff said they did not see anyone from the executive team; however, the ward staff felt they did see them on occasional visits to their wards.
- The divisional management team told us they undertook regular department feedback and views from staff. They said they had an 'open door' policy and we were told surgeons regularly visited the management team for discussions.
- Weekly briefings took place for the wards and units and this was where organisational news was shared.
- Some staff in theatres felt their concerns were not listened to or acted on by the divisional management team, for example, allegations of bullying, and they felt that action was not taken. They also felt there was a high turnover of managers in the divisional management team which staff felt had an impact on continuity of management. They felt that each manager had a different area they wanted to improve. However, some staff in the theatres told us the divisional management team had listened to their concerns about the bank nurse hourly rate and this had recently been increased. Since October 2014 senior divisional staff had received a single allegation of bullying, however, management was unable to investigate as they had not been provided with any further details to enable this.
- Staff in the ward areas told us they had supportive line management and good support at divisional level.
- Staff in interventional radiology felt well-supported by their immediate line management and department management.

Culture within the service

- The majority of staff told us there was an open and transparent culture that was not about blame. They were encouraged to report incidents as it was seen as by the trust as important learning.
- Staff told us that the trust also had a culture of being open and transparent with patients when incidents took place.

- Staff also spoke of a strong culture of teamwork and providing the best care for their patients. Staff spoke of their concerns about staffing and recruitment of staff to vacant posts. They were aware of the difficulties faced with recruitment and staff covered vacant shifts where they were able.

Public and staff engagement

- Patients were able to give their feedback through the NHS Friends and Family Test. We saw some of the results on the wards we visited and they were mainly positive. They also included comments from patients.
- Staff told us they were able to give their views at their ward or unit meetings and they said they were told these were shared with the divisional management team.

Innovation, improvement and sustainability

- The trust told us that one of their consultant orthogeriatricians had been nominated in the NHS Kent, Surrey and Sussex Leadership Collaborative Recognition Awards for 2014. This was for their work in improving the trust's performance on treating patients with hip fractures.
- This consultant had also led a partnership project with local nursing homes to reduce inappropriate admissions to hospital. They were the lead clinician for the orthopaedic early supported discharge service.
- The divisional management team told us about the proposed merger plans with another local trust. They said some of their visions and plans for the future development of their services were part of the proposed merger.

Critical care

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

Information about the service

At St Peter's Hospital there is an intensive care unit (ICU) on level three of the Duchess of Kent Wing and a high dependency unit (HDU) on level four. Both units are managed by the critical care team.

The ICU is a nine-bed ward which offers care to both high dependency patients and those who are critically ill. The unit admits around 700 patients a year aged 16 years and above. When we visited, the unit was able to care for up to nine intensive care patients (described as level 3) but was normally configured for eight intensive care beds and one high dependency bed (level two). The unit had two side rooms and six beds facing the central nurses' station and a further side room alongside. Each bed area was screened by curtains. The unit had windows and natural light.

The HDU is a four-bed ward which offers care to high dependency patients. It had been a medical HDU for around two years, but in October 2014, became part of the critical care department and is now a generic HDU (that is, not used exclusively for any patient group). The unit admits around 400 patients a year aged 16 and above. The four beds were arranged in a square with a bed in each corner and the unit had windows and natural light. The nurses' station was at the entrance to the unit from where all four patients were visible. Each bed area was screened by curtains.

On this inspection we visited the ICU Wednesday to Friday, 3 to 5 December 2014 and the HDU on Wednesday 3 December 2014. We spoke with a full range of staff, including consultants, doctors, trainee doctors and nurses from different grades. We met the unit's clinical nurse manager and lead consultant for critical care. We spoke with a physiotherapist, two of the outreach team nurses, the pharmacist, the ward administrator and clinical data and audit manager. We met with those patients who were able to talk with us, their friends and relatives. We observed care and looked at records and data.

Critical care

Summary of findings

We have judged the overall performance of critical care as requiring improvement. This was due to the unit needing to improve safety and governance. The effectiveness, caring and responsiveness of the unit was good.

The most pressing issue for the safety of the unit was the shortage of substantive and experienced nursing staff on the units and the outreach team, and the significant use of agency nursing staff. Work on quality and performance safety audits, analysis of incidents, and responding to patient risk was not given the priority it required. There was a lack of good data available on patient harms. Patient records were outstanding in the ICU, where the use of an electronic patient records system contributed to patient safety and quality. This CQC inspection was the first assessment of the safety of the HDU environment and equipment since the unit was incorporated into critical care in October 2014.

The clinical effectiveness of the unit was good. Care and treatment was delivered by trained and experienced medical staff and committed nurses. The service followed national guidelines, practice and directives. The units were recording consistently low death rates. The unit was not able to deliver as much teaching as required internally and for the outreach nurses on the wards. There was an insufficient number of nursing staff with post-registration qualifications in critical care.

The care given to patients and their relatives by staff was good. Patients and relatives were happy with the care provided. The care we observed from the nursing staff was kind, reassuring and supportive. Patients were treated with respect and their dignity was maintained.

The critical care service responded well to patient needs. Delayed discharges and discharges on to wards at night were below (better than) national average rates. There was a very low rate of elective surgical operations cancelled due to unavailability of a critical care bed. The facilities in the ICU were good and met many of the modern critical care building standards. The HDU was, however, less fit for purpose and there were limited facilities for patients, staff and visitors.

We have judged the service as requiring improvement in terms of governance. There was no robust programme of governance, risk assessment, assurance and audit. The governance arrangements of the service were not providing feedback on incidents, audits or results from those quality measures it had. There was a lack of accountability for driving actions and improvements.

There was, however, a strong culture of teamwork and commitment in the critical care service. All the staff we met were dedicated and professional. Staff were supportive to their patients and to one another. All staff had similar worries about the unit, and these centred on the shortage, retention and recruitment of nursing staff.

Critical care

Are critical care services safe?

Requires improvement

We have judged the safety of the unit as requiring improvement. The most pressing issue for the safety of the unit and the outreach team was the lack of substantive and experienced nursing staff, and the consequences of this. This was also the highest priority for the senior staff team. There was a significant use of agency nursing staff due to recent high staff turnover. Priorities were to keep patients safe, but other work on quality and performance safety audits, analysis of incidents, and responding to patient risk was not given the priority it required.

Staff were open and honest in their reporting of incidents, but evidence showed there was little analysis of trends in incidents or a good culture of delivering feedback to staff. The data available on patient harms was not detailed or useful and there was no evidence of improvements being made in these areas. There was no evidence to suggest that patients were not being well cared for, and most harms were avoided. However, there was little in the way of a robust approach to good data or changes to practice.

Patient records were outstanding in the ICU, where the use of an electronic patient records system contributed to patient safety and quality. The safety of the HDU had not been risk-assessed against the Core Standards or Department of Health environmental recommendations since it was incorporated into critical care in October 2014.

Consultant cover was good and mandatory training for all staff was up to date (although not all records were available to us).

Incidents

- Staff were open, transparent and honest about incidents. Almost all staff we met said there were no barriers to reporting incidents and nothing would put them off. The ICU staff (who rotated between the ICU and HDU) were able to access the electronic incident reporting system at the patient bedside, so there were no barriers to access. Investigations took place when things went wrong. Staff said they felt they were not blamed for errors, and were treated fairly. Systems and processes were examined to see why any errors had occurred and how to avoid recurrence. Staff competence was considered if there was evidence it needing improvement. The clinical nurse educator was made aware of issues with competence and delivered updated training or teaching.
- There was evidence that incidents were reported in most circumstances. For example, the ICU incident reports from 1 April to 4 December 2014 included: patients admitted with pressure ulcers or, on fairly rare occasions, ulcers acquired on the unit; equipment failures; patient or staff accidents or incidents (including falls); and risks or incidents as a result of shortages of nurses or medical staff. Other incidents included staff errors, such as giving an incorrect dosage or wrong type of medication. Near misses or 'no harm' incidents, such as a failure to take account of a patient's allergy status, were reported. These incidents were reviewed by the appropriate manager and actions taken or recorded where required.
- There was no evidence that trends in incidents were being routinely picked up. Incidents were discussed with staff at critical care unit (CCU) meetings and, in those minutes we reviewed, there was evidence of particular trends being considered. However, none, apart from an increase in medicine errors, were identified. We analysed the incident report from 1 April to 4 December 2014 and identified 11 incidents relating to patients being treated for pressure ulcers around the face area from face masks and elastic straps. There were four relating to not identifying patient allergies to medicines. These had not been recognised in any staff meeting minutes or the October 2014 clinical governance meeting.
- The recording of data and information from incidents and the management of that information at clinical directorate level needed improvement, although staff were aware of this. There had been no formal clinical governance meetings in the unit with directorate management until these were established in October 2014. The minutes from the first meeting recorded the incidents viewed from 1 April until 30 September 2014, stating, "many were inappropriately allocated and need allocating at source by clinical governance team". The incident data was therefore not fully reliable as there were some entries not allocated against the most appropriate definition. Staff could not necessarily see emerging trends and make appropriate changes to practice or knowledge.

- Incident investigations and analysis were not always fed back in a routine way to staff who reported them. Staff described feedback as "mixed", "fairly infrequent" and "OK in the department, but not much from further up" (meaning directorate level or trust staff). Staff could request incident feedback by ticking a box on the electronic form.
- There was a formal process for serious incidents requiring investigation, although accountability for subsequent actions needed improving. Serious incidents were infrequent in the critical care division. We reviewed two from 2014. The circumstances were well-investigated with a linked action plan. One of the actions was to ensure that nutrition and fluid assessments were always completed. We saw these completed well in all the patient notes we reviewed during our visit.
- In the investigation about a pressure ulcer, there was no evidence in records of the patient's relatives being told about the pressure ulcer deterioration. There was no action plan to address this poor communication. It was noted that communication had, however, improved following the second incident we reviewed from November 2014. The error was thoroughly investigated and a number of risk factors were identified. A comprehensive linked action plan had been produced, although no staff had been tasked with taking the executive lead or delivering the actions. There was also no date set for the actions to be completed.
- From November 2014, and following the Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry), NHS providers are required to comply with the Duty of Candour regulation. Although this was a new requirement, senior staff in critical care were aware of their duty to inform all relevant parties of notifiable patient safety incidents and to be open, transparent and candid with patients and relatives when things went wrong. Some staff were not entirely clear about what constituted a notifiable patient safety incident, but most knew about the requirement to be open, transparent and candid, and to issue a meaningful apology to the relevant person or people.
- Patient mortality and morbidity (M&M) was reviewed and discussed. This was undertaken at critical care division level (the HDU was now incorporated) on a monthly basis as part of the service multidisciplinary team meetings. Minutes of the meetings showing who was present and the cases reviewed were produced and distributed. We looked at the minutes of meetings picked from four months in 2014. Attendees included a range of consultants and doctors, nurses (although not a regular presence in the meetings we reviewed), the senior dietician, and physiotherapists. The meeting minutes included a summary of any learning points or actions, however, there was no named person allocated to take forward actions or learning, and no evidence of reporting back on actions and performance improvements.

Safety thermometer

- Detailed Safety Thermometer data or trend analysis was not available to make any judgement about the level of patient harm on the unit. Evidence we saw suggested there was a high rate of harm-free care. We were given snapshot data for the ICU on one day each month from April to November 2014 (excluding July 2014) and for the HDU from September to November 2014. We were also given quality, experience, workforce and safety (QEWS) dashboards for August, September and October 2014. These covered the whole hospital by wards or units. The information had no cumulative data or longer-term trends to see whether harm-free care had improved, deteriorated or was stable.
- Pressure ulcer data was recorded in different ways and the snapshot data did not provide the whole picture. In snapshot data there was one new (hospital-acquired) pressure ulcer (category 2) recorded for the whole reporting period (although July 2014 was missing). We know from the incident reports for 1 April to 4 December 2014 that there were a number of hospital-acquired pressure ulcers in this period. The QEWS dashboards recorded three hospital-acquired pressure ulcers for August 2014 (category 2 and above) attributed to critical care, although none were in the period of the snapshot data. For September 2014 there were no hospital-acquired pressure ulcers in the ICU. For October 2014 there were three attributed to the ICU and two to the HDU where, despite this, new harm-free care was scored at 100%. Therefore, the snapshot data did not provide any realistic data, and QEWS did not demonstrate trends or cumulative data for more than three months.
- Falls on the unit were recorded in snapshot data as zero. Of the 64 patients covered in the data (from admissions in the period of around 500 patients) there were no patient falls in either unit, although from the incident

reports there was a fall in the ICU in April 2014 (the only fall on the incident register). Data was not available to provide a clear overview of falls with or without consequent harm.

- The only data provided to us in relation to venous thromboembolism (VTE or blood clots) assessment, prophylaxis and treatment data was the snapshot data. We were not provided with any other reports where VTE data was reported or an item on ICU meetings. We therefore do not have data to provide a clear overview of the incidence of VTE.
- There was no publication or display of Safety Thermometer data on the unit for patients and visitors.

Cleanliness, infection control and hygiene

- Rates for hospital-acquired infections were low. There were no MRSA infections across the trust in the current financial year (April to December 2014). The critical care division (ICU and HDU) had no Clostridium difficile (C. difficile) in the current financial year (April to 4 December 2014).
- Data reported by the hospital to the Intensive Care National Audit and Research Centre (ICNARC) (an organisation reporting on performance and outcomes for around 95% of NHS ICUs nationally) supported this evidence. There were no unit-acquired infections in blood reported since quarter three 2013 and none in 2014 so far. This was the case for all types of admission including ventilated patients and emergency surgical patients.
- At the time of our visits the ICU and HDU were visibly clean in most areas. The bed spaces were clean in the easy- and hard-to-reach areas. We observed a member of the nursing team cleaning one of the bed spaces thoroughly following the discharge of a patient to a ward. The only area in the bed space where cleaning was not thorough was where the plastic mattress cover had a fold, and there was a lot of dust from the linen gathering in the fold. We saw this on two of the mattresses we were able to see (the other beds being occupied). The linen we saw was in good condition, was clean and free from stains or damage to the material. In the ICU there was a significant level of dust on top of the cupboards in the nurses' area. Information folders were kept on top of the cupboards, making them hard for the domestic staff to keep clean. There were also some notices stuck to walls in the clinical area of ICU using sticky tape, which should not be used. We otherwise saw the cleaning staff working diligently and effectively. We looked closely at the cleaning in the bathroom on the HDU and the majority of the equipment, flooring and walls were thoroughly clean. The only area needing attention was the plug hole, where debris had gathered. We saw two cleaning audits for the ICU from November 2014. One had scored 98.15% (21 November 2014) and this had improved to 100% by 27 November 2014.
- Results for hygiene were good. The department scored 100% in recent hand-hygiene and personal protective equipment audit observations. We observed nursing staff following the protocol for the units in washing their hands between patient interactions, and wearing gloves and aprons at bedside. There was no information about whether staff were observed in hand-washing audits but from the content of the audits we have concluded it related only to nursing staff. Our observations of medical staff were mostly good. The doctors conformed to wearing gloves and aprons when interacting with patients, but not all doctors were bare below the elbow when they were within the unit in accordance with recommended best practice. The operational policy for critical care did not state what part of the unit constituted the 'clinical area' and the trust policy was not specific on this point. There was an area around the patient bed space marked on the floor with a red line. Staff were not permitted to work in this area without gloves and aprons, although this was not mentioned in the trust policy or the critical care operational policy.
- Visitors were required to follow infection control protocols. They were asked to use alcohol gel when arriving on the unit. When visiting the ICU visitors were asked to wash their hands before putting on plastic disposable gloves and aprons when at the patient's bedside. Visitors were also asked to consider their own health when visiting and to not come to the unit if they were unwell or becoming unwell. The HDU was situated close to Aspen Ward with no door or physical barrier between patients and visitors on the HDU, therefore making it more difficult for staff to monitor the compliance of visitors.

Environment and equipment

- The ICU bed spaces had all the relevant equipment. Although they did not meet all the modern building standards as required by the Department of Health Building Note (HBN) 04-02, they met the key areas. For example, there were ceiling-mounted, twin-armed

pendants to hold a range of medical equipment and prevent cables trailing across the floor. There was a sufficient provision of medical gases and electrical sockets at each bedside. Although the oxygen and air outlets had small markings cast into them indicating their purpose, a number had their coloured labels missing, so their use was not immediately apparent. There was a high-backed chair with foot elevation and tilting facility in some bed spaces, but not all. Each bed space had a hand-wash basin, aprons, gloves of all sizes, and hand sanitising gel.

- The ICU had sufficient ventilators to support up to all nine patients at any one time. There were 10 standardised ventilators available, which meant at least one was spare at all times. The ventilators and other essential equipment were checked by nursing staff at each handover session. The ventilators were registered with the biomedical engineering team and labels on each piece of equipment showed they had been serviced, as required, in the last 12 months.
- Each bed space in the ICU had appropriate safe levels of equipment. The ICU met the Department of Health requirements for equipment in a critical care unit. At patient bed spaces there were, for example, flat-screen monitors, multi-parameter patient monitoring equipment, a minimum of three infusion pumps, and a minimum of four syringe pumps. There was other relevant equipment including a portable x-ray machine, an ultrasound machine, three haemodynamic (blood pressure and heart rate) monitors, defibrillator, and full provision of piped medical air and gas.
- The ICU had appropriate equipment for use in an emergency. There was a 'difficult intubation' trolley divided into different trays according to the intubation strategy and equipment to be used with the patient. There was a standard resuscitation trolley. The trolley had been checked each day and the check recorded.
- The local environmental audit carried out for ICU was incomplete. There was no risk assessment of areas or any measurement of possible risks. All areas throughout the report were marked as compliant, even though there was an issue with the temperature of the drug cupboard on the trust risk register. There was no audit of the HDU available.
- There was some out-of-date equipment in the store in the ICU. The stock in the equipment cupboard was not being routinely checked for both the expiry date of equipment and whether the quantities kept in stock were appropriate. For example, we found at least 20 of the same sterile items that were out of date and had been since earlier in 2014. They were at the bottom of a box where newer pieces had been added on the top. The clinical lead consultant said these were now used infrequently.
- Equipment in the HDU was limited. There was, for example, no resuscitation trolley. There was one, however, located in the corridor on Aspen Ward which could be reached in around 10 seconds, if it was not being used elsewhere. Space to keep equipment in the HDU was severely limited. Hoists and other large pieces of equipment were kept in the corridor, which doubled as the nurses' station. Other equipment was stored in the stairwell entrance on shelving, which was also being used as a staff rest area.
- There was no audit of the safety or the environment and equipment of the HDU since it had been incorporated into critical care. The HDU did not meet all the requirements or recommendations of the Core Standards of Department of Health Building Note. This had not been assessed or any shortcomings escalated to the trust's risk register.
- All new staff had an induction and orientation to the unit. This included completing a comprehensive and detailed workbook. This workbook covered, among other things, health and safety, infection control, the environment, equipment, unit security, and the electronic patient record system.
- The ICU was secure, although there were no doors or barriers to entry on the HDU. The ICU was locked and doors opened remotely by staff, who firstly identified visitors (via CCTV in the main corridor) or had their own swipe-card access. Visitors to the unit were admitted through one set of doors but not through the second into the unit unless clearly identified or accompanied by staff. The HDU had open access from the main corridor of Aspen Ward. In relation to access and security, the ICU met the requirements of the Department of Health building requirements. The HDU had no barriers to entry for any visitors and was insecure if people entered from the adjacent stairwell.

Medicines

- Medicines, including those requiring cool storage, were mostly stored appropriately. Records showed they were kept at the correct temperature, and so would be fit for use. The medicine refrigerator in the HDU was

accidentally unplugged in October 2014 and, as soon as this was discovered, the medicines were removed and replaced by pharmacy on the same day. The clinical room in the HDU was, however, unsecured. The lock on the door had broken three days prior to our visit and, although this had been reported, was not repaired for four days. The controlled drugs were locked in the clinical room, but other medicines, fluids and equipment were unsecured. The room was not visible to staff, as it was around the corner from the entrance to the HDU, so it was not supervised. In the ICU, controlled drugs, other medicines and fluids were stored and managed appropriately. Records of controlled drugs we reviewed were accurate, clear and legible.

- A specialist senior pharmacist visited the unit every weekday. They attended daily ward rounds to provide support with prescribing and use of medicines. Patients had access to medicines when they needed them, and the visiting pharmacist helped to ensure that medicines were used safely. There was a pharmacy top-up service for unit stock, and other medicines were ordered on an individual basis.
- Patient medicine records were mostly well-managed within the units' electronic patient record system (which was only used in the ICU). This system had many outstanding features, and was used extensively by staff for all notes, data, results and observations pertaining to patients. There was, however, a weakness with some aspects of the pharmacy area of the system. For example, an incident had been reported recently where a medicine was prescribed to be administered orally, but the system defaulted to show administration as intravenous. The medicine was administered intravenously and this meant some of the patient's fluid balance was not fully accurate. This was corrected by the pharmacist and no harm came to the patient.
- Medication errors were reducing. Incident reports had fewer errors in the second part of the series of entries from 1 April to 4 December 2014. This had been reported at the first clinical governance unit meeting in October 2014. There were four incidents from 1 April to 4 December 2014 relating to patients either being given or almost given medicines they were allergic to. The most recent occurrence of this was in November 2014, although the patient had not been able to provide this information and it was otherwise not known to staff.
- The pharmacist for critical care followed antibiotic protocols. There was support from the trust's senior antibiotic pharmacist and protocols for each antibiotic. Drug charts were audited and indicated that 100% of antibiotic prescriptions were stopped when they should have been (so patients were not taking more than required). Critical care had antibiotic protocols for medications used frequently and those specific to critical care patient use.

Records

- Those patient records we reviewed were completed well. This included nursing, medical and allied health professional notes. The ICU used an electronic patient record system and the HDU used paper-based records. The electronic patient system was due to be introduced into the HDU in January 2015. The electronic record system had been developed with an external software company and adapted for use in the ICU. The system was detailed and easy to follow. Each patient had standard daily, hourly or periodical observations, as required. These were well recorded, including: the insertion of medical devices and when they were due for changing or removing; dates and times of any investigations; daily checklists, including the resuscitation checks (airways, breathing, circulation, disability and exposure); and records for the safety of equipment and intravenous fluids. The one area that did not yet have full electronic interaction with the hospital was laboratory results. These needed to be entered manually, although the clinical lead consultant for critical care (who had commissioned, established and maintained the integrity of the electronic system) was hoping to be able to interface with the laboratory system in the near future.
- Standard care plans were used within the electronic system in the ICU and on paper records in the HDU. Of the records we reviewed, all were well-completed. This included medical line management, skin care bundles, catheters, and ventilator care bundles. We were able to see where identified changes in risk for a patient (such as pressure areas showing signs of redness) led to changes in care planning.
- The ICU electronic patient record system was able to produce good comprehensive handover documentation when a patient was discharged to a ward. This included risks of patient harm such as pressure ulcers, falls, infection status and mental state. This was less consistent in the HDU. We saw one unsatisfactory HDU handover document for a patient transferred to Ashford

Hospital. There was also an incident report describing where a doctor had neglected to complete a drug chart for a patient leaving the ICU for the HDU. A doctor who did not know the patient concerned agreed to produce the chart. This left the patient on the HDU at risk to not having their medication on time and room for possible errors – although none were reported on this occasion.

- Confidentiality of patient records was mostly handled well. On the ICU patient records were electronic, and confidentiality of records was maintained as staff closed the computer screens at patient bedsides or on the nurses' station when they were no longer using them. On the HDU patient records were on paper and less secure. When we visited the unit, staff said they supervised patient records, but agreed, due to very limited storage space, there was not ideal secure storage available for patient notes in general use. Any patient records reviewed on the computer (such as x-rays and pathology) were however, visible to visitors. Due to the poor layout of the HDU, the computer screen used by staff faced visitors when they arrived. The electronic patient record system was due to be introduced to the HDU in early 2015.

Safeguarding

- Staff were trained to recognise and respond in order to safeguard a vulnerable patient. This extended to any children associated with a patient or relative. Mandatory training was delivered and most staff were up to date with their knowledge, although child protection courses for 11 nursing staff on the roster were out of date in 2012/13. The nurses in charge of the ICU and HDU knew who to contact within the hospital for adult and child safeguarding. Staff were clear about their responsibilities to report abuse, as well as how to do so. One of the nurses in charge of the HDU on our visit gave us an excellent example of when they had contacted social services with concerns over the child of a patient in the unit. A strategy had then been put in place by social services to safeguard the child while the parent was supported in hospital.

Mandatory training

- Most nursing staff in the critical care division had completed their mandatory training. The trust's target for compliance with mandatory training was 90%. In the ICU, 86.3% of the nursing staff and 87.3% of the HDU staff were compliant with training in courses including, for example, health and safety, infection control, child and adult safeguarding, and equality and diversity.
- Information provided on consultant training was not complete. With the records we were given, which listed six of the 10 consultant intensivists (consultants trained in advanced critical care medicine), most were up to date with their mandatory training. Of the 10 consultant intensivists, three had joined in 2014 and were not listed on the staff training register for the directorate. The other established member of the team was not listed on the register we were given. We needed to extract consultant information from the trust-wide training report, as the critical care consultant intensivists were not linked directly to critical care, but to anaesthesia and theatres. Three of the six consultants we were able to review had not undertaken any equality and diversity training, and there were courses due to be updated in 2015.

Assessing and responding to patient risk

- Ward rounds took place at regular intervals. There were two ward rounds each day, morning and evening, including weekends, led by the consultants on duty. There was input to the ward rounds from unit-based staff, including trainee doctors, nurses and the pharmacist. Other allied healthcare professionals were asked to attend when required. There was good teaching demonstrated on the ward round we joined one morning. For all patients there was a full range of clinical indicators available on the electronic patient record system, including blood results, radiology, observations, and physiological data. Some aspects of routine patient care were not discussed in a structured manner for every patient during the ward round we observed. This included the management of invasive lines, sedation, analgesia and VTE prophylaxis.
- There were detailed handover sessions held each morning. Each began on the ICU when the senior nurse on duty overnight outlined planned admissions, patients for step-down to the HDU or discharge to a ward, and activity with patients or the unit in the night. Staff then moved to the seminar room for a more detailed discussion of each patient. On the one we attended there were two consultant intensivists and five trainee doctors, two who were on their first day of their trainee rotation in critical care. The nursing staff did not

join the handover session. The electronic patient record system was displayed on the projector and all information about the ICU patients was therefore available. The patients on the HDU were discussed first. This was followed by the patients on ICU, and the trainee doctors working in the HDU were able to hear about ICU patients who were likely to step-down through their unit. All patients were discussed in detail over the course of an hour. This included discussions of observation charts, organ support, laboratory results, and x-rays. There were teaching and question and answer sessions during the handover and there were no interruptions to the session. The session was time-consuming but provided an excellent response to patient risk and continuity of care. However, there was no documentation in the electronic patient record of the handover discussion and decisions taken for each patient. This was a missed opportunity in this otherwise excellent handover session.

- The hospital had a policy for responding to acutely ill patients in ward environments. The policy had been compiled by an experienced specialist outreach nurse (outreach was a service provided by critical care where trained nurses and sometimes medical staff would attend a deteriorating patient on a ward or other unit, such as A&E and maternity). The basis of the policy was a completion of patient Modified Early Warning Scores (MEWS) by ward/unit staff. Certain observations in patients such as temperature, respiratory rate, pulse rate, systolic blood pressure, level of consciousness, and urine output, were scored. If a patient scored three to four in total, an urgent call was made to the outreach team for support and advice (along with the primary medical team doctor and clinical site nurse practitioner at night). If a patient scored 5 or above, an emergency call was made to the outreach nurse, along with the medical team specialist registrar and clinical site nurse practitioner at night. The policy was based on national guidelines, although the trust had taken the decision not to implement the more recent version of the scoring system, the National Early Warning Score (NEWS) developed and recommended by the Royal College of Physicians to standardise the assessment of acute illness severity in the NHS.
- The outreach team was not sufficiently staffed to provide full cover. The specialist nurses were a major part of the response team for acutely unwell patients elsewhere in the hospital. The trust website said the outreach team provided 24-hour cover, but this was not happening. The clinical lead consultant for critical care and one of the specialist nurses said the objective was for 12-hour cover each day (8am to 8pm) seven days a week. This was also not able to be delivered with the reduced staffing in the team. For example, in the period 29 November to 7 December 2014 (nine days) there was cover on five days (8am to 8pm), but no cover on 29/30 November (weekend) and 1 December (Monday) or 6 December (Saturday). If no cover was available, the deteriorating patient response became the responsibility of the clinical site manager. The outreach team were unable to provide the teaching and education services to the rest of the hospital. Staff shortages meant this was not easy for the outreach team to achieve and courses were often cancelled by wards (often at the last moment) when they were also short of nursing staff.
- There had been no audit within the hospital (such as a snapshot audit of the hospital over a short period) to assure the outreach team or the executive team the MEWS scores were being correctly calculated or that all patients who passed the threshold score of 3 were being appropriately referred for assessment and support.
- Patients were monitored for different risk indicators. For example, each ventilated patient was monitored using capnography, which is the monitoring of carbon dioxide in respiratory gases. It was available at each bed on the unit and was always used for patients during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertions. Continuous end-tidal carbon dioxide monitoring was employed in all patients with an artificial airway receiving ventilatory support (as recommended by the 2011 Royal College of Anaesthetists' fourth National Audit Project report).

Nursing staffing

- The critical care service (including the outreach team and the clinical nurse educator) had insufficient nursing staff. In the last three months the situation was as follows:

October 2014

November 2014

December 2014

Nursing grade

Critical care

WTE funded*	**3**
WTE in post	13
Gap	9
WTE funded*	**4**
WTE in post	13
Gap	8
WTE funded*	**5**
WTE in post	Band 5
Gap	45
Band 8	39
1	**6**
1	45
0	33
1	**12**
1	45
0	29
1	**16**
1	Band 3 or 4
0	4
Band 7	3
10	**1**
8	4
2	3
10	**1**
7	4
3	3
10	**1**
7	Total
3	73
Band 6	61
13	**12**
10	73

53

20

73

48

25

* Rounded figures of Whole time equivalent (WTE) nurses needed to meet safe staffing levels

- The gap in nursing staff had increased from 12 WTE nurses short in October 2014 to 25 in December 2014. In each month, the majority of vacancies were for band 5 nurses, but in percentage terms, the highest vacancies were in the senior nursing bands 6 and 7. By December 2014, the total vacancies of 25 nurses represented 34% of the established workforce. In October 2014 (the most recent information we have) the ICU had safe staff levels only 31% of the time (the first month this statistic had been shown on the safety dashboard), although the HDU had safe levels 96% of the time.
- The nursing staff vacancies were not being fully covered by bank (overtime) and agency staff. The levels of staff the units judged were needed to care for all patients met the Faculty of Intensive Care Medicine Core Standards 2013 (the core standards) requirements. This was one nurse for every level 3 patient and one nurse for every two level 2 patients. The staffing establishment was set to meet the acuity of patients with the correct number of nurses. However, on many occasions the required number of nurses was not covered. This was due to agency and bank staff with the right qualifications not being available, or temporary staff not turning up or cancelling their availability at the last minute. In November 2014 there were around 50% of shifts not fully covered by one or two nursing staff per shift. In December 2014 there were planned to be up to 50% of agency nursing staff on many shifts. In November 2014, on one occasion there were six agency nurses from the nine staff rostered (more than 50%). The most prevalent use of agency staff was at night when, in one week in December 2014, we saw up to five (more than 50%) on a number of nights. The core standards recommended there were no more than 20% of agency nursing staff on any shift.
- Sickness levels among nursing staff were low. In September 2014 (the most recent data we were provided with) the sickness rate was just 1.8% and 1.6% in August 2014. The NHS average was around 5%.
- Due to staff shortages, the senior staff were not always able to be supernumerary. The core standards required units of more than six beds to have a supernumerary sister on duty 24 hours a day. There was a supernumerary sister factored into the shift rotas to cover both the ICU and HDU, but, as nursing staff told us, this often did not happen in practice. On the days of our visits the sisters in charge were carrying out their management roles, but they were also supporting patients. Two of the nursing staff we met described their shifts (speaking separately to us) as “really stressful”.

Medical staffing

- The experienced consultant presence followed the recommendations of the core standards. There were 10 consultant intensivists working in rotation in critical care and on call. All 10 were intensivists and Fellows of the Faculty of Intensive Care Medicine.
- There was good dedication to the unit from the consultants to ensure that consistent and mature skills and experience were used. The 10 consultant intensivists worked 70% of their time in critical care, and 30% as anaesthetists. The core standards required consultants to have a minimum of 15 programmed activities of consultant time committed to the ICU each week, and this was met and often exceeded.
- There was full coverage from consultants. The ICU consultants were on duty from 8am to 9pm then on call at home. The HDU consultants were on duty from 8am to 6pm then on call at home. Consultants did not need to regularly attend the units out of hours (around once a month was usual) but frequently took calls from staff. This arrangement was for seven days a week, so weekends had the same level of cover. When consultants were on duty or on call, their commitment was dedicated to critical care and not extended elsewhere in the hospital. There was a doctor on duty in the ICU overnight who was usually an anaesthetist or experienced staff grade doctor, and a more junior doctor covering the HDU and Aspen Ward.

Critical care

- There was a good consultant-to-patient ratio. There were two consultants on duty or on call across the two units for 13 beds. This was significantly better than the core standards recommended ratio of one consultant for a maximum of 15 beds.
- There were risks to patients from occasions (albeit infrequent) where the skills and experience of medical staff on duty did not meet patient needs. This is, of course, always possible when a hospital is busy with emergencies and has too many unplanned or unanticipated competing priorities. However, there had been occasions when there were not enough doctors with certain skills but no other competing priorities. There had also been occasions when there were no doctors (generally anaesthetists) on duty with training in advanced airway skills to provide safe coverage at all times, and no doctor with experience to insert a central venous catheter or naso-gastric feeding tube. The core standards recommended that CCUs had immediate access to a practitioner skilled in advanced airway techniques at all times. There had been no harm identified from incidents raised at these times (and we stress they were infrequent) but some of the nursing and medical staff said the situation had been stressful for all concerned. There had been no action plan or response to these being raised on the incident report.
- There was good support to trainee doctors. There were between two and five trainee doctors on rotation in the department. Now the HDU had been incorporated with the critical care service, the time spent on the unit for trainee doctors had been increased. There was now one month spent in the HDU as opposed to two or three days, as in the recent past. We observed good training and education at the handover session in ICU and from the ward rounds. The trainee staff we observed came across as confident and encouraged to ask questions and look for guidance.

Allied health professional staffing

- The unit did not meet the core standards for pharmacy staffing levels. The ICU had a dedicated specialist clinical pharmacist, as required, and cover for periods when they were unavailable. However, there was no other pharmacist cover. The core standards stated there should be 0.1 WTE 8a grade specialist clinical pharmacists for each level 3 bed and for every two level 2 bed. The unit had eight funded level 3 beds and one level 2. If the units were full, this would equate to pharmacy cover of 0.85 WTE to meet the standard. This was not being achieved as the pharmacist also covered theatres and the surgical day unit. They felt they achieved around 50% of the recommended level only. The HDU had separate pharmacy cover which did not equate to 0.2 WTE as this pharmacist also had extensive other duties.
- The department met the core standards for physiotherapy staffing levels. The suggested level of physiotherapy staff in the core standards was one WTE physiotherapist for four beds, regardless of patient acuity. The unit had at least two WTE physiotherapists and would have support from three if patient acuity dictated this. There were two physiotherapists available on the weekends and on call out of hours.

Major incident awareness and training

- The hospital trust had a major incident operational plan. It had been issued in January 2012 and updated most recently in October 2014. There was an action card for ICU in relation to admissions and discharges in a major incident. The plan was available to all staff on the trust intranet.

Are critical care services effective?

Good

The clinical effectiveness of the unit was good. Care and treatment was delivered by trained and experienced medical staff and committed nurses. The team in critical care included allied health professionals such as pharmacists, physiotherapists, dieticians and speech and language therapists. The service followed national guidelines, practice and directives.

The units were recording consistently low death rates. The mortality figures also demonstrated a lower than expected death rate among patients who had been discharged from critical care. Essential inputs into patient care, such as pain relief, nutrition and hydration were managed well.

In terms of staff support, appraisal rates for non-medical staff were relatively good. Staff shortages were a factor in the unit not being able to deliver as much teaching as required, both internally and for the outreach nurses on the

wards. Also, due to a large cohort of agency nurses currently supplementing the substantive staff, there was not a sufficient number of nursing staff with post-registration qualifications in critical care.

There were appropriate processes to identify and manage people at risk of abuse and staff were well-trained. Consent to care and treatment was provided in line with legislation and guidance, although the standard operating procedures were potentially misleading in relation to consent. There was a framework around the use of restraint and how it related to the Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- The unit followed NHS guidance when monitoring sedated patients. Each patient who was sedated was subject to a 'sedation hold' each day. This involved the doctor or nurse discontinuing the sedation infusion and monitoring the patient's response. Sedation was then continued or adjusted depending on how the patient reacted to the change. The unit used the recognised Richmond Agitation Sedation Scale (RASS) scoring tool. This was, however, not covered in the operational policy.
- Patients admitted to the unit were not being formally assessed for delirium. The core standards recommended all patients were screened for delirium with a standardised assessment tool – usually the confusion assessment method (CAM) for the ICU). Nursing staff said patients were not formally assessed but were identified by any agitation. Some staff were trained in CAM – ICU and one of the nursing sisters said it had been used occasionally, but not as routine.
- The relevant guidance from professional bodies was incorporated into policies and followed in practice. For example, the policy pertaining to how to respond to a deteriorating patient was based on National Institute for Health and Care Excellence (NICE) guidance 50: Acutely ill patients in hospital, and also guidance from the Intensive Care Society and Department of Health. The operational policy for arranging follow-up meetings with patients was based on NICE guidance 83: Rehabilitation after critical illness.
- The average length of stay on the unit was lower (that is, better) than the national average. It is recognised as sub-optimal in social and psychological terms for patients to remain in critical care for longer than necessary. The average length of stay was lower for all types of admission (that is, ventilated patients, patients admitted with severe sepsis, emergency surgical admissions, and patients admitted with trauma, perforation or rupture) with the exception of elective surgical patients, where the length of stay was equal to the national average. The mean average length of stay for all admissions was 3.7 days, compared with the national mean average of just over four days. The median (that is, the middle of the range of days stayed) was 1.9 days.
- The unit participated in and led on organ donation work for the trust. The trust had a clinical lead for organ donation and was supported by specialist nurses for organ donation. The trust was part of the UK National Organ Donation programme and followed NICE guideline CG135: Organ donation for transplantation. The latest report was for the six months from 1 April to 30 September 2014. In this period, as in the same period in 2013, rates of donation were low. In the six months of 2014 there had been 12 patients meeting organ donation referral criteria. Ten of these (83%) had been referred to the specialist nurse for organ donation, which was above the national average (76%). In the same period in 2013, all 18 appropriate patients had been referred to the clinical lead, so the referral rate had fallen in 2014. Of the five patients who were deemed eligible, four families were approached with the involvement of a specialist nurse in each case. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved in discussions with the family. Only one patient from the group who gave consent (33%) went on to become a solid organ donor, which was below the national average of 45%. However, two patients received a transplant from this donor.

Pain relief

- Pain relief was well-managed. Patients we were able to speak with said they had been asked regularly by staff if they were in any pain. Nursing staff said, and we observed, that patients who were awake were regularly checked for pain. Pain scores were documented in patient electronic records, using recognised techniques and measures.

Nutrition and hydration

- Patient nutrition and hydration was effective. The electronic patient records we reviewed in the ICU were

well-completed and safe protocols followed. Fluid intake and output was measured, recorded and analysed for appropriate balance, and any adjustments necessary were recorded and delivered. The method of nutritional intake was recorded and evaluated each day. Energy drinks and food supplements were prescribed and used for patients who needed them.

- Both the ICU and HDU had support for specialist feeding plans. A dietician attended the units on weekdays to support patients with naso-gastric tubes and total parenteral nutrition feeding (nutrients supplied intravenously to the bloodstream). One of the consultant intensivists was the lead for nutrition and was able to provide specialist support and teaching.
- The unit had specialist input into dietetics and nutrition. Nutrition care plans were drawn up for all patients to identify those who needed supplements.
- For patients able to take their own fluids, particularly in the HDU, drinks were available on bedside tables and within reach of patients. Unconscious patients had their circulatory fluid volumes continuously monitored by nursing staff through central venous pressure lines.
- The small number of patients we were able to ask said the food was good. Patients who were able to eat and drink from the hospital menu said the choice was "actually quite nice" and "despite what one hears about hospital food, the quality has been really good".

Patient outcomes

- The unit collected data to determine patient outcomes against recognised indicators. The unit contributed data to the Intensive Care National Audit & Research Centre (ICNARC). Participation in a national programme was a recommendation of the core standards. It provided the unit with data benchmarked against other units in the programme and units similar in size and case mix. The data returned was adjusted for the health of the patient upon admission to allow the quality of the clinical care provided to come through the results.
- For the ICU, death-rate ratios fluctuated but, over time, were at anticipated levels. The latest ICNARC Case Mix Programme data for the ICU covered 1 April to 30 June 2014 and was for 185 patients. Unit mortality ratios in the most recent reporting period were at anticipated levels. ICNARC and Acute Physiology and Chronic Health Evaluation (APACHE II) measures of mortality (2013 models of mortality) reported deaths just slightly above (for ICNARC), and just slightly below (APACHE II) that of the respective anticipated rates. Post-unit hospital deaths were at much the same levels of similar units. These were patients who died before being discharged from hospital, excluding those discharged for palliative care. The rate of post-unit deaths in the ICNARC period was 9% against a national average of 7%. This rate had risen slightly over the last 12 months. For the HDU, the most current data (1 April to 30 June 2014) related to a period when the unit was a medical HDU and not a general HDU managed by the critical care team, so we are not reporting on it here.
- There was a low ratio of patients needing readmission to the unit. The early readmissions (within 48 hours of discharge) for the ICNARC period were zero against a national average of 2%. This rate had fallen to zero each quarter over the previous 12 months. The late readmissions (those readmitted later than 48 hours following discharge but within the same hospital stay) rate was just over 2% which was below the national average of 3%.
- There was no written evidence, but separate corroboration with staff indicated that there was a very low rate of patients accidentally or purposefully removing medical devices. This would include tracheostomy tubes and medical lines. The clinical nurse lead and clinical lead consultant said this would be recorded, but was rare. There were around two or three incidences of this each year, and it was always accidental. Other nursing staff confirmed this and another doctor said it happened "hardly ever".
- Local audit work was not being undertaken with any regularity. There was, for example, no regular calendar of audit to judge effectiveness of care and treatment or demonstrate continuous improvement. There had been participation in the recent National Cardiac Arrest Audit, although no gap analysis was produced for critical care. We were told that a working group had been established to develop action plans around the results. The unit had contributed to an internal audit called the Best Care Measurement and Accreditation Tool: Critical Care. This was a snapshot audit of patients on one elected day to check indicators such as nutrition, observations, skin integrity, medication, and privacy and dignity being maintained. We looked at the results from August 2014 and, although the checks had been done, the results were not totalled and so there were no overall results and no actions to address any shortfalls

in any indicators. We noted that there was no field in the audit of the environment to check if equipment was within its expiry date, and we found there was expired equipment in the store cupboard.

Competent staff

- Medical staff were evaluated for their competence. The consultants we met said the revalidation programme was well underway. This was a recent initiative of the General Medical Council (GMC), where all UK registered doctors are required to demonstrate that they are up to date and fit to practice. This is by doctors participating in a robust annual appraisal leading to revalidation by the GMC every five years.
- There were insufficient substantive nursing staff with post-registration awards in critical care nursing. There were a number of longstanding, experienced and highly trained nursing staff in the team. But due to a recent high number of them leaving, and temporary staff filling posts, a relatively high proportion of the nursing workforce did not possess specialist experience; this was below 50% of nursing staff. The core standards recommended that there be a minimum of 50% of nursing staff with a post-registration award in critical care nursing.
- There was a strong commitment to training and education within critical care. The service had a clinical nurse educator with extensive experience in critical care. There was a good programme of training and education and comprehensive workbooks and portfolios for nursing staff to complete. The clinical nurse educator worked alongside trainee doctors and new nurses or those requiring identified or requested education or development. New, experienced staff were supernumerary for two weeks, or longer if this was deemed necessary. The trust had recently sponsored one of the healthcare assistants to train and achieve their clinical assistant practitioner qualification.
- Appraisals for staff were below the trust targets, which were for 98% of appraisals to be completed. Records for October 2014 showed that 76.5% of the ICU staff and 86.7% of the HDU staff had been formally appraised in the last year. These numbers had dropped from 82.8% and 93.3% respectively in September 2014, suggesting that a number of staff appraisals fell due in October 2014. All the staff we talked with said they had been appraised in the last year and raised some concerns as to whether the data provided was fully updated.
- There was good teaching for physiotherapy staff. There was teaching delivered for one hour every six weeks and access to study leave. One of the senior physiotherapists we met said they were following a leadership and management course. They had also had training to deliver effective appraisals to their own staff.
- Agency and bank staff were given an induction to the unit on their first shift. Many of these staff were regular workers. All new staff had an induction and orientation to the unit. Details of senior staff, and policies and procedures were included before the workbook moved into details about patient care. Each area was assessed for competence and signed by the new member of staff and the manager or supervisor responsible for their induction.
- There was good training in life support. All band 6 and 7 nurses and all doctors were trained in advanced life support. Three of the nursing staff were accredited advanced life support instructors. All other nursing staff were trained in intermediate life support.

Multidisciplinary working

- There was a dedicated physiotherapist team in both the ICU and HDU. There were two or three physiotherapists working regularly in ICU and another team covering HDU. The team covered other departments in the hospital, but attended the unit every day, usually in the morning. Staff worked from 8.30am to 4.30pm each day (including weekends) and were on call at home by rotation. Each physiotherapist was able to attend the hospital within 45 minutes at most. Members of the physiotherapy team attended the units each day to review weaning plans, early mobilisation and rehabilitation for patients. There was full physiotherapy input into weaning plans which were well-documented on the electronic patient record system.
- There was good cover from the consultant microbiologist. They attended the units on a Monday and Friday, met with the consultant intensivist and pharmacist, and were available at other times on request. Their involvement was reflected in the good adherence to infection control practices, and the very low hospital-acquired infection rate.
- Good multidisciplinary work produced effective care. The units had input into patient care and treatment from the pharmacist, dietician, speech and language therapists and other specialist consultants and doctors as required.

Critical care

Seven-day services

- There was good cover from the consultant intensivist team seven days a week. Consultants all lived within a 30-minute journey of the unit when they were at home on call.
- There was good cover from the allied health professionals across the week. Physiotherapists were on call when not present on the unit. All staff on call were able to attend the unit within 45 minutes. Pharmacists provided a full service during the week and were on call on the weekend for any urgent prescriptions or discussions.

Access to information

- Patient records were usually available in good time. Staff said records were usually provided relatively quickly in emergency admissions (all patient records were on paper). Each patient admitted to the ICU was given an electronic record and important information from their paper records was transferred.
- Test results were generally provided in good time. There were a few incidents reported where test results were late or had to be repeated, but this was not a common occurrence. Staff said the service was usually good.
- There was generally good handover information when patients were discharged from the ICU. The electronic patient record system was able to produce automatically a comprehensive and detailed handover document. Handover information was less detailed when patients left the HDU as information was transcribed on to a standard written document. We found an example of a patient being discharged to Ashford Hospital and the HDU handover information was poor. Staff were going to look in to that example and address any shortcomings they identified. The electronic record system was due to be introduced into the HDU in early 2015.

Consent and Mental Capacity Act

- Care and treatment was given to patients who could not give valid informed consent in their best interests. General day-to-day care and treatment decisions, such as giving medications, giving personal care, nutrition and hydration, and performing tests, were made by the medical and nursing teams. If decisions on more fundamental issues were needed, staff would hold best interest discussions in line with the provisions of the Mental Capacity Act 2005. These would take place with those people who could speak for the patient to hear and discuss all the views and opinions on the treatment options. Such discussions were documented in the patient notes reviewed.
- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient, or in an emergency. Staff said patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness, or when the emergency situation had been controlled. We saw good recording of consent in patient records where patients were able to provide it.
- The critical care operational policy did not correctly state the legal position around consent. The policy suggested there were situations when consent or "assent" could be appropriately provided by a patient's next of kin. However, for adult patients or children assessed as competent to make their own decisions, consent provided by any other person would only be valid in very limited circumstances.
- Staff were using the guidance of the Mental Capacity Act 2005 when assessing if a patient was being, or could be, deprived of their liberty. The flowchart for deciding if a deprivation of liberty might be taking place followed the provisions of the Mental Capacity Act 2005 as it related to decision-making and capacity to consent.
- Staff understood how to act when restriction or restraint might become a deprivation of liberty. The trust policy on Deprivation of Liberty Safeguards (DoLS) recognised there was a distinction between these activities. Senior staff said they would consider each case on its merits and follow trust policy if any activities, such as physical or pharmaceutical restraint, met the threshold to make an application to the local authority to temporarily deprive a patient of their liberty. There had been no circumstances in the last year where staff had made an application for a DoLS Authority. However, some of the nursing and medical staff said that the critical care department should bring the subject more to the fore in clinical practice and multidisciplinary discussions.
- Decisions about resuscitation for a patient who was assessed as at risk from cardiac or respiratory arrest were well-documented. We saw an example of a well-documented decision to not commence resuscitation. This had been discussed with the patient's relatives, and the conversation documented, with

reasons clearly recorded. Doctors we spoke with knew how the discussions should be held, how they should be recorded, and ensured that all relevant staff were aware when a decision had been taken.

Are critical care services caring?

Good

The caring given to patients and their relatives by staff was good. Patients and relatives were happy with the care provided. Staff were described as "very kind", "I cannot speak highly enough of them" and "they have been great". One patient who was in the HDU and well enough to observe the unit and staff said the staff were "always kind and cheerful with patients. Privacy and confidentiality is good for patients and families". The said of their short stay in the ICU that "the unit was brilliant. Both doctors and nurses were amazing".

The care we observed from the nursing staff was kind, reassuring and supportive. Patients were treated with respect and their dignity was maintained. Patients and relatives were given the information they wanted to have, and staff handled bad news or difficult messages with compassion and understanding. The relative of a patient had recently raised £1,500 for the critical care department in memory of a patient due to their gratitude for the care of staff.

The consultants and doctors were professional, thoughtful and respectful. There was some psychological support available for patients on the unit. But there were few of the latest innovations in patient support such as beneficial patient diaries or memorial services for bereaved families or friends. There were some follow-up clinics, but a poor uptake from patients.

NHS CCUs were not yet involved in the NHS Friends and Family Test when this visit took place. However, other feedback from patients about their care was not being recorded in any formal way. There were developments underway, however, to capture patient feedback when a new internet resource is launched in 2015.

Compassionate care

- Patients and relatives we met spoke highly of the service they received. A patient said of care: "I have been really well cared for" and "nothing has worried me, it's all been really good". We were able to talk at some length with one patient in the ICU and another in the HDU. They both said the units were quiet enough at night and patients were able to rest. If there had been activity at night, and nurses were aware that a patient had been disturbed, they explained what had caused the activity (usually a new admission) and reassured the patient.
- We observed good attention from all staff to patient privacy and dignity. Two patients confirmed that curtains were drawn around patients when necessary and voices were lowered to avoid confidential or private information being overheard. The nature of most ICUs means there was often no ability to provide single-sex wards or areas, and this was the situation with the ICU and HDU. Staff said they would endeavour to place patients as sensitively as possible in relation to privacy and dignity. If available, one of the three side rooms in the ICU would be used if a patient aged 16 to 18 years (or a young adult if considered appropriate) was admitted or if a patient was at the end of their life and safe to be moved to a side room.
- The unit was sensitive to patients' and relatives' needs. There were no set times for visiting hours but visitors were asked to refrain from visiting between noon and 2.30pm to allow patients to rest. There was limited space in the units and visitors were asked to restrict numbers to two at any time, as too many visitors had been recognised as tiring for patients in critical care. However, visitors and nursing staff said they would accommodate visitors as much as possible at all times. Staff indicated when they needed to support the patient and asked visitors to step outside for a short time. Visitors said the staff explained why this was necessary. When we were visiting, a nurse came in to the visitors' room to reassure a relative that this was just while routine care was carried out and would be for a short time only.
- Care from the nursing and medical staff was kind, patient and delivered with warmth. Nurses talked quietly with patients and reassured them continually. All staff introduced themselves to patients and their visitors. Nurses were observed talking to patients and explaining what care they were delivering, even if the patient was not conscious. Staff said it had been recognised that patients may be able to hear conversations or pick up on words or even atmospheres

even when minimally conscious. Staff kept this in mind, particularly with difficult conversations with relatives and friends and these were mostly done away from the patient in a private room.

Understanding and involvement of patients and those close to them

- Patients were involved with their care and decisions taken. Those patients who were able to talk with us said they were informed about their condition, tests being arranged, how long they were expected to be staying on the unit, and the treatment provided or planned. We observed staff giving good explanations of what was happening and including relatives where possible. Staff, including the approachable and helpful ward receptionist, made sure visitors were identified and only gave information to them if they were entitled to have it, or when the patient was able to give permission. One of the patients we were able to talk with in the HDU said the nursing staff explained what medicines they were giving them "every time without fail, and even though they did it only a few hours before".
- Friends and relatives of patients were kept informed and involved with decisions where needed. Relatives we met said they were updated about the patient on each visit to the unit, even if they were frequent visitors. They said they were able to ask questions and could telephone the unit when they were anxious or wanted an update, and that staff were helpful. One relative said they were "overwhelmed" by the ICU (which was a recognised reaction for some relatives visiting an ICU) but staff had been "sensitive to that" and "have not overwhelmed me with information as it's not easy to take it all in".
- Patients and relatives said staff asked appropriate questions to get to know patients, including the patient's preferred name, if they had any specific interests, and what foods and drinks they liked.
- Patient confidentiality was respected. When we were on the units we did not overhear information about patients where others could easily hear. Patients and visitors agreed. They said conversations with doctors or nurses were either held in areas away from other patients, or with the curtains closed and voices lowered.

Emotional support

- There was psychological support available. Staff from that service would visit patients on request of the clinical staff, the patient, or a relative. The clinical lead consultant said the service was "very good" and had provided some "excellent support" for patients. There was also support from the drug and alcohol service and the chaplaincy on request.
- There were follow-up clinics that completed depression scores. Long stays in ICUs have indicated that patients may get depressed, anxious or have other mental health issues for which they might need additional support.
- The unit extended emotional support to follow-up clinics, although they were not well-attended. The clinics were consultant-led with input from the multidisciplinary team, including a nurse and physiotherapist. There were procedures for these based on the NICE guidance 83: Rehabilitation after critical illness. Those who could attend were patients who had been on a ventilator for more than five days with an appointment within six weeks of discharge. The uptake for the clinics had not been high, but one of the senior nurses had produced a useful report on the data and actions recommended from the meetings in 2014. So far, based on the criteria for inviting patients to a follow-up clinic, 53 patients had been eligible and of 19 (36%) who had accepted an invitation, 14 (26%) had attended. Some actions had been identified by the senior nurse to improve follow-up clinics in future, including widening the criteria, comparing best practice with other units, and looking at home visits.
- There was limited use of some of the innovative ideas for patient support. Patient diaries had been considered but were not being completed with any real commitment from staff at the time. There were also no memorial services arranged for families of patients who had died on the unit. When time and resources permitted, there were aspirations among staff to look at improved emotional support for patients in the unit, but also those discharged and the families of survivors or those who had died.
- There was a directory available to staff for pastoral care. This comprehensive document covered: how to contact the pastoral team; services at the hospital; details of many recognised faiths including information about last offices; contact numbers for leaders of other faiths; and guidelines for the marriage in hospital of the dying patient. Although this was an extensive, detailed and carefully prepared resource, it was located under a pile of files in the ICU staff room and some senior staff admitted they were unaware of its existence.

Critical care

Are critical care services responsive?

Good

The critical care service responded well to patient needs. There were bed pressures in the rest of the hospital that sometimes meant patients were delayed on admission and discharge from the unit, but incidences were below (better than) national average rates. Some patients were discharged on to wards at night, when this was recognised as less than optimal for patient wellbeing, but this was also below (better than) national average rates. There was a very low rate of elective surgical operations cancelled due to unavailability of a critical care bed.

The facilities in the ICU were good and met many of the modern critical care building standards. The HDU was, however, less fit for purpose and there were limited facilities for patients, staff and visitors.

There was a good response from consultants and nurses when new patients were admitted. All patients were seen by a consultant within 12 hours of admission. Patients were treated as individuals and there had been good multidisciplinary working both internally and with external parties for a patient with learning disabilities.

Service planning and delivery to meet the needs of local people

- The critical care beds were all occupied most of the time. The trust had identified and responded to an increased need for beds. Patient acuity (health needs) was increasing. A recent audit in the hospital had demonstrated that at least 50% of patients were 'level 1 or 'level 1 plus' (defined as patients requiring higher levels of care or at risk of their condition deteriorating, whose needs can be met with advice and support from the critical care team). This had led in October 2014 to the medical HDU coming under the management of the critical care team as a generic HDU. This did not increase the bed capacity overall, but provided specialist care for the HDU for both medical and surgical patients and a step-down facility for the ICU. The difficultly with this arrangement was from the sub-optimal facilities in the HDU and the geographical challenges with the unit being on another floor of the hospital, although in the same wing. It was also located at the far end of another ward and accessed only through the ward. The arrangement had, however, increased the number of funded ICU and HDU beds from eight and one to eight and five. There was a working group now looking at the hospital's preparedness for higher-acuity patients and, among other things, plans to co-locate the ICU and HDU.
- There was a good response from consultants when new patients were admitted. The shift patterns were established so all patients were seen within 12 hours of admission by a consultant intensivist.
- The ICU environment was designed to meet patient needs. The unit was opened in 1998 and designed with input from experienced staff. There was an intercom and CCTV at the main entrance. Visitors were not able to access the clinical area when they first arrived. Staff were able to see patients in the open bed space area, and patients in the side rooms were supervised and visible to staff working in the immediate area. With the design of the unit being mostly linear, the bed space immediately in front of the door did compromise the patient's privacy and dignity to an extent. If the bed space was not screened by curtains (which most of the time it was not) people could see the patient from the external hospital corridor if both sets of doors were open. Side rooms were, as recommended, square or rectangle and not L-shaped, where visibility could be reduced. Doorways were wide enough to allow equipment to pass easily. When we visited, the room temperature was comfortable. In the ICU the bed spaces and side rooms were of a reasonable size and each had lockable storage for patient's medicines and valuables. There were work surfaces for staff to use and each bed space was fully screenable from the next.
- The HDU environment was limited in modern facilities. The unit had been established in a corner bay of Aspen Ward and did not fully conform with many of the modern building standards as they related to HDUs. There were, for example, no facilities for visitors to meet with staff in private. Staff said they would need to use a room in the adjacent Aspen Ward, which was a large respiratory ward. To reach the HDU, patients, staff and visitors had to walk through Aspen Ward to the far end. There was no separate door for patients or visitors and only a fire exit stairwell if staff wanted another access route.
- Patient and relative facilities were limited. In the ICU there was a large relatives/visitors waiting room with

plenty of chairs and information about the unit. There was a second small room with chairs and a sofa bed for one person to be able to stay overnight. This room was used for more private conversations with visitors. There was a toilet for visitors and a vending machine, but no kitchen facilities for relatives without accessing the main unit or leaving the unit.

- Not unlike many other critical care units, there was limited space for staff offices, administration staff and private staff conversations. Offices were cramped and non-patient corridors were used beyond their design capabilities for storage and facilities like photocopiers. There was a reasonably large seminar room for meetings and handover sessions with the consultants and doctors and this had a large screen and access to the required computer systems. Other staff shared offices and there was limited room for private conversations between staff.
- The hospital had the ability to temporarily increase capacity to care for critically ill patients in a major incident, such as a pandemic flu crisis or serious public incident. This would involve using the recovery unit in theatre.

Meeting people's individual needs

- Patients were treated as individuals. Nursing staff told us they had used other staff with specific fluency in other languages to provide translation. There were telephone translation services for patients and relatives where English was not spoken or not easily understood. In the HDU, however, nursing staff said this could be problematic as the wired telephone did not reach the patient's bedside. There were communication boards for patients with tracheostomies to write messages or point at symbols and images. The trust's policy on translation services included a number of resources for staff, such as an emergency phrasebook on the trust's intranet and a computer-based tool for using with people with hearing impairment. None of the staff we asked mentioned these resources and only talked about the telephone translation services.
- There were some good leaflets and general information available for patients and their families. Information had been taken from several sources, including staff experience, and national organisations such as 'ICUsteps', an intensive care patient support charity. Staff demonstrated a caring and experienced attitude to a patient on the HDU with learning disabilities. The unit had encouraged the patient's care worker to spend time with the patient and support staff with knowledge of the patient and help with communication. There had been regular contact with the care home supporting the patient. The patient had been admitted through A&E with a Hospital Passport, a document prepared under guidelines of the local authority. This helped staff orientate the patient, know what they could and could not do, their likes and dislikes, and other more clinical information such as their medicines and health issues. Although the patient lived in a care home, staff endeavoured to contact the patient's relatives to make them aware of the hospital stay. We met with one of the neurological doctors who was knowledgeable about the patient and was taking the whole person, not just the current episode, into account. Staff told us how they were planning the patient discharge at an appropriate time, and how they would hand over new information to the care workers about changes in medication. Unfortunately, due to issues with the hospital transport, and despite the best efforts of the HDU nursing staff, the patient, who was due to leave the unit at 5pm, did not get picked up until 9pm. All the parties involved agreed the discharge was still safe, even though the time of the day was sub-optimal.
- Both the ICU and HDU would admit patients from 16 years old. As a 16- and 17-year-old patient would be strictly classified as a child, they would be attended each day they were on the ICU or HDU by a paediatric nurse. The hospital trust clinical site manager had helped to support the mother of a young person who had been admitted to the HDU and found them somewhere to stay in the hospital so they could remain in close contact with their child.

Access and flow

- There was a standard operating procedure (the operational policy) for admissions to critical care. The operational policy included emergency, planned and unplanned admissions, usually following elective surgery. There were guidelines for staff to follow when an admission had been accepted. These included handover requirements, a primary survey of the patient under resuscitation guidelines (checking airways, breathing and circulation), followed by a secondary survey and treatment plans being drawn up.
- The discharge from the ICU was mostly achieved at the right time for the patient. Studies have shown discharge

at night can increase the risk of mortality, disorientate and cause stress to patients, and be detrimental to the handover of the patient. ICNARC data (1 April to 30 June 2014) for discharges made out of hours (between 10pm and 7am) placed the unit below (better than) the national levels for night-time discharge for similar units. About 7% of all discharges (13 patients) took place at night (against a national average of around 8%). The HDU was not managed by the critical care team when the latest ICNARC data was presented, so we are not using that data for comparison on this occasion.

- Similar to many critical care units in England, there was a high level of delayed discharges from the ICU. Over 60% (just below the national average) of all discharges were delayed by more than four hours from the patient being ready to leave the unit. Four hours is the indicator used for comparison with other units and set by ICNARC. It is used to demonstrate the ability, or otherwise, to move patients out of critical care in a timely way. Although patients remained well cared for in the ICU when they were medically fit to be discharged elsewhere, the unit was not the best place for them. This was recognised by staff, who were aware the unit could also be a difficult place for visitors. The delays were, however, mostly less than 24 hours, and none were more than three days. The rate of delayed discharges had been relatively stable for the last 12 months and improved from a poor performance in 2010 to the end of 2012.
- Patients were rarely discharged home from the ICU and most were stepped-down to a ward or the HDU for support and monitoring before eventually going home. This was a further indicator that delays in discharge were relatively short, as patients were not spending too much time in critical care where they improved enough to go home. Delays were therefore also not preventing other patients from being admitted to the unit.
- Occupancy levels on the ICU were high. The number of admissions to the ICU had increased from around 100 each quarter in 2009 to almost double that in the second quarter of 2014. In the ICNARC data from 1 April to 30 June 2014, there were very few patients transferred into the unit from an HDU or the ICU in another hospital. This rate was the same as the national average for similar units. The ICU had no patients admitted from other units for non-clinical reasons – that is, admissions to the unit due to no bed capacity in another hospital unit. The unit was therefore mostly managing its own patients and predictable admissions. Patients were not often transferred to other units for clinical reasons. Usually transfers out were for patients to be accommodated closer to home or for specialist care. Non-clinical transfers for the ICU in the ICNARC data period (where a bed was needed in another unit as the ICU was full) were around 0.5% (probably just one patient) and the same as the national average.
- There was a very low rate of 'urgent operations' cancelled due to a lack of an available bed in the ICU. In the six months from April to September 2014, there had been only two cancelled operations reported to NHS England (in September 2014), the same number for NHS units of a similar size bed capacity.
- There was a very low rate of patients discharged from the ICU too early on to wards (that is, when they were not quite well enough) to make way for new admissions. In the ICNARC data from 1 April to 30 June 2014 there was just over 1%, which was below (better than) the average for similar units and all other NHS units.
- The unit had an escalation policy for closing beds when a number of factors came together. This included a high percentage of agency nursing staff, a low number of nursing staff with specific critical care training, and a low number of qualified nursing staff on shift. Despite low numbers of nursing staff, this policy had not been invoked on many occasions in the last year.

Learning from complaints and concerns

- Complaints would be investigated and reviewed. As with most critical care units, there were very few complaints. Staff told us none had been made to the ICU in the last year, although the clinical governance meeting minutes for October 2014 said there had been two made through the Patient Advice and Liaison Service. Staff described how they would manage a complaint. It would involve responding to the complainant and making an apology where this was appropriate. Complaints would be investigated on the unit and, if actions were needed to prevent a recurrence, they would be produced and circulated to all staff.
- Complaints procedures were available to patients and visitors. The unit had the trust's concerns leaflet on display in the relatives' room. This described how to correspond with the trust, which could be written or verbal. The process for raising complaints and their confidentiality were described. The planned response time to acknowledge a complaint was within three days.

This acknowledgement would say how long the trust felt it needed to address the complaint fully. There were also instructions on how to obtain the complaints procedure in a different language or format.

Are critical care services well-led?

Requires improvement

We have judged the service as requiring improvement in terms of governance. All the senior staff were committed to their patients, their staff and their unit. However, there was no robust programme of governance, risk assessment, assurance and audit. The unit's governance arrangements were not allowing for feedback on incidents, audits, or results from those quality measures it had. There was a lack of accountability for implementing actions and improvements. There was no audit programme or demonstration of continuous improvement plans. There was also weak input into, and support for, the governance of critical care from its directorate.

There was, however, a strong culture of teamwork and commitment in the critical care unit. All the staff we met were dedicated and professional. Staff were supportive to their patients and to one another. All staff had similar worries about the unit, focusing on the shortage, retention and recruitment of nursing staff.

Vision and strategy for this service

- The senior management, senior nurses and consultants were committed to an effective service that was able to support patients at all times. There was a vision and strategy for the service, although this was not described in any local governance documents. It was described to us by the leadership of the department as a future strategy to bring the separate ICU and HDU into either the same place or adjacent to each other to provide better responses and continuity of care.
- The leadership of the service, including the outreach team and clinical practice educator, were committed to delivering high-quality care to all patients. Part of the recent strategy in transferring the medical HDU to a general HDU under the management of critical care had been realised.

Governance, risk management and quality measurement

- There was insufficient time and resources given to governance and safety, quality and performance review. The clinical lead consultant for the unit led on governance, but this did not get a satisfactory level of commitment among the other tasks and responsibilities being managed on the unit. The other consultant intensivists had lead roles, but none of these included governance, risk and quality improvement.
- Audits and performance measures of certain aspects of safety within the unit were not carried out and there was no audit calendar. There was no programme for standardised audits, such as ventilator-associated pneumonia incidence or central venous catheter line checks, to demonstrate or show the need for continuous improvement. Performance data and quality management information was not being collated and examined by the unit to look for trends, celebrate good performance, or further question poor results.
- Some time-consuming data collection was being done, but with no clear purpose. The outreach nurses were collating important and useful information from their interactions on the wards and departments advising about or supporting deteriorating patients. However, despite the time spent collecting this data, and the labour-intensive input into a spreadsheet, nothing was being done with the information to look at or acknowledge performance, quality or safety of their work.
- The trust's risk register had a very low number of identified risks and concerns relating to critical care. There were three risks highlighted which involved staffing shortages, the temperature of the drug room, and the risks of manually entering pathology results to the electronic patient records. There was no progress to resolving the problems around the risk of the temperature of the drug cupboard, although some solutions had been tried (but not worked). This was entered on to the register in June 2014 and the next review was January 2015. There was some progress on the pathology results, but more testing was being done before being approved. Two of the three risks on the register were not discussed (or minuted) at the inaugural clinical governance meeting in October 2014. The staffing risk was minuted, but "waiting for sign-off".
- There were standard operating procedures for critical care (in the form of an operational policy) but the document did not have executive or directorate approval. The department had experienced and

committed staff, particularly in the senior management. However, there was a lack of executive oversight and directorate support for the unit in clinical governance. An example of this came from the first meeting for clinical governance only being held in October 2014 for which there were no terms of reference or agenda circulated in advance.

- The unit did not display data relating to performance or quality. For example, there was a lack of local examination and display of patient harm data, such as unit-acquired pressure ulcers, patient falls, or VTE incidents. Safer staffing levels, infection rates, and cleaning audits, for example, were not displayed.
- The unit participated in a national database for adult critical care as recommended by the core standards. The unit contributed data to the ICNARC Case Mix Programme for England, Wales and Northern Ireland. There was a trained member of the administration team responsible for ICNARC data input. ICNARC reported that the data supplied was well-completed and of good quality. There was, however, no evidence of the findings from these respected reports being presented to the executive team or the board to demonstrate the strong outcomes for patients.
- As recommended by the core standards, the unit was part of a local critical care network. For the past decade at least, the hospital had been part of the small Surrey-wide network, which had provided good support and shared working. This network had recently been extended to a new larger community covering Kent, Surrey and Sussex. This network was new and the benefits, or otherwise, from this change had yet to be seen or realised.
- Staff were included and informed about the running of the unit, although this needed improvement in some areas. There were unit meetings each Tuesday, although these were mostly focused on patients and not specifically governance. The meetings had input mostly from doctors and therapists. The shortage of nursing staff meant the input from this team was limited at the present time. There were shift-leaders meetings which, for the two sets of minutes we saw (July and November 2014) were reasonably well-attended by a mix of the staff team, including doctors and senior nurses. We were told that the meetings were monthly but, although there was a meeting scheduled for December 2014, there had been no meeting between July and November 2014. There were discussions about staffing levels, the budget status and equipment, for example, but no performance or quality indicators were presented. The good results for effective, caring and responsive treatment and support against comparative measures were not demonstrated or recognised in these meetings.

Leadership of service

- The consultant leadership of the service by the clinical lead consultant intensivist and the team of experienced intensivists was strong and committed. The commitment to an outstanding and innovative electronic patient record system had delivered an effective, efficient and impressive tool which saved time and enabled consistent care.
- The nursing leadership of the service was strong. The Clinical Nurse Leaders (or clinical nurse lead) and senior nursing staff were committed to their staff and patients. They were visible on the unit and available to staff. The Clinical Nurse Leaders said they were encouraged to have a strong voice and raise awareness of their unit with the nursing management. The consultants we spoke with had a high regard and respect for the Clinical Nurse Leaders and nursing team.
- There was a good working relationship between staff on the unit. The senior team of doctors and nurses all told us they had a close working relationship and strong commitment to the service. There had been issues in the recent past with staff and the unit remained understaffed in terms of nursing. The substantive staff remaining, however, showed commitment, strength of character and support for one another.

Culture within the service

- Staff said they were encouraged to raise concerns. Almost all the staff we spoke with said they did not feel they were blamed when things went wrong and were subsequently not discouraged from speaking up.
- A strong culture of teamwork and commitment was spoken about among staff in the critical care department. All the staff we spoke with said the strength of the unit was the commitment to the unit, the patients and each other. Staff were aware that the turnover on the unit had been high recently, and there were a few more of the nursing staff moving on. However, staff said they were hopeful but confident the unit would settle down in the near future. Patients and relatives also commented on the positive nature of the staff they met.

Critical care

- Trainee doctors were well-supported on the unit. We were told consultants were easy to contact when trainee doctors needed advice. Nurses were also supportive and helpful to trainee medical staff.

Public and staff engagement

- There was no system used in 2014 to gather systematic feedback from patients. There had been some questionnaires completed in 2013, but these were only for five patients. A new system was in development to get meaningful and measureable information from patients and relatives. But there had been no information gathered since March 2013 to report on, identify trends or improvements, or celebrate good results. We saw a number of cards from patients and relatives displayed on the unit. The comments were all good and people spoke highly of the care and support delivered. There was, however, no way of record this information to demonstrate more widely the feedback from people using the service.

Innovation, improvement and sustainability

- The electronic patient record was an outstanding example of innovation in this critical care department. There were still some areas to improve, including the pharmacy and pathology interfaces, but these were recognised and on the agenda for 2015.
- There were no current plans formally agreed to improve or develop the service. Although the HDU had been recently brought within the management of the critical care department, the physical environment and location of the unit were not ideal.
- The team working in critical care had strong, shared values, but there were no longer-term safety, quality or performance objectives for the team to work towards. Nurses we talked with said their annual appraisals had not included any particular quality or safely goals for themselves or the department to work towards.

Maternity and gynaecology

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

Information about the service

Maternity services at Ashford and St Peter's Hospitals NHS Foundation Trust are centralised at St Peter's Hospital and there are just under 4,000 births per year. Women typically access the service through their GPs and a referral is made to the midwife.

There were 29 whole time equivalent (WTE) community midwives spread across five community midwife teams. Most of the antenatal care was provided by the community midwives from the local GP practice or health centre. There was also an antenatal clinic at St Peter's Hospital with seven consultation rooms, a day assessment unit, scanning department and early pregnancy unit. The homebirth service for women with a low-risk pregnancy was provided by the community midwives.

The new Abbey Birth Centre was opened in May 2014 for women anticipating an uncomplicated, normal birth supported by a midwife. There were four modern birthing rooms with facilities for water births and for women to move around during their labour in a relaxing environment.

The labour ward was close by and had a three-bay triage unit for the assessment of women on arrival. There were nine labour rooms, a four-bed observation bay and two obstetric theatres. There was always a consultant obstetrician on call, a middle-grade obstetric registrar, a junior doctor and an anaesthetist on duty. There was also a level 3 neonatal intensive care unit (NICU) at St Peter's Hospital for babies needing additional support. After giving birth, women transferred to one of the 30 beds, including some single rooms, on the Joan Booker Ward for postnatal care and support. Gynaecology services were provided on the Kingfisher Ward.

Maternity and gynaecology

Summary of findings

We found that the maternity and gynaecology services provided were good for safe, effective, caring and responsive but required improvement in well led.

There was a sense of pride in the service and optimism for the future. Midwives and doctors collaborated well to achieve the best outcomes for women and their families.

Feedback from women using the services was good, through the NHS Friends and Family Test.

The midwife-to-birth ratio was 1:31 which was just outside the recommended ratio of 1:29. Many of the managers worked as supernumery and clinical and there was a flexible system for the deployment of staff to deal with peaks in activity.

The recent opening of the Abbey Birth Centre had enhanced the service by ensuring that women were cared for in the areas most appropriate to their needs.

There was a new engaging and participative leadership style with clear standards set for safety and quality and a greater empowerment of midwives to make decisions, as appropriate, and provide a normalised childbirth experience.

Introduction of the Perinatal Institute's Growth Assessment Protocol had led to some duplication of postnatal records and gaps in information.

We found a considerable number of staff had been impacted by what had been acknowledged as inappropriate leadership behaviours. The current leadership team had developed a vision and were working on an action plan following the external review which focused on quality and team work.

Are maternity and gynaecology services safe?

Good

Incidents were reported within the maternity and gynaecology services and action was taken to understand the cause of serious incidents and learn from the experience to improve the safety of the service. The wards and units were clean and uncluttered and the equipment was tested and ready for use. Medicines were stored, managed and dispensed appropriately. The service had recently transferred to use the Perinatal Institute notes for patient records and we found that these were incomplete, with important information missing. The process of note-taking also involved some duplication which was both time-consuming and frustrating and the 'digipen' technology (a system to digitise documents that are handwritten) seemed to be universally disliked throughout the service.

Processes for safeguarding, assessing and responding to risk were appropriate and there was a system for escalation in triage. We found that mandatory training was in place and levels of staffing, both medical and midwifery, were appropriate and within expected levels. The midwife-to-birth ratio was 1:31 which was just outside the recommended ratio of 1:29. Many of the managers worked as supernumery and clinical and there was a flexible system for the deployment of staff to deal with peaks in activity.

Incidents

- There were 10 serious incidents recorded on the maternity dashboard from April to October 2014. These were recorded through the Datix - patient safety incidents healthcare software reporting tool. Staff confirmed that there was a good culture of reporting and learning lessons from incidents.
- A range of causes for these incidents was identified, including maternal sepsis, pre-eclampsia and stillbirth of unknown cause.
- We attended a meeting of the fortnightly incident reporting group, chaired by the divisional clinical governance manager, where the learning from incidents

was discussed. An example of this was the manner in which a 'T-shaped' incision had been recorded at an earlier caesarean section and how the availability of this information may have contributed to an incident.
- There was a discussion of a recent Never Event, where a swab had been retained in theatre, and the investigation report that was awaited from NHS England. In advance of receiving the report, staff at the meeting ran through their protocols for accounting for all swabs used in theatre, and particularly when a new person entered the theatre.
- Details of a serious incident involving sepsis were reviewed, teaching sessions held, guidelines updated and practice strengthened as a result of this case. For example, senior midwives were now permitted to take blood cultures and this new practice would prevent delays in obtaining blood cultures from women whose health was deteriorating. The governance manager discussed how they could escalate concerns to the patient safety managers in the trust. They described a good, supportive relationship. It was also agreed that the management of sepsis was going to be included as part of the mandatory training.
- We saw a monthly newsletter for staff which contained and shared the learning from incidents.
- A clinical risk midwife was available to assist staff in identifying, reporting and learning from incidents. In addition, a clinical skills facilitator was available to support the development and improvement of individual practice.
- Governance and incident reporting were part of the maternity study days. We noted that 1½ hours were allocated for this session.
- We reviewed a number of serious untoward incident reports where a root cause analysis had been conducted and found that each had a set of recommendations and action to take as a result.
- Trends were monitored through the incident group, the action tracker and quarterly governance committee.

Cleanliness, infection control and hygiene

- The wards and units were clean and tidy. The recently opened modern birth centred looked particularly fresh and free of clutter.
- Equipment had stickers on it with the date it was last cleaned.
- Gels and hand sanitisers were in position at the entrance to wards. We saw them being used by staff and visitors.
- Puerperal sepsis was monitored on the dashboard with 16 cases in total from April to October 2014.
- The women's health incident group discussed a case of sepsis and some changes to the protocols were made as a result. High-risk women were seen by the consultants and there was an audit of all interventions and new guidelines for preventing sepsis.

Environment and equipment

- We saw that the glucometer machine, used for checking glucose levels for women with diabetes, was checked regularly and that the records were signed, up to date and complete.
- Obstetric emergency equipment was clearly labelled and accessible.
- Staff were aware of the location of the equipment. Two members of staff had participated in 'skills drills' on the labour ward to practise their responses to emergency situations.
- We also saw emergency equipment in the birth centre to be used in conjunction with the birthing pools. We were informed that staff were updated on the use of this equipment regularly.
- We saw that the cardiac arrest trolley was checked daily and staff signed to indicate that they had checked that the defibrillator was working, that the monitoring electrodes were present and that the tamper-proof seals were intact.
- We reviewed daily checks to the paediatric resusicitares in theatre and noted that these checks were not completed every day. Checks were not completed two or three days a month and, on a few occasions, not for two days consecutively.

Medicines

- The lead midwife had the role of monitoring medicines management and compliance. This included checking fridge temperatures and that sharps boxes were labelled with the date of use.
- Since being in post, the lead midwife had changed the practice of administering medicines individually to a formal drugs round at set times. This had reduced the incidence of omitted and delayed medication.
- There was a medication assessment included as part of the Best Care Measurement and Accreditation Tool for

Midwifery. This included a check that ward records confirm that the daily checks of controlled drugs were carried out once a day for the last 10 days. The unit was meeting this standard.

Records

- We were informed that the service had recently moved over to using the Perinatal Institute's notes and the associate director of midwifery and gynaecology had sent out a notice at the beginning of November 2014 about the process for completing these new notes. The lead midwife had been conducting spot checks in November and reported that, "approximately 70% of the notes have not followed the expected process, which is disappointing".
- One of the reasons for the transfer to these notes was to adopt a programme to improve the detection of growth-restricted babies through the use of customised charts, training and audits. This was an action from the external review of the maternity services. We saw that training had taken place on the correct completion of these notes.
- We reviewed five sets of notes for mothers in pregnancy and postnatally.
- The pregnancy notes were completed to a high standard but the postnatal notes were incomplete. We looked at five sets of notes and all five were incomplete. Missing information included GP details, name of midwife and details of next of kin.
- On the postnatal ward there was a poor understanding by midwives of what needed to be completed. A system was in place that required midwives to record care in the postnatal notes. On discharge home the records were retained in the unit and the midwives had to complete a second set of records for use in the community. The midwife was also required to complete electronic documentation of care given.
- There was a duplication of effort and this may have been having an impact on the standard of recording-keeping. One member of staff told us, "The paperwork drives us crazy". Other midwives also mentioned the, "tiresome duplication of documentation".
- These findings were discussed with the clinical midwifery managers and the postnatal ward manager. We informed the associate director of midwifery and gynaecology of our findings about record-keeping. From our discussion with the associate director and lead midwife, improving the standards of record-keeping was a priority for the service.
- The maternal early obstetric warning system (MEOWS) was in use. Five charts were reviewed: three for postnatal and two for antenatal women.
- Observations were recorded on the health records but not on the charts. One set of observations in a postnatal record was such that it would have triggered action had it been plotted on the chart. These findings were reported to the lead midwife for action.
- The community midwives were using 'digipen' technology to record information. This system was a source of frustration at all levels within the service as it was time-consuming and inefficient. One community midwife said that, "notes for one patient could take 45 minutes to complete".

Safeguarding

- We observed a safeguarding meeting with the safeguarding midwife in attendance along with a number of hospital-based and community midwives and ward and midwifery managers. A social worker and health visitors who usually attended had sent apologies. We heard a good discussion of cases where the needs of vulnerable women were understood and support was agreed as part of an individualised plan of care.
- A number of cases discussed were from the prison (HMP Bronzefield Women's Prison) and there was a case involving a baby being placed with foster carers. The midwives appeared to have a good understanding of the procedures and the details of the cases.
- We saw a set of slides from a presentation to staff by the named midwife for safeguarding for handover of care for women from the prison. The presentation concerned how safeguarding concerns were communicated at the point of handover to another hospital. We also saw the slides from a presentation to staff at the prison about the effects of substance misuse on the foetus. These slides demonstrated the collaborative approach taken with the prison.
- We saw the maternity safeguarding children guideline for 2014, evidence of joint safeguarding meetings, training and multi-agency referrals.
- There were detailed policies on safeguarding issues, including a policy on security for newborn babies and the risk of abduction.

Maternity and gynaecology

Mandatory training

- We spoke with the associate director of midwifery and gynaecology and they indicated that mandatory data was managed through the electronic staff record. We saw a copy of the divisional education strategy. This contained a programme of training for 2014 and included fire, health and safety, Mental Capacity Act 2005 and manual handling.
- The service aimed for 90% attendance at mandatory training each year and, taking into account sickness and maternity leave, '80% attendance would be the minimum accepted.
- Training and staff competences formed part of the key performance indicators measured through the trust-wide audit process. We saw a copy of the Best Care Measurement and Accreditation Tool for Midwifery. The frequency of reassessment via this tool was dependent on the overall score achieved at the last assessment, for example level 3 or 'green' required a reassessment in six months and level 0, or 'red', meant a reassessment in two months. At the time of the inspection, the service was assessed as level 2 'yellow' and would be assessed again in four months. We were informed that the recruitment issues were the main reason for not achieving a level 3 assessment.
- We spoke with 13 midwives at a focus group and they confirmed that they were well-supported with training and development. We saw evidence of attendance at level 3 training in safeguarding and in the growth assessment protocol training provided by the Perinatal Institute.

Assessing and responding to patient risk

- There was a nominated consultant lead for risk management.
- The service was using the maternal early obstetric warning score) although it was not always fully completed (see records).
- We saw that clinicians were completing the World Health Organization (WHO) surgical safety checklist.
- We saw clinical guidelines for admission to the Abbey Birth Centre which covered inclusion and exclusion criteria. We were informed that the criteria were adhered to and had been reviewed and updated since the centre opened. The criteria had been adjusted to admit women with a slightly higher body mass index (BMI) and for those with hypothyroidism, providing it was well-controlled with medication.
- Triage (assessment) protocols were clear in the Abbey Birthing Centre. Women usually telephoned but occasionally just arrived and spoke with a midwife who conducted a detailed assessment. The midwife had a triage proforma with questions about the pregnancy, gestation, timing, length and strength of contractions and any other concerns. For example, the team leader informed us that, if there seemed to be a reduction in the baby's movement, it was important for the midwife to ask, "Is that normal for your baby?" The midwife may advise the woman to either stay at home to call back, or to come in to the Abbey Birth Centre or the labour ward. The team leader said, "If the woman is very anxious and has telephoned three times, we would invite her in". The team leader informed us that there was a significant amount of 'footfall traffic' in the birth unit and, "there may be six to eight women contacting or attending the birth centre each day for every two births." If there appeared to be a complication that elevated the level of risk for the woman or the baby, the default position was to transfer to the labour ward for a full assessment.
- Triage on the labour ward was for higher-risk pregnancies, such as multiple births or for women with a history of raised blood pressure, diabetes or a previous delivery with an element of complexity. There was a logbook for all telephone calls and each of the women had an obstetric plan for the birth. Triage was effective and risks were identified. We spoke to a couple on the postnatal ward who had been seen in triage and sent home to come back later. They said, "We were worried because our first baby came very quickly. The traffic was heavy so, as soon as we got home, we had to turn around and come back again".
- There was a day assessment unit open Monday to Friday 9am to 5pm. We found that there was no dedicated medical cover and no guidelines relating to this service. There was no named consultant for the day but there was a registrar on call who would also be covering other areas. At the weekends and out of hours assessment was through triage. There was also an early pregnancy unit for any difficulties occurring before 12 weeks of pregnancy. The midwives we spoke with said that they

had no difficulties finding support when they needed it. We raised it with the associate director and who said that they were planning to review the configuration of this service in 2015.
- There was a consultant-led caesarean section meeting to review all cases weekly.
- The unit had a list of clinical situations where discussion with a consultant was mandatory, such as any decision to perform a procedure in theatre, and where the attendance of the consultant was required, such as for maternal collapse.
- There was a perinatal mortality meeting to review safety and quality of care on a monthly basis.
- We looked at the entries of the risk register for women's health and noted that the service had identified a risk around the 'lack of allocated team for maternity theatre elective caesarean section lists'. This had been an item on the risk register for over a year and was due to be reviewed in February 2015. It was noted that 'this results in midwives needing to leave labouring women without one-to-one care to scrub for caesarean sections as short notice and were unable to guarantee 100% one-to-one care for labouring women'. The associate director informed us that it had been agreed that a general theatre team would be recruited and in place by April 2015.

Midwifery staffing

- The associate director of midwifery and gynaecology had overall responsibility for ensuring that appropriate midwifery staffing levels were maintained throughout the trust.
- They confirmed that, because of the high turnover, and the constant need to fill shifts with bank (overtime) staff, maternity staffing was an item on the divisional risk register and discussed at the divisional governance meeting.
- We were provided with a recent maternity staffing report prepared in November 2014. The report discussed the principles of optimum midwifery staffing as well as the midwife-to-birth ratio calculated using the Birth Rate Plus tool to benchmark existing establishments for midwifery and support staff.
- We saw from the clinical quality dashboard for maternity that the actual ratio had been 1:31 since April 2014. This was within the target set by the trust of 1:32. The recommended ratio is 1:29.
- An acuity tool was completed every four hours to measure the level of risk against the number of staff on duty. We saw evidence of this.
- There was one-to-one midwife support for women during labour.
- We observed that, in response to peaks in activity, flexibility was provided by: midwifery managers who could also perform a clinical role; some movement of midwives between community, antenatal, the birth centre, labour and postnatal wards. In addition, maternity care assistants were available across the service and could provide one-to-one support for women and babies in the postnatal period for vulnerable women.
- The service had also created a template of minimum staffing levels for each working area. For example, there was usually a minimum of: eight midwives on the labour ward and two maternity care assistants; four midwives on the postnatal ward and two maternity care assistants; two midwives in the birth centre and one in maternity triage. In addition, there were also two community midwives on call overnight.
- Staff informed us that staffing levels had been improved in recent months and the labour ward manager was able to demonstrate the use of the acuity tool in helping to set safe levels of staffing. Staffing was reviewed on a weekly basis and findings reported to the chief nurse.
- Staffing was reorganised wherever possible to optimise the deployment according to levels of activity in each area of the service.
- A rolling audit of midwifery and obstetric staff occurred at the publication of each rota. This included the number of midwife shifts lost through sickness, maternity leave, study leave and any other reasons.
- We were informed that each of the 29 WTE community midwives had a caseload of 150 cases. The requirement was for women to be booked by their community midwife before 12 weeks and six days of pregnancy. This was achieved in 2014 in more than 90% of cases.
- The staffing was displayed on a whiteboard in the clinical areas to ensure that patients and visitors were aware of the staffing numbers and any shortfalls.
- Any shortfalls, for sickness or vacancies, were covered by bank midwives, most of whom were employed by the trust in permanent roles. Bank usage was also recorded and monitored on the maternity dashboard.

Maternity and gynaecology

- Midwifery and support staff numbers were reported each day through the minimum staffing template, and monthly through the maternity dashboard. Staffing numbers were reported to the board by the chief nurse and assurance was given on safety.
- Staff we spoke with said that the staffing levels had improved in the last year and were "safe". They told us that the difficulty was with retention and turnover and this meant that there was "greater pressure on the more senior midwives". The ratio of midwives to supervisors of midwives was 1:18 against a trust target of 1:15. We were informed that the high turnover made this a continual challenge but that new midwives were completing the supervisors' training programme and they would improve the ratio. There was a supervisor of midwives on call 24 hours a day who had to be informed of specific issues, such as staffing levels affecting safe clinical care.

Medical staffing

- There were nine consultants obstetricians providing 60 hours of cover on the labour ward. This was confirmed on the maternity dashboard which recorded actual hours of cover. The divisional director of women's health and paediatrics informed us that a business case had been submitted for three additional obstetric consultants but that this had not been accepted by the trust in 2014. They said that they were now aiming for an additional one or two consultants and this was dependent on the birth rate remaining below 4,000 a year. If the birth rate rose above this figure, the service would require 98 hours of cover.
- We spoke to one of the consultants who said that it would be difficult to respond quickly if the birth rate increased, and further hours would be needed.
- The consultant obstetricians were present on the labour ward between 9am and 9pm, Monday to Friday, and four hours at weekends. Outside of these hours, a consultant obstetrician was on call and could be called in for advice, support and to attend patients as required. The consultant said that, as a group, they worked well together and respected each other's decisions.
- In addition to the consultants, there were nine middle-grade doctors (and a number of junior doctors) providing a 24-hour presence on the labour ward on a shift rota. They also worked in the antenatal clinic supporting the consultant's clinics and the day assessment unit.
- There was a lead anaesthetist for maternity with a duty consultant obstetric anaesthetist available at all times. At least one duty anaesthetist was resident on the labour ward 24 hours a day. During weekdays, a second consultant anaesthetist was always available if required and on call out of hours.
- The trust was compliant with the Royal College of Gynaecologists' 'Safer childbirth' recommendations.

Are maternity and gynaecology services effective?

Good

The service was using evidence-based guidelines and these were accessible to staff. Pain relief was available and an anaesthetist was on duty at all times to administer epidurals. Support was offered to women feeding babies, and food and drinks were available for mothers at all times.

Patient outcomes were being closely monitored via the maternity dashboard and an external review had been commissioned due to higher-than-expected rates of stillbirth. These rates had now returned to expected levels. Levels for caesarean section were higher than the England average and work was ongoing to improve the rates for normal birth. Staff were competent in their roles and worked well together in a multidisciplinary team in the interests of patients.

Evidence-based care and treatment

- We found that guidelines on the trust's intranet were in-date and clearly marked with the next date for review.
- The service was adhering to the Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (RCOG 2007)
- The service was aware that the National Institute for Health and Care Excellence (NICE) had been asked by the Department of Health and NHS England to produce guidelines on safe staff capacity and capability in the NHS. The service was awaiting the guidelines on nursing and midwifery staffing levels to continue to ensure an appropriate skill-mix across the wards and units and in relation to the changing acuity of patients.
- The department was using NICE guidelines throughout the service. For example, the midwife team leader for the birth centre showed us a shared learning database

submission on the use of NICE guidelines. Intrapartum care: Care of healthy women and their babies during childbirth. It places the guidelines in the context of care of women with low-risk pregnancies in labour.
- The November 2014 issue of the newsletter informed staff that a number of guidelines had been updated, including: mental health, referral to maternity services, new born security (including baby abduction) and foetal heart rate monitoring.

Pain relief

- Pain relief was available and an anaesthetist was on duty at all times to administer epidurals.
- Women could access the analgesia they wanted.
- Pain relief was also available during labour and on the postnatal ward.
- Although it was at an early stage, the Abbey Birth Centre was reporting a reduced uptake of pain relief and greater mobility to cope with pain in labour.

Nutrition and hydration

- We spoke with a maternity support assistant and observed how she taught mothers about feeding techniques and patterns of feeding. The service was preparing for assessment for the United Nations Children's Fund (UNICEF) baby-friendly accreditation at level 3 in March 2015.
- We observed the maternity support assistant at work and saw how she greeted mothers in the morning and introduced herself and the rest of the team. There was an infant feeding workshop run by midwives, but it was planned that the maternity support assistants would run the workshop in the future.
- We saw that mothers were given a breastfeeding support information pack.
- There was an infant feeding care pathway for babies with weight loss through accident and emergency. There was a plan to begin a weight loss clinic on the ward. We saw that this had been recorded in the notes.
- The women we spoke with were happy with the food and said that "tea and toast" was freely available following labour. Some women said that they had not been immediately aware that breakfast was self-service on the postnatal ward.

Patient outcomes

- The maternity dashboard indicated that there had been more than 330 births a month between April and October 2014, apart from April and June when the number of births fell slightly short of 330. The projected number for the full year was 3,963.
- The number of elective and emergency caesarean rates was above the trust's target every month between April and October 2014, apart from July when it was equal to the target of 23.6%. In April and June it was 29% of all births in those months. This is a little higher than the England average.
- The consultant on duty informed us that there was a clinic and a discussion group for women having a second baby, after having had a caesarean section with their first. This was to encourage women to think about planning for a normal birth with their second baby where there was no obstetric reason for another caesarean section.
- A survey of the risks of benefits of this approach was underway and success rates were recorded and monitored as part of the maternity dashboard.
- The newly opened Abbey Birth Centre was also available for women with a low-risk normal birth with between 45 to 55 births a month.
- The rates for the induction of labour were also higher than the trust's target of 15%.
- An external review of maternity services at Ashford and St Peter's Hospitals NHS Trust was commissioned and completed in July 2014. The reason for this review was a higher-than-expected perinatal mortality (particularly stillbirth) rate which had been reported over the previous two to three years.
- This review did not identify any major concerns about the care provided to women but suggested some changes to "improve the experience and outcomes of care for women and their babies". This resulted in the decision to appoint a midwife to take the lead on perinatal mental health issues and to consider how to meet the needs of women with more complex social factors or stress.
- The recommendations had been accepted by the service and action was being taken to improve access to interpretation services for women whose first language was not English. The service was also considering adopting the Perinatal Institute's growth assessment protocol, a programme to improve the detection of growth-restricted babies through the use of customised charts, training and audits.

- By the time the external review had been completed, the stillbirth rate had returned to the level of the England average.
- Birth outcomes were monitored as part of the national diabetes audit programme and presented at the 'bonus study days' in the trust to inform midwives, and as part of the departmental audit meetings. Obstetricians reviewed the audit reports as part of educational meetings.
- We were informed that experience to date suggested that the new birth centre was enhancing the care of women in the high-risk labour ward by ensuring that women were treated in the environment most appropriate to their needs. The team leader for the birth centre said that, "low-risk women experienced a reduction in intervention rates when cared for within a culture of normality receiving one-to-one care from experienced midwives with excellent clinical competencies and decision-making skills".
- Although no data was provided at this early stage, the Abbey Birth Centre was reporting improved outcomes for reduced uptake of pain relief, mobility in labour, less use of Syntocinon for augmentation of labour and fewer operative deliveries.

Competent staff

- The ratio of midwives to supervisors of midwives was 1:18 against a trust target of 1:15. We were informed that the high turnover made this a continual challenge but that new midwives were completing the supervisors' training programme and they would improve the ratio. There was a supervisor of midwives on call 24 hours a day who must be informed of specific issues such as any staffing affecting safe clinical care.
- Maternity support Assistants were to be trained to complete baby's observations.
- We were informed that that there were some delays in 'tongue tie' referrals but that midwives were to be trained to treat these cases. This was recorded in meeting minutes.
- Evidence of training in the care of critically ill women was seen. A presentation contained information on how to complete modified early obstetric warning score charts and there was information on the escalation pathway for warning triggers.
- We saw the slides from a presentation on 'Care for critically ill women: the role of the midwife'. This presentation covered: sepsis; risk factors in pregnancy; common signs and symptoms; and what tools to use observations and treatment, (such as the modified early obstetric warning score chart for respiratory and pulse rate and blood pressure).
- We were informed by senior managers and clinical staff that a coaching system had been introduced to enable staff to develop solutions to problems.
- We spoke with a new midwife and maternity support assistant on the postnatal ward, and both confirmed that they had attended the trust induction programme and had received ongoing training in their first year at the trust.
- Two members of staff on the labour ward told us they were aware of how to use the obstetric emergency equipment and knew where to find it. They said that they had participated in live 'skills drills' on the labour ward to practise their response to emergency situations.
- The associate director informed us that the service was a little behind with appraisals and that only 60% of staff had appraisals this year. She said that the reason was a change in the trust process and that they had "got a bit behind because they had been focusing on other things".

Multidisciplinary working

- We observed multidisciplinary working at a range of meetings, including the daily ward handover sessions, incident reporting meetings and perinatal mortality meetings. This included discussion of any transfers from the Abbey Birth Centre to the NICU (level 3).
- The consultant for obstetrics and gynaecology informed us that there were regular educational half-day meetings involving midwives and other healthcare assistants, including physiotherapists, ultrasonographers and anaesthetists. These included sessions on 'skills and drills'.
- The consultant also said that there were monthly teaching meetings with an emphasis on updating and reviewing any serious incidents or 'near misses'. He said that, for example, they had examined and learned lessons from a maternal death that occurred in 2013.
- We were informed by several members of staff that communication between midwives and doctors had improved since the new associate director of midwifery and gynaecology had arrived. Midwives were now being encouraged to escalate problems upwards at the appropriate time.

Maternity and gynaecology

- Multidisciplinary meetings were held weekly to discuss the details relating to each caesarean section.
- We heard a consultant discussing with the community midwife and an obstetric registrar the care of one woman who had been brought into the hospital for induction of labour, to understand why the induction had been booked and the arrangements made by the family.

Seven-day services

- Maternity services provided the whole range of provision seven days a week. The workload was unpredictable and susceptible to peaks in activity.
- There was medical cover, a consultant obstetrician and an anaesthetist, 24 hours a day.

Are maternity and gynaecology services caring?

Good

We spoke to 10 women and their partners and they all said that the maternity services were caring and staff were compassionate. Most of the women and their families said that they felt involved in their care, that they understood what was happening and that the staff had explained it well. Some patients felt that, when the service was particularly busy, they were left alone for long periods or with the less-experienced staff.

There was an effective counselling service offering sensitive emotional support. Feedback for the birth centre was particularly positive.

Gynaecological surgery is performed at Ashford Hospital and gynae-oncological surgery is mainly performed at Royal Surrey County Hospital NHS Foundation Trust. We visited some patients on the Kingfisher Ward and they told us that they were happy with their care.

Compassionate care

- The trust scored higher than the England average for maternity services. We saw some of the recent feedback and saw that the Abbey Birth Centre also had the best score for September 2014 when compared to the other 23 wards across the trust.
- One of the comments read: "Wonderful, wonderful, wonderful! 10 out of 10, 5 stars and every compliment I can think of." This person goes on to say: "The midwives were beyond anything we have dreamed of, everything that was done there was with real empathy, caring and understanding combined with exceptional knowledge and skill. A delightful experience for us and our baby".
- The postnatal ward also had a good score for September 2014 and an average of 4.73 out of 5 would recommend the service from 65 respondents from the NHS Friends and Family Test.
- We saw visitors being greeted and helped with queries by staff on the postnatal ward. Staff were compassionate, considerate and reassuring.
- We spoke to four patients on the postnatal ward who said, "The midwives and assistants have been lovely but I have not seen a consultant".
- The visitors book in the birth centre was full of positive feedback such as "amazing experience – would do it all again. Staff were friendly, helpful – couldn't have done it without them. Thank you all so much!"
- We spoke to one couple who commented, "They said I was not in labour so we were sent home only to turn around and come straight back because the traffic was heavy and the baby was coming".
- Another couple said that they "felt we were left with two trainees and we were anxious until the experienced midwife arrived".

Understanding and involvement of patients and those close to them

- The trust scored better than other trusts in the CQC maternity survey for advice at the beginning of labour.
- Overall comments were positive but one respondent to the NHS Friends and Family Test said: "Felt slightly bullied into doing something by a certain midwife. She also made me feel useless by taking over bottle feeding and changing my baby".
- Some women and their partners had a mixed response. One couple reported having been left on a monitoring machine for over an hour when they had been told it would take just 30 minutes. When they asked why, they were told it was just because the unit was busy. The same couple felt that they had not been given all the facts by the doctor and had discovered an issue by having a scan elsewhere.
- Another couple said: "All our questions were answered and there was good quality care".

Emotional support

Maternity and gynaecology

- The maternity service had an effective counselling service for families requiring support with pregnancy and birth or with anxiety, depression or loss.
- At the time of our visit, we saw a sensitive approach to some parents who were bereaved where the counsellor visited the ward to provide support at a difficult time.
- The service offered bereavement support and guidance on the options and facilities available for sensitive funerals and burial.
- The counselling service also collected feedback through 'birth reflections' and these were shared to continually improve the quality of the service.
- We also saw how staff in general, midwives and doctors, dealt with issues sensitively and offered emotional support to women and their families.

Are maternity and gynaecology services responsive?

Good

The service was responding to the changing needs of local people and planning new pathways of care to cater for families with complex social needs. With the opening of the Abbey Birth Centre, the trust service was providing greater choice for local women.

Access and flow was being closely managed and the maternity services had not closed for almost two years. The number of complaints received were monitored through the maternity dashboard and information shared via the staff newsletter.

Service planning and delivery to meet the needs of local people

- We saw that staffing was flexible and midwives could be redeployed to help out at busy times.
- The service supported pregnant women from the local prison and delivered 20 to 30 babies each year.
- The service was working to improve continuity of care with the same midwives providing care in the community and in the birth centre.
- About 2% of births were home births supported by community midwives.
- In response to feedback through the NHS Friends and Family Test and the maternity services liaison committee, visiting time had been extended. One woman on the postnatal ward said: "He has been able to stay with me all the time and we have not felt under pressure for him to leave".
- Further work was planned to support women with complex social needs as identified in the external review of the service completed in July 2014. This included women and families whose first language was not English and needed to use interpreters.
- There was a specialist nurse for women with diabetes and an established care pathway for diabetes.
- There was a lead consultant for mental health and the service was also recruiting a midwife to lead on mental health.
- There were further plans around women with high-risk pregnancies, for example, because of a raised BMI. The criteria for giving birth in the Abbey Birth Centre had been changed to include a BMI up to 33. In addition, the development of the family nurse partnership in Surrey is intended to provide young mothers with additional support by senior midwives in the community.
- A pull-down double bed was available for partners to use to stay on the Abbey Birth Centre. There were some facilities on the labour ward in the 'low-risk' rooms.
- The service worked collaboratively with the maternity service liaison committee, with senior midwives attending committee meetings to provide support and information.

Access and flow

- We were informed, and the data confirmed, that the unit had not been closed since January 2013.
- Over 90% of first-time bookings were on target.
- The CQC's Survey of Women's Experiences of Maternity Services for 2013 demonstrated that women who used the call button in this service received a response similar to that in other trusts in England.
- The average length of stay in the Abbey Birth Centre was between six and 24 hours. The target number of births for the first year of the birth centre was 360. The projected number of births, based on the first six months, was for about 550 births in the first year, or 45 a month. The target for births in the longer term was for 60 a month.

Maternity and gynaecology

- The criteria for admission to the birth centre were very clear and, in cases where labour was not progressing normally, women were transferred to the labour ward. The overall transfer rate was 29% in July and August 2014.
- We were informed that waiting times in the antenatal clinic had been an issue and the service had recently introduced a new numbering system to improve the situation. We observed an effective handover meeting between the labour ward shift lead and the postnatal ward manager, to identify capacity issues, update on the progress of high-risk women and agree who could be transferred between the wards, and when. We were informed that this meeting occurred each week day and the ward manager was supernumerary. At the weekends the shift leaders completed the task by telephone.
- A business plan had been written and agreed to release midwives from the responsibility of assisting with caesarean sections in theatre. Instead, this role would be performed by specialist nursing staff, making more time available for midwives to offer one-to-one care to women in labour and to support the midwifery work on the labour ward. This will reduce delays in theatre and improve the service to women in labour.
- There was a long-term plan for a general theatre team to take over responsibility for the recovery and observation bay on the labour ward. This would allow midwives to develop high-dependency skills. Some staff have been identified to attend an external education course on high-risk care. This initiative was in response to the growing number of higher-risk women using the service, including women with a raised BMI.
- We attended a handover meeting on the labour ward including the ward manager, midwives, the consultant for obstetrics and gynaecology, registrars, senior house officers and an anaesthetist. There was a discussion of each patient listed on the board and who could be transferred to the postnatal ward.
- We were informed that there were occasional 'flow' problems from the labour to the postnatal ward.
- Where the services were busy, elective caesareans could be delayed until the following day. There was no dedicated list for caesareans and these operations shared the same resources with the team performing emergency caesareans. This issue was on the risk register.

Meeting people's individual needs

- The associate director of midwifery and gynaecology provided us with a recent maternity staffing report prepared in November 2014. The report said: "The maternity staffing model focuses on a need for a flexible, adaptable and responsive workforce. This is particularly true of midwifery staff where the requirements of women are not only health-related but also need addressing in a social and cultural context with care encompassing the whole family".
- We met with the diabetic specialist midwife and reviewed the pathway for pregnant women who were diabetic. We noted that the specialist midwife received early referrals and was able to facilitate early intervention to improve outcomes for women and babies. Early pregnancy referrals were faxed through to diabetic midwives.
- Diabetic clinics were run weekly with a range of multidisciplinary staff attending, including midwives, an endocrinologist, a specialist diabetes midwife, dietician and a consultant obstetrician with a special interest in diabetes. We were informed that the number of pregnant women with diabetes attending was increasing due to age, ethnicity and BMI. Where women failed to attend these clinics, the diabetic nurse liaised with the community midwife who followed-up with the women.
- We were informed of the plan to recruit a specialist midwife for mental health in 2015. This was a recommendation following the external review. This post holder would work alongside the safeguarding midwife.
- In response to NHS Friends and Family Test feedback, ward visiting times had recently been extended to allow partners to visit for longer.
- We heard how the chair of the maternity services liaison committee had supported the service in setting up a breastfeeding room. We were informed that this was particularly appreciated by women who were feeding their babies at night and did not want to disturb others on the ward.
- Partners were able to stay with women in the birth centre where there were pull-down beds and ensuite facilities. Some of the rooms on the labour and postnatal wards had ensuite facilities.

Learning from complaints and concerns

- The service received 21 complaints between April and October 2014.

Maternity and gynaecology

- Feedback from the complaints was shared across the service via a monthly newsletter. Learning from complaints was shared and changes were made in response, including extending visiting hours, and providing better access to information on transfer to the postnatal ward. Staff told us that they were involved in investigating and learning from complaints.
- Complaints usually came first to the associate director of midwifery and gynaecology and then would be passed to the unit or ward manager to deal with. Often the first stage would be to invite the complainant in to discuss the complaint and find out what outcome they wanted. Depending on their response, this would be followed up by actions and a formal written response. Staff would be involved as appropriate and the learning from the complaint would be shared across the service.

Are maternity and gynaecology services well-led?

Requires improvement

Overall we found that the improvements were required in this domain for the service. We found a considerable number of staff had been impacted by what had been acknowledged as some inappropriate leadership behaviours. The new Associate Director of Midwifery had been in post for 14 months and a new engaging leadership style was evident.The current leadership team had developed a vision and were working on an action plan following the external review which focused on quality and team work

Midwives were proud to work for the trust and felt there was an open and friendly culture, pride in the service and excitement for the future.

Staff within the service told us that they understood the vision and strategy for the service and had a sense of direction and purpose. The vision and strategy was contained in several documents. The business plan included clear, longer-term goals for maternity services.

The trust-wide audit process was being well-received by staff and the governance and risk arrangements were clear and working well. The current leadership of the service was appreciated after a period of more limited progress.

Vision and strategy for this service

- The 13 staff members who attended a focus group for midwives were able to describe the vision and strategy for the service. They said that they offered, “safe and compassionate care with an emphasis on a normal birth where appropriate”. Some midwives said that, with the new Abbey Birth Centre and the emphasis on ‘normal’ births, there was a danger of “over-medicalising” the labour ward.
- Other midwives spoke about how the sense of direction had become much clearer in recent months and that levels of engagement and participation in decision-making had improved.
- The associate director told us that the vision and strategy was set out in multiple documents, across the business plan, education strategy and the maternity staffing report.
- The business plan for 2014/14 contained some clear goals for normal births, increasing choice and reducing the rate of caesarean sections.
- There was a great deal of clarity around the vision and strategy of the birth centre.

Governance, risk management and quality measurement

- The maternity dashboard was being used to monitor performance and quality against a range of targets. A separate dashboard for the Abbey Birth Centre included targets for increasing the gradual migration of appropriate birth to the birth centre to one in six of all births.
- Governance arrangements were appropriate and working well, including the incident report and investigation process, the risk management system and the processes for escalation. The associate director attended the incident reporting meetings.
- The associate director had oversight of all maternity issues on the trust’s risk register and attended the trust governance committee as required.
- The local supervising authority midwifery officer undertook an annual review of the maternity service, benchmarking it against others in the region.
- The report for 2013 found improvements in the following areas: there was 100% submission on the local supervising authority database for the preparation of midwives for supervision of midwives; the ratio of

supervisors of midwives to caseload had been evened out to create greater equity; and the profile of supervisors of midwives had been raised in the service through the use of photo boards and leaflets.
- All midwives had a named supervisor of midwives. The supervisory completion activity rate was 93.6% for 2012/13.
- Seven investigations of incidents had been completed in 2012 and student midwife meetings had begun.
- The annual review reported that the supervisors of midwives team demonstrated an improvement and impact on the wider governance agenda through: mentorship of student midwives which was now evaluated by the university; the 'Women First' questionnaire had been developed to inform supervisors of midwives meetings; and an evaluation of the service had highlighted that the service was working well, although the day assessment unit needed improvement.
- The trust-wide audit process Best Care Measurement was well-regarded by the staff we spoke with and they said they found it "motivational".
- The external review of the maternity services was also a constructive process for measuring quality and improving the performance of the service.
- The associate director of midwifery and gynaecology informed us that they had access to the Trust Board through the divisional director and associate director of operations.

Leadership of service

- The associate director of midwifery and gynaecology had been in post for 14 months and was well-respected and "clinically credible". We were informed that "she does what she says she will and is supportive".
- We were informed that managers were being held accountable for their performance and encouraged to engage in decision-making.
- Members of staff at all levels within the service said that the trust had been slow to act on poor leadership performance in the past. This had contributed to an extended period of time where the service had not progressed as well as it should. This had improved and all staff we spoke with said they were more engaged in decision-making and optimistic about the future.
- In addition, we were also informed by about 20 members of staff that the trust was too tolerant of the unhelpful behaviours of a minority of staff in key clinical leadership positions. This was mentioned in a number of meetings and it was referred to in the report of the external review undertaken in January 2014 and completed in July 2014. The report highlighted several areas where improvements could be made in team working including the engagement of the whole medical team in maternity work and recommendations for the service to provide more opportunities for multidisciplinary working and training and to tackle problem behaviours and bullying, and empower staff to be able to challenge and speak up. The report also recognised the associate director of midwifery as being a positive influence in the future of the unit.
- The current leadership team had developed a vision and were working on an action plan following the external review which focused on quality and team work. The action plan which identified work was taking place to address the issues raised by the external review was provided as part of the inspection.

Culture within the service

- Overall, we found the culture within the service to be friendly, open and transparent.
- The midwives who attended the focus group said that they were, "proud to work for the trust and in the maternity service". However, they also said that the culture within the service had improved in the last year and they could now see "exciting opportunities ahead".

Public and staff engagement

- We spoke with the chair of the maternity services liaison committee. This committee met bi-monthly and the meetings rotated around children's centres and hospital venues. Meetings were attended by user representatives, managers of the service, supervisors of midwives, midwives and members of the National Childbirth Trust. They discussed issues such as waiting times in the antenatal clinic, information required on transfer from the labour to the postnatal ward, and visiting times on the wards.
- The chair informed us that there was a collaborative relationship between members of the committee and the trust and that engagement was encouraged. The chair "walked the patch" regularly and reported findings to the committee, such as: "Midwife care during labour was excellent"; and "Better information is required about the facilities available for new mothers on the postnatal ward".

- The committee was using social media to increase participation and the progress of this was reported within recent meeting minutes.
- The committee members were active in promoting and improving the services, particularly the birth centre and the development of a new room for breastfeeding. The committee were also aware of the level of activity in the service. In July the minutes of the meeting recorded: "Busy summer for maternity services; last month had the highest number of bookings for the year". The committee were also involved in resolving some of the challenges, including the issues around recruitment and retention of midwives and the plans for a possible midwife-led healthy eating clinic.

Innovation, improvement and sustainability

- The service was making improvements as a result of the new leadership of the service and in response to the external review.
- These improvements included the development of public health pathways and the development of services for women and families with complex social needs.
- A new midwife with lead responsibility for mental health was to be appointed shortly and the service was preparing to participate in the Perinatal Institute's initiative for growth-restricted babies.
- The associate director was also developing the strengths within the senior team.

Services for children and young people

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

Information about the service

Paediatric services were located on the St Peter's Hospital main site. St Peter's Hospital provided 23 inpatient beds plus four day assessment beds (Ash Ward), 12 day surgery and oncology beds (Oak and Little Oak Ward), eight transition beds (where babies and mothers stay together, babies were looked after by neonatal nurses and mums by postnatal ward staff). There were a further 24 cots in the level 3 neonatal intensive care unit (NICU) – consisting of eight intensive care, four high dependency and 12 special care – paediatric A&E (reported on under the A&E section of the report) and paediatric outpatients (reported on under the outpatient and diagnostics section of the main report). Community paediatric nurses employed by the trust were based at the hospital and worked in the local community. There was also a school on site (run by the local authority).

We spoke with 40 staff, including nurses, consultants, medical staff and support staff, five parents and five children and young people during our inspection. We visited all of the paediatric wards and departments within the hospital and observed care, looked at care records and other documents in each of the areas visited.

Summary of findings

Services for children and young people were found to require improvement, with safety requiring some improvement. Children received good care from dedicated and caring staff who were skilled in working and communicating with children, young people and their families.

Children and their families were involved in their care and treatment and their feedback regularly sought and listened to. We had positive comments from all of the parents and children we spoke with. We observed positive, inclusive interactions with babies, children and their families.

The arrangements for safeguarding had recently been reviewed and new policies and procedures were in place. As a result, the systems were not yet embedded in practice. Staff told us about the developing culture that encouraged them to report issues as they arose.

Services for children and young people required improvement in the well led domain. Staff on Ash Ward told us they had not had any formal leadership for the last six months and it had been a very difficult period. We were told of a number of new appointments to senior posts that were just about to start, meaning that all of the wards and departments would have their current designated senior posts filled. A Recent senior

Services for children and young people

nursing staff appointment had been welcomed as there had been a period of time without leadership within the paediatric services. Staff told us positive changes had started to happen as a result.

Due to lack of beds regionally, Ash Ward sometimes provided high dependency care in the 'close observation' bay. This put extra pressure on staff as the ward was not funded for this and did not have the resources required to meet the needs of these children. Despite that, the staff provided good care to these children and their families.

The NICU and Oak Ward (day surgery and oncology day care) functioned well with appropriate systems and procedures.

Accommodation was available for parents who had babies in the NICU and letters and cards displayed in the unit showed how important that was so parents could be close to their babies at all times.

Separate areas for adolescents had been created on Ash Ward and those using the facilities during our visit appreciated the efforts that had been made.

The play therapy team was very active in supporting children and their families. They worked well together as a team and provided a six-day-a-week service – soon to be seven days a week once one person had completed their training. The team had won a £3,000 prize for innovative ways of improving the play room.

Are services for children and young people safe?

Requires improvement

Records were child-centred but not always fully completed. The staff used the Paediatric Early Warning Score (PEWS) system very well to identify whether a child's condition was deteriorating. However, this did not include a pain score.

Updated children-specific safeguarding procedures had not yet been embedded in practice. Following a recent safeguarding incident, a registered mental health nurse was on duty 24 hours a day on Ash Ward. This was time-limited and we were not clear about what would happen once the timeframe had expired.

On Ash Ward we found that medication fridge temperatures had not been consistently recorded. Rooms used for medicine storage on Ash and Oak wards were too hot at times. This had been recognised by the trust and a business plan was being developed for wall-mounted air-conditioning units. Medicines were stored securely and the stocks were subject to regular checks by the on-site pharmacy team. Following investigation of two recent drug errors, it was found that on Ash Ward medication management training for nurses was 69% completed. Steps were being taken to ensure that all staff received up-to-date training in this area.

We saw good infection control practices, with most staff washing their hands or using hand sanitiser as required. The play specialist team selected toys that could be suitably cleaned to reduce the risk of cross-infection.

We were not assured there was a robust system for handover of a child at the operating theatre to confirm with a parent that the child was receiving the expected procedure.

We were told there was a hot drinks policy that had, until recently, been displayed on Ash Ward. We saw a potential incident with a hot drink averted by a parent who removed it from a trolley on wheels which a young child was about to grab. We were assured that parents and staff would be reminded of the policy.

The appointment of several senior members of nursing and management staff in the last three months meant that

clear leadership was now in place throughout the paediatric departments. Staff told us they had seen positive changes, felt supported and were now looking forward to the future. There were still staff shortages but recruitment was ongoing and staff were aware that a staffing review was underway to ensure that all areas had the required levels of staff. An acuity (dependency) rating tool was not used but was being introduced in the near future.

Ash Ward often admitted children that needed high dependency care, although the ward was not funded or equipped for this type of care. Discussions were ongoing with the local care commissioning group (CCG) who funded the services provided.

Incidents

- The paediatric department had systems to make sure that incidents were reported and investigated appropriately. Staff told us that they would have no hesitation in reporting incidents now, although in the past they had been discouraged from doing so, particularly around staffing levels. Staff told us they sometimes received feedback after reporting an incident. This was reported to have increased since the associate director of nursing for paediatrics had started in post in September 2014.
- Staff gave us examples of actions that had been taken to reduce the risk of similar incidents occurring and how patient safety had been improved – for example, how medicines were checked and dispensed.
- Within the paediatric department, two serious incidents had been reported between April 2013 and March 2014.
- We looked at the investigations around the incidents. They were thoroughly investigated with identified learning and actions to reduce the risk of similar incidents in the future. Information was disseminated via department meetings and safety briefings.
- A recent safeguarding incident had occurred and, although systems were put in place to prevent it happening again, the seriousness of the situation had not been grasped by the staff on duty and a similar incident happened again the following day. Immediate actions were taken by the associate director of nursing for paediatrics to reduce the risk of a similar occurrence.
- Mortality and morbidity meetings were held. We saw minutes for the paediatric meeting and the neonatal meetings for September 2014. Several cases were discussed in detail, with learning points noted for each case. We were told that the minutes, including learning points, were made available to relevant staff and ward or unit meetings.
- The pharmacy team said there was no communication from pharmacy to disseminate learning from medicine incidents within the trust. However, the trust provided an example of a lessons learned newsletter (edition no. 2 October 2014) which discussed incidents within the trust and how to access training. Although this was available, not all staff were aware of it.
- Staff across all paediatric disciplines did not recognise the term “Duty of Candour” t regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided). However, their description about how complaints and concerns were managed assured us they were implementing the principles of the Duty of Candour and kept families and children informed about how their concerns and complaints were being managed and outcomes shared.

Cleanliness, infection control and hygiene

- In all wards and departments we visited, we observed most staff at all levels washing their hands and using hand sanitiser according to the trust’s policy. There were times on Ash Ward where we saw staff not adhering to the policy. We observed the appropriate use of personal protective equipment such as aprons and gloves. There were sufficient hand-washing sinks and hand gel dispensers in each area. All the ward and department areas we visited looked clean and tidy and individual cleaning schedules were being maintained.
- Hand hygiene audits from September 2014 showed the NICU to be 97% compliant, with Ash Ward 100% compliant. Oak Ward showed several months where the information had not been submitted for inclusion in the audit. The same audit for November 2014 showed 100% compliance for Oak Ward and the NICU, and 90% compliance for Ash Ward.
- There were infection control link staff on the NICU. They acted as a resource for staff within their clinical area, conducted audits and assisted with teaching other staff on infection control principles.
- Where children or young people were potentially suffering from or had an infectious condition or had a

poor immune system, single side rooms were used to reduce the risk of cross-infection. Where this was necessary we saw signs informing other staff and visitors of what precautions they needed to take.
- The operating theatres used for paediatric lists were clean and daily cleaning checklists were used and reviewed weekly for compliance. Equipment was stored in dedicated storage areas. Staff wore theatre scrubs and we saw appropriate use of personal protective equipment such as gloves, aprons and masks.
- The play specialist team selected toys that could be suitably cleaned to reduce the risk of cross-infection.

Environment and equipment

- All the wards and units we visited had a mixture of two- and four-bed bays and single rooms. Separate toilet facilities were available for children, parents and staff. The NICU had a separate four-room facility for parents to use so they could be near their babies. It included a sitting area, a kitchen and shower facilities. Letters and cards on display in the unit showed how families appreciated the accommodation.
- Each ward/unit had secure access to maintain the safety of the babies, children and young people. Staff were able to control access to their departments via a keypad system. The paediatric outpatient doors were open during clinic times but there were always staff at the reception desk to monitor who was accessing the department.
- Each ward/unit had resuscitation equipment appropriate for babies, children and young people. We saw that this equipment was checked daily and that this checking was carried out consistently.
- Equipment was serviced according to the manufacturer's instructions.
- We visited the NICU and found that each bed space had the necessary equipment. Machines with batteries were plugged in to the mains to make sure that the batteries were charged. We saw that the equipment used when transferring neonates to other hospitals was checked daily and batteries charged as required.
- The play specialist team had won £3,000 for innovative use of resources in changing and brightening a children's play area.

Medicines

- On all the wards/units we visited, we found that medicines were securely stored. Medicines were kept within a locked room accessible only by staff. Controlled medicines were stored in separate locked cupboards and were checked daily by two qualified nurses. The pharmacist had completed a check on 26 November 2014. Where medicines needed to be kept in fridges, the temperature of the fridges was checked daily, apart from Ash Ward where they had not been checked since 27 November 2014. Prior to that, minimum and maximum temperatures had been recorded which were within the required range.
- We saw that room temperatures were recorded where medicines were stored. Ash Ward was too warm at 26oC (25oC and below is the recommended level), and we were told that Oak Ward was hotter, even though there was an air-conditioning unit in place. An interview with the chief pharmacist showed 12 areas that had been identified trust-wide where 25oC was exceeded on a regular basis. A business case for wall-based air-conditioning in these areas was being written.
- We saw allergies recorded on prescription charts and no missed medication doses were seen. On Ash Ward we saw that only one prescription chart gave reasons for administering as required medicines. We saw the policy used if a medication error occurred, including investigation, re-training where necessary and competency checks following the investigation.
- We noted that pre-packed tablets to take home were sometimes not available for commonly used items such as soluble Prednisolone meaning each discharge supply was being individually dispensed by a pharmacist, sometimes delaying a discharge. However, where take-home packs were available on the wards, they were issued. Nurses double-checked and recorded the issue. There was a clear audit trail and staff were able to respond easily to any queries about what medicines the patient was discharged with.
- We saw there was good access to medicines out of hours, with an emergency cupboard and a list on the trust's intranet about which wards medicines are kept on.
- There was good access to medicines resources, including current children's drug formularies.
- The associate director of nursing for paediatrics explained that, as part of investigating two recent drug errors on Ash Ward, they had noted that medication

management training for nurses on Ash Ward was 69% completed. They were ensuring that all trained nurses completed the training to ensure the safety of the patients.
- Where medication administration errors had taken place, we saw evidence to show that they had been reported and investigated in line with the trust's incident-reporting procedures. Where necessary, appropriate action had been taken to prevent their recurrence.
- We saw there was a ward-based paediatric pharmacy service with a good seven-day and overnight on-call pharmacy team.

Records

- Medical and nursing records were stored in trolleys at the nurses' station. Although they were not locked away, there was no personal information on view and at no time did we see the nurses' stations left unattended. Nursing monitoring charts such as fluid charts and observation charts were kept at the end of each child's bed or outside their side rooms.
- We looked at five combined medical and nursing records in all the areas we visited. We saw that they were mostly clear, detailed notes that reflected each baby's and child's care and treatment. Entries were signed and dated in accordance with the trust's record-keeping policy. We saw one set of notes that did not have the name of the child or their age on the preoperative checklist. This did not ensure safe practice and therefore the safety of the child.
- In the records we looked at, we saw that core screening had been completed for each child; this included risk assessments for the patient's safety, infection control, pressure areas and moving and handling. We saw that care plans were in place; while these were generic paediatric core care plans, they were individualised for each child depending on their needs.
- Observation charts (temperature, pulse, and so on) were available for children and young people of different ages. These charts were comprehensive and included PEWS scores. In the notes we looked at, we found that these observation charts had been completed consistently, apart from Ash Ward where they were not always completed as often as they should have been. During an unannounced visit to Ash Ward, despite the fact the ward was extremely busy, the two children whose cases we tracked who had been admitted from paediatric A&E that day did have care plans for intravenous fluids and antibiotics.
- The paediatric departments used standardised admission, assessment and observation charts across all the wards and departments. Integrated care pathways were used within day case surgery and incorporated preoperative checklists and anaesthetic care through to postoperative care.
- The records we looked at during our visit showed that the admission and discharge paperwork and checklists had been completed appropriately.
- We were told that there was no administrative support for the community paediatric nursing team which added pressure to the already depleted team and meant that staff often completed records in their own time.

Consent

- We were told that consent was obtained for all children who were admitted for surgery requiring written consent or for a procedure at the preadmission clinic or prior to surgery itself. The consent forms included details of the specific procedure and the potential risks and complications of surgery.
- It was clear during discussions with staff that they used the principles of the Gillick competencies (used to help assess whether a child has the maturity to make their own decisions and to understand the implications) when making decisions about people's ability to consent to procedures, especially with adolescent patients.
- Consent was obtained from parents or carers for each child or young person. Staff were aware of the appropriate procedures in obtaining consent. We saw staff talking to and explaining procedures to children in a way they could understand.
- We followed a child from the ward through to the anaesthetic room and observed theatre staff checking the details on the consent form with the parents only and not a member of the ward staff. This only provided a double-check system that the correct child had been called for the correct procedure and placed too much responsibility with the parent.

- We saw examples of how staff on each ward/unit involved children and young people in their care and treatment and would seek the child's consent prior to doing anything, for example, taking a temperature or pulse.

Safeguarding

- The trust had recently strengthened their safeguarding team. The team were establishing their roles and providing support to the associate director of nursing for paediatrics following a recent serious safeguarding incident.
- As a result of the incident, the trust had ensured that Ash Ward had a permanent registered mental health nurse presence. This was to provide one-to-one support to patients with mental health issues and was to be reviewed after six weeks. It was not clear how this support would be maintained in the long term.
- Records showed medical and nursing staff were trained to level 3 in children's safeguarding and relevant ancillary staff were trained to level 2. We saw evidence to show that the majority of staff had completed their training and that it was up to date. Those staff who had yet to complete it or who required a training update had dates scheduled for their training. Some staff we spoke to said they had received training but were not sure at what level.
- An updated safeguarding policy had recently been introduced across the trust. The staff we spoke with knew how to access the policy and were able to explain the different types of abuse. We were not assured that the new policies and procedures were yet embedded in practice in the paediatric departments. There had also been a reluctance to report incidents in the past and, although the culture had changed in recent months, we were not assured that all staff were aware of the importance of accurately reporting incidents, including safeguarding issues.
- The patients' notes had a system to alert practitioners to any child where safeguarding concerns were already known. This made staff aware of additional things that might need to be considered for that individual child.
- Where children or young people failed to attend two clinic appointments, a referral would be made to the safeguarding team and contact would be made with the child's GP and health visitor to find out if there were any issues for concern.
- We saw minutes for the trust's safeguarding children steering group for September and November 2014. They showed detailed discussions about policies, training and staff responsibilities in relation to safeguarding children.

Mandatory training

- The trust held central mandatory training records for all wards and departments, including the paediatric departments. We looked at the training records for paediatrics and they showed that all staff were either up to date with their training or had training days scheduled.
- The staff we spoke with all confirmed that they were up to date with their mandatory training. They said that very occasionally they had to cancel attending due to work pressures but they were usually able to attend soon afterwards. Staff said the trust held training in high regard and they were always encouraged to attend.

Assessing and responding to patient risk

- Each child had a paediatric nursing assessment on admission. These included risk assessments in relation to manual handling, nutrition, pain and pressure ulcer risk. These were all completed in most of the records we reviewed during the inspection.
- All the wards and departments used the PEWS system.The scores helped staff recognise when a child's condition was deteriorating and when to seek further help and support from medical staff. The staff we spoke with were all very familiar with PEWS and problems had been escalated appropriately in the records we looked at.
- Anaesthetists visited all children on the ward prior to surgery to check consent and preadmission details and to explain the anaesthetic procedure to the parent and the child (where appropriate).We were told that parents were given time to ask questions to ensure they understood the procedures.
- World Health Organization (WHO) surgical safety checklists were used in theatres. The staff we spoke with were all aware of the checks that needed to be done to make sure that consent had been obtained for each child for the correct procedure. We saw staff completing these checks appropriately in the anaesthetic room. We observed that, once a child arrived at the operating theatre, the accompanying nurse left and the theatre staff checked with the parent that the procedure was

what they were expecting to be carried out for that child. We brought this to the attention of the associate director of nursing for paediatrics as we were not assured that this was a robust system, with perhaps too much responsibility on the parent.

- When children were moved to the recovery area after their operation, the staff followed discharge criteria to make sure that children were safe to return to the wards. Parents were allowed to be with their child once they were awake and a qualified nurse escorted the child back to the ward.
- There were occasions when children were seen in adult outpatient settings, for example dermatology. We were told these departments had good communications with the paediatric team and that, with planning, a paediatric nurse or play therapist could attend the clinic to help with distraction if required.
- We saw evidence of the use of a Situation, Background, Assessment, Recommendation (SBAR) document between the paediatric A&E and Ash Ward. SBAR is a recognised communication tool to ensure that appropriate information is handed over verbally and an adequate response is received.
- We saw an incident on Ash Ward, where a toddler grabbed the side of a wheeled trolley where a parent had placed a hot drink. The parent noticed in time and moved the drink. We asked staff if there was a policy about parents and staff putting hot drinks on trolleys with wheels and in reach of small children. We were told the policy was available and, until the recent refurbishment, had been displayed on the wall of the ward. Staff told us they would make sure parents and staff were reminded of the policy.
- Ash Ward had a close observation bay where they sometimes looked after children who were assessed as needing high dependency unit (HDU) care. The ward was not funded or designated as a HDU, meaning it did not have the staffing levels to manage these children. However, the staff worked hard and made sure the children and families got the support they needed. We were told that all trained staff looking after these children had advanced paediatric life support training. We were told the trust were in ongoing discussions with the local CCGs to agree HDU status.

Nursing staffing

- There had been significant changes in senior nursing staff since September 2014. This included a new associate director of nursing for paediatrics, a governance lead and clinical practice educator. Prior to this, Ash Ward and the NICU had been without a ward manager for some time. NICU nursing staff had been able to work through this as they had enough staff to cover essential aspects of the role. However, on Ash Ward there had not been enough staff to cover the shortfall and so the ward lacked the presence of a person in the leadership role. The ward Clinical Nurse Leader from Oak Ward was covering both Oak and Ash wards during our inspection to provide some leadership. This meant they were spending time on both wards clinically and in a management capacity.
- We were told a new Clinical Nurse Leaders had been appointed for Ash Ward and would be starting work in January 2015. Staff were very much looking forward to this appointment and felt that staffing levels and leadership would improve. Staff felt these improvements had come about since the associate director of nursing for paediatrics had started in September 2014 and thought this person had recognised their difficulties and was working quickly to resolve them.
- The community paediatric nurse we spoke with told us they had had severe staffing issues in the last few months and had not been able to provide a service on a Monday for several weeks. A senior nurse (band 7) was starting work with the community paediatric nursing team on 8 December 2014, so we were assured a seven-days-a-week service would be resumed. This would also allow for a more reasonable on-call rota for end of life children and young people.
- The associate director of nursing for paediatrics told us there was no acuity (dependency) tool used to decide on staffing levels within the paediatric departments. They said that, since starting in post in September 2014, they had begun a review of the current staffing establishment to help decide if there were enough staff, especially on Ash Ward where the dependency of the patients could be high at times. They were aware that a Paediatric Acuity Nursing Dependency Assessment Tool (PANDA) was to be introduced in the near future. A skills mix review was underway to ensure that the balance of staff was correct for the amount and dependency of children the paediatric department looked after.
- The paediatric departments had some staff shortages. Regular adverts were placed for skilled paediatric nurses and the trust was exploring new and innovative ways to

attract and keep staff. On-site parking, poor public transport systems and the cost of housing was an issue for all grades of staff in the trust and was cited as a reason the trust could not always recruit and retain staff. Staff housing was available on site and we were told this was a great advantage for those who could use it.

- The paediatric department's staffing generally complied with the standards set by the Royal College of Nursing and had a nurse-to-child ratio of 1:4. This did not take in to account the HDU-type patients they looked after or the skills mix of the current staff group. This ratio was increased to 1:2 for the NICU high-dependency areas and increased again to 1:1 in NICU intensive care areas.
- Where there were shortfalls in staffing due to sickness or annual leave, staff within the particular clinical area would be flexible and cover shifts. Where this was not possible, bank (overtime) staff were used and, as a last resort, agency staff would be employed. Procedures were used to request additional staff. During our observations on Ash Ward we saw one member of staff had to leave the shift for personal reasons and another had to go off sick. This left the ward with less cover than they should have had. At the same time, a new admission arrived from the paediatric A&E department. Although this added additional pressure to the staff, they absorbed the extra work and continued to be pleasant and professional to the parents and children in their care. Staff told us the ward was often short of staff and very busy.
- Each ward and department had access to paediatric nursing advice 24 hours a day.
- Each department had a designated nurse in charge of each shift. Qualified neonatal nurses on the NICU were complemented by healthcare assistants and nursery nurses with additional skills and training. They also had a community neonatal team supported by nursery nurse and healthcare assistants who rotated from the NICU. Qualified paediatric nurses on the wards were complemented by a small number of healthcare assistants and a team of play therapists also with additional skills and training. The paediatric departments had clinical nurse specialist links who would visit children on the wards and attend some paediatric outpatient clinics.
- The community paediatric nursing service had been very short-staffed and not able to provide a service on a Monday for some time. This was being resolved on 8 December 2014 when an additional member of staff was starting. We were told this would ensure a five-day service and on-call cover for end of life children and young people.
- We saw staffing levels displayed on the wards/units together with the staff who were currently on duty on any given shift.

Medical staffing

- Each specialty within the paediatrics departments had their own team of specialist consultants. In September 2013 the paediatric departments had a higher proportion of registrar doctors (54%) compared with the England average of 51% but slightly fewer consultants at 25% compared with the England average of 34%. There was double the amount of junior doctors at 14% compared to the England average of 7%. Recruitment was ongoing to ensure the skills mix among the medical staff was able to meet the needs of the patients they saw.
- Every specialty developed its own medical staff rotas to maintain cover for their specialty. The consultants were supported by registrars, middle-career doctors and junior doctors. Consultants were available overnight via on-call arrangements. There was also an emergency rota to ensure extra cover when required. On the evening of 14 December 2014, during our unannounced visit, the children's services were so busy the consultant decided to come to the hospital to help ease the pressure.

Major incident awareness and training

- Senior staff we spoke with were aware of the trust's major incident policy and understood their roles and responsibilities.

Are services for children and young people effective?

Good

The effectiveness of children's services were rated as good. There was evidence of policies, procedures and guidelines which were developed in line with national best practice where available, for example, pain control in the NICU.

Services for children and young people

There was no acuity tool to determine the dependency of the children the paediatric services looked after. The associate director of nursing told us one was being implemented in the near future.

There were some inconsistencies in recording children's pain levels but pain relief was given when required. There was no dedicated paediatric pain team but advice was sought from the adult pain team as necessary.

Emergency admissions from the paediatric A&E were often admitted to Ash Ward who were not funded or equipped to provide HDU care. However, the medical and nursing team often kept these children and were able to provide appropriate levels of care, despite the sometimes low numbers of staff, due to the commitment and flexibility of the staff.

The play therapists were creative and innovative in their approach, providing distraction therapy. They also worked with children as part of the planning process for future procedures to allay anxiety and fear surrounding hospital admissions.

The NICU had an established neonatal community outreach team who visited families once they had been discharged home, often after a very long stay on the NICU.

We saw good multidisciplinary working practices with internal specialists and those from the local area, benefitted the children and their families.

Evidence-based care and treatment

- Policies, procedures and guidelines were developed in line with national best practice where available, for example, pain control in the NICU.
- Policies, procedures and guidelines were available to all staff via the trust's intranet. Staff we spoke with knew how to access them when necessary.
- The new associate director of nursing told us that there was no acuity tool used to determine the dependency of the patients they saw. They told us one was being implemented in the near future. This had also been a recommendation made in the Royal College of Paediatrics and Child Health service review report (commissioned by the trust) in June 2013.
- On the NICU we saw the research nurse and neonatal nurse with a special interest in training who both told us of practices that were in line with published guidance. We saw guidance and good practice suggestions displayed on boards throughout the unit.
- Documents and pathways of care we saw throughout the paediatric departments had been developed in line with guidance from a variety of sources, for example: the Royal College of Anaesthetists Good Practice Guide (2002), British Thoracic Society Guideline on the management of asthma (revised 2012) and British Society of Paediatric Endocrinology and Diabetes Guidelines for the Management of Type 1 Diabetes in Children and Adolescents (2009).
- The NICU had information about how to contact Bliss (a charity working to provide care and support for premature and sick babies and their parents). Staff told us they worked in consideration of the Bliss baby charter that sets out the rights of premature and sick babies and associated best practice.

Pain relief

- The paediatric department did not have a dedicated paediatric pain team. Advice was sought from the adult pain specialist team as necessary.
- The staff in the NICU had carried out audits to inform, develop and change practice within the unit. For example, developing an understanding of how premature babies experience pain and how to manage it effectively.
- A pain assessment and management policy was used across the trust. The paediatric day surgery pathway, anaesthetic and recovery pathway and postoperative care plan reminded staff to assess a child's pain in accordance with the Acute Pain Service guidelines. For example, Wong Baker FACES Pain rating scale. (the use of happy and sad faces) were used for younger children, and a visual analogue scale (scale of 1 to 10) was used for older children and young people.
- Pain scores were not an integral part of the inpatient observation charts used at the bedside on Ash Ward. There was, however, a pain assessment section of the paediatric nursing assessment document. During an unannounced inspection of Ash Ward on Sunday 14 December 2014 we saw the ward was full and not able to accept any more patients. During the visit we tracked the case notes for two children who had been admitted through paediatric A&E during the day. For patient 1: the

pain chart was not done in A&E; the drug chart indicated pain relief was given twice in A&E as the patient had waited six hours in the department as no beds were available on the ward. Once on the ward we saw the Wong Baker pain chart in the assessment document was not completed. One reference was made in nursing notes to a pain score reducing from 10 to 7 during the afternoon. Patient 2: observations were recorded five times, but no pain level had been recorded as the PEWS system did not have a facility to record a pain score. Pain relief was given, with pain scores recorded on the assessment form on admission, but no other scores were recorded.

- The play specialist team was available throughout the paediatric departments and settings across the trust where children may receive care and treatment, such as some adult outpatient clinics. They provided valuable distraction therapy for children undergoing tests and procedures.

Nutrition and hydration

- Children and young people were able to choose what they wanted to eat from a menu. Snack trolleys were available on the wards and children (once assessed) could help themselves to drinks and snacks throughout the day.
- The paediatric departments had access to paediatric dieticians who were available for specialist advice and support with diets and food. The staff were aware of how and when to access the dietician service. The staff were also aware of how to order specialist menu choices such as halal food or gluten-free meals.
- The records we reviewed showed that any fluid or dietary intake was monitored and recorded where necessary.
- The children and young people thought the food was generally good.
- There was a stock of donated expressed breast milk for use by the premature babies on the NICU. The system for its collection, screening and its use was robust and greatly appreciated by the staff and parents.

Patient outcomes

- The hospital play specialist team was trained to use play therapy with children and young people. Staff across the wards and departments told us how important this was due to some children being scared about particular procedures. The play team was able to work with the children and family to overcome those fears through play. The play specialist team was highly regarded by children, parents and staff alike. They told us that they were trying to encourage the engagement of junior doctors, for example, to use them to distract a child when putting up a drip. A member of the play specialist team attends the junior doctor induction to help make them aware of what they can offer and how it can help the children have a better experience.
- The number of multiple emergency admissions (April 2013 to April 2014) for children with asthma and diabetes was lower than the national average. The number of multiple emergency admissions (April 2013 to April 2014) for children with epilepsy was higher than the England average. We were told that the private company that managed most of the local paediatric community services was aware and the trust had regular meetings with them to discuss any ongoing concerns such as the epilepsy readmission rates. Evidence showed that readmission rates were lower than the England average for general and specialist paediatric surgery.
- Emergency admissions from the paediatric A&E were often admitted to Ash Ward. Ash Ward were not funded or equipped to provide HDU care. However, the medical and nursing team often kept these children and were able to provide the care, despite the low numbers of staff. The medical team liaised with hospitals in neighbouring counties who did provide HDU beds but these were often full and it may not have been in the best interests of the child to transfer them to another site. The children were therefore looked after on Ash Ward in the close observation bay. The staff managed these children despite not being designated and not staffed to provide HDU care.
- We saw there were clinical pathways for a number of paediatric-related conditions – for example, acute asthma in children under 16 and paediatric diabetic ketoacidosis. They had clear guidance about how to manage the child or young person in A&E and for the admission pathway once stabilised.
- Adult and paediatric clinical nurse specialists were available for advice and support in areas such as respiratory care, diabetes and pain.
- The staff worked hard, with the clinical nurse specialist to ensure that patients with diabetes had a high

standard of care and there was a well-established transition to adult services. Staff told us they were proud of the service offered to children with diabetes and their families.

- We saw that allied health professionals such as physiotherapists, dieticians and speech and language therapists were available for ward and clinic patients as necessary. We were told they all worked together well as a team to support the child and their families.
- The NICU had an established neonatal community outreach team who visited families once they had been discharged home, usually after a long stay on the NICU. They helped families adjust to looking after their babies at home, sometimes using equipment or administering medications.
- Outcome's for babies receiving care and treatment on the NICU were good across a range of measures in the National Neonatal Audit Programme for 2013 as follows:
  - The unit scored 98% for all babies <> 28+6 weeks gestation having their temperature taken within the first hour after birth against the national standard of 98-100%
  - Mothers who delivered babies between 24 and 34+6 weeks gestation given any dose of antenatal steroids was 92% against the national standard of 85%
  - 95% of all babies with a gestational age of <32+0 weeks or <1501g at birth undergoing 1st Retinopathy of Prematurity (ROP) screening in accordance with the current national guideline recommendations against national standard of 100%
  - The proportion of babies <33+0 weeks gestation at birth receiving any of their mother's milk when discharged from a neonatal unit was 72% against the national benchmark from 2012 of 69%.
  - There was a rate of 91% of documented consultation with parents by a senior member of the neonatal team within 24 hours of admission against the national standard of 100%

Competent staff

- Student nurses told us that they were mentored by experienced staff and supervised in their practice. They said that they had received an orientation to the ward before they started their placement and had all received good support from the paediatric staff while on the wards and departments.
- We saw examples of competency-based preceptorship practical experience and training and orientation programmes for new staff within the NICU.
- Nursing staff at all levels told us about the supervision arrangements in their own ward/unit areas. Most of the staff we spoke with told us their appraisals were up to date or they had dates booked. Staff on the NICU told us they "felt well-supported and worked really well as a team" and as a result, they were flexible in order to cover shifts if necessary. There had been new appointments at senior nurse/management level that were reported as now providing much-needed leadership and support mechanisms.
- The current clinical practice educator had been in post for a short time but was moving to become part of the community paediatric team. They said there had been no handover from the previous clinical practice educator and had found it hard to establish what training staff had undertaken as there were no records only "a drawer full of certificates". As a result, they had created a training file for each staff member and containing certificates for previous training to be used as a working document that could form the basis of ongoing continuing professional development in the future.
- The associate director of nursing advised that they were hoping to recruit a band 8 senior nurse in early 2015 who would have a teaching role as part of their job description.
- We looked at the training records on each ward/unit we visited. These showed that the majority of staff were up to date with their mandatory training. However, 20% of staff had not completed Mental Capacity Act 2005 training and 59% had not completed equality and diversity training. We saw evidence that, where appropriate, nursing and support staff had received additional training, for example, in neonatal intensive care.
- The medical staff we spoke with all confirmed that they had received an appropriate induction to the trust and to the paediatric departments. We observed ongoing teaching during a ward round. Medical students told us there were good teaching sessions on the wards/units and a senior house doctor confirmed they had access to an educational supervisor.
- We saw evidence of job plans for medical staff.

- We observed the handover on Ash Ward. It was detailed but, in some cases, did not give the age of the child or their diagnosis. This meant junior staff or new staff did not always have essential facts about the child at the point of handover.
- We saw that paediatric nursing staff who looked after the children who had been assessed as needing high dependency care had received advanced paediatric life support training.

Multidisciplinary working

- We saw examples of multidisciplinary team working across the paediatric departments, although we were told communication between the paediatric A&E and the wards was not always good. The associate director of nursing for paediatrics had recognised this and was intending to meet with the relevant departments to explore the reasons why.
- We were told about and observed good working relationships with other health professionals for example physiotherapist, dieticians and speech and language therapists. The paediatric services were really proud of their work with children with diabetes and worked very well with the diabetic specialist nurses. We were also told of good relationships with other specialist nurses, for example, respiratory and oncology.
- Good communication and local agreements were in place with local hospitals for "treat and transfer" where appropriate beds were available.
- The NICU was part of the South East retrieval network which transferred babies to and from special care baby units and were part of the ongoing rota.
- The ward rounds were attended by a multidisciplinary team and reviewed each child. Discussions were documented in the combined nursing and medical notes.
- Ash Ward team told us they had good working relationships with the local Child and Adolescent Mental Health Services (CAMHS) operated by Virgin Health but, as nationally there was a shortage of suitable beds, children and adolescents were often admitted to Ash Ward until more suitable accommodation could be found for them. Staff told us they could access the CAMHS team for advice as necessary.
- The paediatric services at the trust looked after babies right through to the age of 18. There were systems to help adolescents transition to adult services. This was particularly well-established for diabetic patients. Sixteen- to 18-year-olds were given the choice if they wanted to be admitted to a paediatric ward or adult ward. We were told that, while the children and adult services worked well together, limited capacity occasionally meant that, for example, an 18-year-old may be admitted to a paediatric ward even if that was not their first choice.
- The paediatric community nursing team worked with a private provider who supplied most of the community-based children's services in the local area and adjoining counties. For example, they had held meetings to discuss the high rate of emergency admissions of children with epilepsy.
- We saw the maternity unit and NICU work seamlessly together during the admission to NICU of a premature baby.
- We heard how the community paediatric team worked with the local hospice when looking after children with palliative care or end of life care needs.
- Discharge information was communicated to the child's GP as well as to their health visitor or school nurse.

Seven-day services

- There were seven-day services within the paediatric wards and units, with the exception of day surgery and outpatient clinics. Play therapists were currently available six days a week, soon to be seven.
- Theatres were available out of hours for emergencies.
- Consultants reviewed their patients daily on the ward rounds and were available out of hours via on-call arrangements.
- Physiotherapy, paediatric pharmacy and imaging services were available out of hours.

Play therapy

- The play specialist team of six supported children and young people during particularly difficult times. The team supported children through play therapy. We were told there was one play therapist in training and, once they had completed their training, the team's service would be available seven days a week.
- The play specialist team was able to provide their personnel to all wards and units across the paediatric departments and a central play room. The play team was informed of planned admissions and involved in multidisciplinary ward rounds as necessary. .

Services for children and young people

- The play specialist team were very proud to have won £3,000 as a result of innovative use of resources to improve the playroom.

Are services for children and young people caring?

Good

Children and young people were treated with compassion and respect and staff were found to be caring. The needs of the babies, children, young people and their families were always put first by the staff. The caring attitude of the staff was evident in every department we visited. The staff showed expertise in caring for and communicating with children and young people. We observed good child-centred care being given. Staff made time to explain and involve children in their care in ways they could understand. All the parents, children and young people we spoke with told us how good the staff were.

Parents were able to accompany their child to the operating theatre to continue to give emotional support.

Chaplaincy services were available throughout the paediatric services and provided support to families and staff if needed.

Compassionate care

- The NHS Friends and Family Test was not carried out in paediatric services at the time of our inspection, but was to be rolled out in line with the national programme.
- During our visit we saw very good interactions between staff, children and young people and their parents. The interactions were compassionate and very caring. Staff were skilled in communicating with children and young people; we observed this on every ward and department we visited, and this continued even on the busiest wards when the staff were under extreme pressure. Children and young people and their relatives told us that staff were very caring; one said staff were "superb", another said, "they will go out of their way to help you". We also saw 'thank you' cards on the ward and units from parents and children expressing their thanks for the care provided.
- We saw evidence that parents were encouraged to be involved in the care of their child as much as they wanted to be. On the adolescent bay, the young people were encouraged to be independent and we heard them being treated with respect.
- Staff on the NICU told us they had a close working relationship with the chaplain who was able to provide support to families and staff if necessary.
- We saw the parent's accommodation (Gallagher Suite) on the NICU which provided an area where parents could sleep, make something to eat or drink and have a shower. There were four separate bedrooms which provided some private space for parents to use, maintaining their need for privacy and dignity. We saw that the special care unit (transition unit) had facilities for mums to stay with their baby. These are babies who may have been admitted straight from the delivery suite or from the NICU when they no longer required close monitoring, so they could get to know their baby and establish feeding routines before going home.
- During conversations with NICU staff it was clear they were very sensitive to parents' needs and supportive when helping them come to terms with their current situation. We saw information displayed and accessible on the trusts website about Birth Reflections a service provided within St Peter's Hospital to give women and their partners the opportunity to talk about their experiences, share feelings and reflect. It was run by specially trained midwife counsellors.

Understanding and involvement of patients and those close to them

- We saw how staff explained things to parents and children and young people. For example, we saw a play therapist explaining a procedure to a child and how the parent could be involved in the possible distraction needed. We saw how this reassured both the child and their parent. Parents told us that staff listened to what they had to say and involved them in the care and treatment of their child. Three parents said that they were kept well-informed by staff. This represented the views of the majority of parents we spoke with.
- Children and young people told us how staff involved them in their own care. Two young people told us that they were able to do a lot of things for themselves but that the staff were available if they needed any extra help or support. They were also able to speak to clinicians on their own.

Services for children and young people

- A range of information on particular procedures and conditions was available for parents on all the wards and departments. These added to the verbal explanations children and their parents had been given. We saw that staff allowed time for questions from parents or the children themselves and checked understanding when having procedures explained to them. We saw that information had been written in a way that children and young people could understand.
- On each ward and department it was clear which nurse was looking after each particular patient. The children and young people we spoke with all knew who was looking after them.

Emotional support

- The chaplaincy service was available throughout the paediatric departments to support parents, children and young people with their emotional and spiritual needs. A multi-faith chapel was available to support people's spiritual needs. Spiritual workers from all faiths were also available to offer support.
- Staff were able to build relationships very quickly with parents, children and young people. We saw evidence of this in every ward and department we visited.
- Children and young people who needed surgery were able to be accompanied by their parents to the anaesthetic room and stay with them until they were asleep. This ensured that parents were able to continue to provide emotional support for their children. Parents were able to see their child in the recovery area as soon as they were awake to provide reassurance and support.
- The community paediatric team worked closely with the local hospice when providing palliative and end of life care to children and their families. We were told this arrangement provided practical and emotional support to children and families during difficult times.

Are services for children and young people responsive?

Good

Services for children and young people were responsive to their needs. The paediatric wards and departments provided local care and treatment to the babies, children and young people. Staff were experienced in caring for and communicating with children, young people and their families. However, staff did not always feel confident in their ability to look after children with complex mental health needs.

We saw clinical care pathways were in place to ensure children and young people had the most appropriate treatment and were admitted to the right place. Each ward and department had escalation plans for when there was lack of capacity due to the demand for their services.

We saw evidence of learning from complaints.

Service planning and delivery to meet the needs of local people

- The paediatric service provided general children's services for the children and young people in the local population of Ashford and St Peter's Hospitals NHS Foundation Trust. All inpatient services were at St Peter's Hospital along with paediatric A&E services. Some outpatient services were held at Ashford Hospital.
- Each ward/ unit and department had escalation plans for when there was lack of capacity and demand for their services. A 24-hour clinical site team had an overall view of capacity and emergencies within the hospital.
- The NICU was the only level 3 unit in Surrey and, as such, had a high demand for their services. This meant local people sometimes had to travel to specialist units outside the local area due to lack of capacity.
- Ash Ward, (the paediatric inpatient ward), was not designated as a provider of a HDU. However, due to the lack of capacity in other local HDUs and the paediatric A&E on site, children who were assessed as needing HDU care were often looked after on Ash Ward. The staff worked very hard to provide the care and support for the children and families but were not funded or resourced to provide HDU care. The medical director told us that the trust was regularly in negotiations with the local CCG who funded these types of services.
- There was a designated adolescent bay on Ash Ward. If there were male and female adolescents needing inpatient care, designated single rooms could also be used.

Access and flow

- For planned surgery, outpatient clinics were held a few weeks before the surgery. During this appointment, all the relevant information was taken from the parents and the child or young person. The procedure was explained

to the parents and the child and consent was taken from the parents (and the young person, where appropriate). Parents were asked to phone the ward on the day of admission to check for bed availability. Planned admissions were occasionally cancelled if emergency admissions had filled the available beds. The data we reviewed showed that no paediatric operations had been cancelled in October 2014.

- During our inspection, we did not observe any outliers (that is, children on wards other than paediatrics due to capacity issues).
- Children were discharged home directly from the wards. If there was any delay in their discharge, there were play specialists on hand to involve the child and their parent in activities while they were waiting.
- We were told that the plan in the future would be to have the four-day assessment beds (currently located on Ash Ward) moved nearer to the paediatric A&E. This would free capacity on Ash Ward and be less distance for children and parents to go to access a bed.
- Some children who had been assessed as needing high dependency care were admitted to Ash Ward, although it was not designated HDU. We were told that some children were transferred to a HDU if a bed became available, but others would not be fit for transfer so were looked after on the ward. Staff said they worked really hard and extra staff were brought in to provide the care and support the child and their family needed.

Meeting people's individual needs

- We saw there were support mechanisms for parents of babies in the NICU and ongoing support for them and their babies when they went home. We saw lots of 'thank you' cards and letters showing families' appreciation for the support offered.
- A learning disability nurse specialist was available in the trust to support children with a learning disability. They also provided advice and support to staff to help them meet children's needs.
- The adolescent bay on Ash Ward catered for the needs of young people. There was access to TVs, games machines and DVDs appropriate to their age.
- Some of the staff on Ash Ward told us they did not feel confident in looking after the number of children and young people admitted with mental health problems. At the time of the inspection, there was a registered mental health nurse allocated to Ash Ward 24 hours a day to provide one-to-one support for a child or young person with mental health problems if necessary. This was for a limited time only while a review of staffing levels was being undertaken. Staff were concerned about what would happen when the registered mental health nurse was no longer available. Employing a registered mental health nurse, to "support staff and clinical activity within the service", was a recommendation made following the Royal College of Paediatric and Child Health Service Review carried out in June 2013.
- Each ward and department catered to the needs of children. This included ensuring that there was enough space by each bed for a parent to stay and providing play and school rooms. Outside play space was available.
- There was no dedicated recovery area for children following their surgery. There was a curtained area that had some pictures on the walls, but to get to the area they had to go through areas with adults who were also recovering from their operations.
- There was a school service (run by the local authority) providing education to relevant children on the paediatric inpatient ward. Where the child was able to, they could attend the school room to make sure they did not fall too far behind in their learning. The service liaised with the child's usual school and could support young people in taking exams if necessary.
- We were told there was access to translation and interpretation services, usually via a telephone. Staff said the system worked well. We saw leaflets were printed in English but also had all the information in several languages, with contact numbers if people needed large print, audio or leaflets in different languages.

Learning from complaints and concerns

- Information was displayed in all wards and departments explaining how parents, children and young people could raise their concerns or complaints.
- Staff we spoke with were all aware of the complaints process. Staff told us that they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process. Staff were aware of any complaints that had been made about their own ward and any learning that had resulted from them.
- All complaints about paediatric services were seen by the associate director of nursing and currently investigated by them until senior ward staff had been

appointed in December 2014 and January 2015. We were in a meeting with the associate director of nursing for paediatrics when they answered a call from a parent who had made a complaint. They were very open with the parent, reassured them, apologised and told them to ring them at any time if they had any further questions. They also gave a timescale for follow-up contact by letter and telephone.

- Trends and themes from complaints and concerns were discussed at ward level, specialty level and divisional level. Good practice advice and required learning was identified and actions taken. Information was then disseminated to staff. The associate director of nursing for paediatrics told us the issues would be discussed at ward/unit and department meetings to ensure staff were aware of how to implement the changes and why. If necessary, staff training sessions would be made available.
- At the time of the inspection there were two complaints being investigated.

Are services for children and young people well-led?

Requires improvement

Services for children and young people required improvement in the well led domain. Staff on Ash Ward told us they had not had any formal leadership for the last six months and it had been a very difficult period. We were told of a number of new appointments to senior posts that were just about to start, meaning that all of the wards and departments would have their current designated senior posts filled. A recent senior nursing staff appointment had been welcomed as there had been a period of time without leadership within the paediatric services. Staff told us positive changes had started to happen as a result.

A staffing and skills mix review was underway to ensure the wards and units had the necessary personnel. Discussions were ongoing with the local CCG about the need for a designated high dependency unit.

Staff described the culture in the paediatric departments as one that put the babies, children, young people and family first. We saw evidence of this during our visit, despite some areas being very busy and short of staff.

Paediatric services were developing governance systems with risks escalated from ward, specialty and division to the patient safety team.

Vision and strategy for this service

- We saw the trust values displayed in a number of areas we visited. All grades of staff knew about the values and some were able to talk about them in detail.
- There had been some very recent appointments to senior nursing staff posts in the paediatric services. They had been welcomed by staff, who had lacked leadership for some time. Staff told us that a staff review was underway to ensure the number and skills mix of personnel was right. Staff thought that once the basics were right they could start to think more about their strategy for the future and how that linked in with the general trust strategy. Staff felt they knew about the trust's strategies by way of the trust newsletter and felt they could influence the future via the chief executive 'sound board' meetings.

Governance, risk management and quality measurement

- We spoke with the women's health and paediatrics division governance lead for paediatrics. They said this was a new trust post from September 2014, involving implementation of the safety and risk management policy and taking observations on the wards and units. It also included discussion with nursing and medical staff around practice errors and reinforcing learning from incidents and encouraging the use of the electronic reporting system when incidents occurred.
- Staffing levels on the NICU had been on the division's risk register since September 2013. It was reviewed in April 2014 and August 2014.The date for achieving adequate staffing levels was 28 February 2015. We saw that senior manager and ward manager posts had been filled or recruited to, with some people due to start their job in early 2015.
- The paediatric services produced a monthly dashboard that showed statistics for a variety of indicators, including staffing and cleanliness. These were not readily accessible by staff on the wards. The associate director of nursing for paediatrics and ward managers we spoke with told us they fed back comments made by parents and children through their regular meetings with staff. Staff also received regular feedback via the trust newsletter.

- Despite asking numerous members of staff we were not clear if there was a non-executive director on the board with a special responsibility for paediatrics. Some staff did tell us they felt that paediatric issues did not get the attention of the board, and others felt that they could "get the attention of the board" if necessary.
- The associate director of nursing for paediatrics was aware of the need to ensure that all audits were completed and results made available to staff, parents and children and young people who used the service. They told us that they thought a number of ward-based paediatric internal audits had not been completed due to the high workload. We saw that audits on the NICU had been completed and the results displayed on noticeboards in the unit – for example, the hand hygiene audit.

Leadership of service

- The staff we spoke with were all aware of who their immediate managers were. Staff described the new associate director of nursing for paediatrics as being supportive, approachable and visible. Staff told us they felt optimistic about the future and were looking forward to positive changes. Staff on Ash Ward told us they had not had any formal leadership for the last six months and it had been a very difficult period. We were told of a number of new appointments to senior posts that were just about to start, meaning that all of the wards and departments would have their current designated senior posts filled.
- Staff at all levels told us they felt they could approach the chief nurse or chief executive if necessary. Those who had felt they had been listened to. Staff told us the chief executive held monthly 'sounding board' sessions for staff to give their views of the trust. They said the weekly Aspire newsletter updated them about current trust issues.
- The new associate director of nursing for paediatrics told us that, since starting in September 2014, they had met all the staff and had gauged how people felt and the improvements that were needed in all of the departments. They were in the process of implementing some changes but did not want to overload staff who had been working incredibly hard, sometimes under difficult circumstances, for some months.

Culture within the service

- The culture in paediatric departments was described by staff as one that put the babies, children, young people and family first. We saw that this was the case during our visit.
- Most of the staff we spoke with were very proud of the care they provided and of their ward or unit. Some of the staff we spoke with said paediatrics sometimes felt like an "add on" to the rest of the hospital and they sometimes struggled to have their voice heard. However, it was reported to us that this had improved since the associate director of nursing for paediatrics took up post in September 2014. Staff felt they were raising the profile of the paediatric departments and, as a result, staffing levels were improving.
- Staff, especially on Ash Ward and community paediatric services, were looking forward to the newly appointed managers (band 7) starting their jobs in December 2014 and January 2015 and hoped for some consistent and long-term leadership.
- The staff described a culture in which they were now encouraged to report incidents, concerns and complaints to their manager. Staff felt able to raise concerns since the associate director of nursing for paediatrics had started in post and felt that they acted on staff concerns.

Public and staff engagement

- The clinical director and associate director for paediatrics said they were looking at ways to better engage parents, children and young people in the service development in the future.
- A children and young people's action group met on an irregular basis and, at the time of the inspection, they had not met for seven months. It was supposed to be every three months. We were told now that "better leadership" was in place, the meetings would be scheduled more regularly and the aims of the group reviewed.
- Comments cards were available in all wards and departments. Themes of comments cards were also discussed at the ward meetings and disseminated through the divisional management structure.
- Staff told us that they currently felt included in changes and developments planned for the paediatric departments and units.

Innovation, improvement and sustainability

- Working and transport arrangements were in place with neonatal intensive care and high dependency units across neighbouring counties.
- As children often walked to the operating theatre from the paediatric ward down a long corridor, a trail of dinosaurs had been put on the walls at eye level. The children were given a card and asked to put a sticker on the card for each dinosaur they saw. This had proved a good distraction for children and reduced their anxiety. We walked to theatre with one child and found them to be very engaged in the dinosaur trail.
- We spoke with the research nurse on the NICU who spoke enthusiastically about research the unit was involved in and some they had instigated themselves as a unit. Staff told us they felt being involved in research helped to motivate them and ensure they were using the most up-to-date best practice.
- A review of staffing levels was underway to ensure the skills mix and number of staff met the needs of the babies and children the trust looked after.
- We were told conversations with the local CCG were ongoing to potentially establish some high dependency beds on Ash Ward as they often took children who had been assessed as needing high dependency care.

End of life care

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

Information about the service

Ashford and St Peter's Hospitals NHS Foundation Trust had more than 400 beds across the St Peter's and Ashford hospitals sites. End of life care was delivered, where required, by staff on wards and departments throughout both hospitals but was principally delivered at St Peter's Hospital. The specialist palliative care team (SPCT) provided support and advice for those patients who had complex care needs or complex symptom management. This included those patients nearing the end of life. In the year April 2013 to March 2014, 1,030 patients were referred to the SPCT.

The SPCT consisted of one whole time equivalent (WTE) nurse team leader for palliative care and 4.8 WTE nurses. They worked as part of a multidisciplinary team with other health professionals to support end of life care throughout the two hospitals. At the time of our visit there was 0.8 WTE palliative consultant cover with a future plan for two WTE consultants, following recruitment. The team was accessible seven days a week between 9am and 5pm with an information service accessible from a local hospice out of hours.

We observed care being provided to patients and relatives throughout the hospital. Before and during our inspection we reviewed the trust's performance information, audits and action plans relating to the delivery of end of life care. We met five patients, spoke with five relatives and reviewed 13 care records. We visited 20 wards and specialist departments and talked to 42 nurses and 18 doctors about end of life care. We also spoke with allied health professionals, administrative staff, porters, the chaplaincy team and bereavement and mortuary staff.

End of life care

Summary of findings

The SPCT were accessible, visible and supportive of all areas in the trust. Team-working with all wards and departments was evident to promote safe and effective end of life care. Staff throughout the trust valued the skills and support of the SPCT. Patients' reviews took place within multidisciplinary meetings to promote coordinated, safe and effective care. Care records demonstrated that potential problems for patients were identified and planned for in advance. This information was recorded clearly in care plans and medical records. The team were piloting and reviewing a person-centred care plan to improve the safe and effective delivery of care, in line with current best practice.

Staff throughout the trust were caring and treated end of life patients and their relatives with dignity and respect. Staff made every possible effort to ensure that patients and relatives had everything they needed to be comfortable and accommodated. The close working relationship between the nursing and medical staff, chaplaincy, bereavement, mortuary services and porter services was evident to support patients and relatives.

Staff throughout the trust understood how and when to make a referral to the SPCT and the systems prompted an alert to make a referral. Ward staff reported that the team responded quickly when contacted.

End of life care was responsive to the individual patient's needs, particularly in the last days of life. However, improvements were needed to identify patients who were potentially in their last year of life to better plan care. Discharge planning arrangements were responsive to support patients to be in their preferred place of care at the end of their lives.

Staff felt well-led by their direct managers. They considered the management of the trust to be accessible and supportive. Monitoring of the end of life service promoted learning and the continued development of the service. Most staff we met were able to tell us the trust's values and we saw that these were available on the trust's intranet. We saw the culture of all staff providing palliative and end of life care focused on kindness, dedication and a will to provide a good experience for patients and relatives in their care.

Are end of life care services safe?

Good

The SPCT provided a consistent service with safe practice, support and advice for patients, relatives and staff. Medicines and equipment were available to manage patients' pain and other symptoms safely. The trust was removing any references to the Liverpool Care Pathway for delivery of end of life care, in line with national recommendations for this obsolete protocol.

The team took learning from incidents and shared it with others in the trust to develop the service. Improvements were needed to identify patients who were potentially in their last year of life to plan care more effectively.

At the time of our visit there was an interim plan for palliative consultant cover with 0.8 WTE consultant sessions, which was six four-hour sessions. There were plans to recruit two WTE consultants.

Incidents

- Staff understood their responsibilities with regard to reporting incidents. Some junior nursing staff told us they had never had cause to complete an incident form but knew how to access the forms. They told us that they would expect to receive feedback via their email account. Staff, including porters, were able to explain clearly their responsibilities to report via the electronic reporting system. We were told by the trust lead for incidents that, to receive a response to incident reports, staff would have to 'opt in' to the reporting process by requesting feedback. Junior nursing staff and some support staff told us that, while they were not all involved in ward meetings to receive feedback from incidents, they were provided with information and changes in practice. They assured us they felt included, albeit at the bottom of the information trail
- One serious incident requiring investigation had taken place earlier in 2014 which had highlighted learning for end of life services. This learning was ongoing. Serious incidents were reviewed through the end of life steering group, part of the governance framework in the trust, to identify any areas which needed to be highlighted to the trust for further learning.

Cleanliness, infection control and hygiene

End of life care

- The ward areas and departments we visited were clean. There were sufficient hand-washing facilities available. Personal protective equipment was available for all staff. Porter staff told us that, on some occasions, they were not advised of the risk of cross-infection when transferring patients. On these occasions they observed if nursing staff wore protective equipment and followed their lead.
- We observed a consistent approach to hand hygiene with staff washing their hands between interactions with patients and on entering and leaving rooms and wards.

Environment and equipment

- The National Patient Safety Agency recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by 2015. These had been removed from this trust. The SPCT provided training for staff throughout the trust to use the alternative McKinley syringe driver.
- The setting up of a McKinley syringe driver was not undertaken by nursing staff unless they had been confirmed as competent to do so by the SPCT. Staff also told us that the syringe driver was not used outside of the hours worked by the SPCT. Staff told us that the SPCT would visit the wards and assist staff at any time to ensure the syringe driver was being used correctly.
- We observed when a need for pressure-relieving equipment had been identified, and this equipment was in place to protect the patient's skin condition.

Medicines

- Wards stocked the drugs and equipment needed for the use of a syringe driver to deliver medicines via a subcutaneous pump. This ensured patients did not have to wait for medicines. Syringe driver records showed that they were well-observed, monitored and recorded.
- Records of all medicines prescribed and administered we saw were completed well. Audits of controlled medicines took place and any learning was shared through a newsletter seen on a ward wall. Staff pointed this out to us as a learning tool for them to remain updated on audit results. The auditing of opioid prescribing for toxicity did not take place. Any excess medicine usage would flag an alert for pharmacy staff to investigate.
- The lead nurse for the SPCT had qualified as a nurse prescriber. They attended the independent prescribing forum which provided information to the drug and therapeutics committee to ensure information around prescribing was shared.
- Chemotherapy was delivered through outpatient clinics or under the supervision of specialist chemotherapy staff. As a precaution, some wards had an extravasation kit to support staff should chemotherapy medication need to be discontinued by ward staff. Extravasation is the leakage of a drug or fluid from a vein into the surrounding tissue during intravenous administration. The drug or fluid may damage the surrounding tissues.
- Resuscitation trolleys were checked daily and weekly by staff to ensure there were equipment and drugs needed to resuscitate patients in cardiac arrest. The trolleys were sealed when updated and so not able to be tampered with. Each use prompted a restock and reseal.

Records

- On admission each patient with end of life needs had an assessment which took a holistic approach to all aspects of care needs, including health and social needs. There were plans to develop this document and use it to inform each patient's multidisciplinary meeting.
- Records of the assessment of end of life for nursing staff were included in the patient's admission assessment document. We reviewed 13 sets of patient records. This record made a reference to the Liverpool Care Pathway which was no longer a recommended protocol. The trust assured us that this was being removed.
- A pilot of personalised care plans specific to end of life care was taking place but was only available on one ward. The remaining hospital areas used a standard format care plan (Care plan 91) which was pre-populated and not specific or personal to the patient. This was used to inform and guide staff and trigger an alert to the SPCT. The SPCT were aware that the standard format care plan was insufficient and this had prompted the current pilot.
- The patient's multidisciplinary records contained the handwritten details of the patient's end of life care as planned by the SPCT. We saw that detailed discussions between clinical staff, patients and relatives were recorded sensitively.
- We looked at 13 do not attempt cardio-pulmonary resuscitation (DNA CPR) forms. All had been completed in line with the national guidance published by the

British Medical Association, Resuscitation Council (UK) and Royal College of Nursing. All discussions and decisions had been clearly recorded in the patient's notes. All patient notes seen in relation to DNA CPR were written clearly and signed by the doctor or nurse and detailed current and planned care. These plans were signed only by a registrar or senior-level doctor and were audited monthly to encourage an improvement in how they were completed.

- Some wards and departments did not ensure the safety of patient's information. In one area we saw the handover sheets which contained details of all patients on that ward left accessible at the nurses' station with no staff in the area. These could have been removed, compromising the confidentiality and privacy of those patients. Other areas had patient information on a board which was clearly evident to patients and relatives. These boards used coded indicators to identify patients with falls risks and dementia.

Assessing and responding to patient risk

- All patients admitted to A&E with a suspected cancer would be referred to the acute oncology service. The oncology consultants at St Peter's Hospital were seconded from another hospital to provide full-time treatment for patients. There were a further two acute oncology doctors employed at the hospital. The service would attend A&E to assess the patient and, if a need was identified, contact the SPCT for support for end of life.
- There were no clear systems throughout the trust's two hospitals to identify when end of life or the palliative period was considered to be. The National Institute for Health and Care Excellence (NICE) guidance states that people approaching the end of life should be identified in a timely way. No tools were used by the hospital to identify if patients had anticipated 12 months of life left. We were advised by the SPCT lead that this assessment was undertaken based on experience, insight and observations.
- For those patients approaching end of life, the Modified Early Warning Scores (MEWS) system was used to identify deterioration in health. This would prompt staff to review the appropriate care provided.
- Patients admitted to St Peter's Hospital with end of life needs could be transferred to whichever ward was most appropriate for them. An oncology consultant was on secondment full time from another hospital to attend to all patients with oncology identified issues. A further two oncology doctors were also available at the hospital to ensure that sufficient medical oncology cover was available.
- The transfer of patients at the end of their lives to other wards within the hospital took place at day and night. Staff told us of three recent incidents when patients had been transferred at night to another ward within St Peter's Hospital. This did not promote dignity and respect and was recognised as less than optimal for patient wellbeing. We checked a selection of four wards during our visit and unannounced inspection and found that no further night-time transfers of patients with end of life needs had taken place.
- Some nursing staff felt that, without a clear trust policy for end of life care, they did not have the support to decline patient transfers. While observing care on a ward at St Peter's hospital we saw an incident of a nurse being requested to transport a patient who was near the end of their life. The nurse explained that the patient was on an end of life care pathway and so could not be moved. A further example demonstrated that, at times, staff were under pressure from the bed manager to transfer home a patient at the end of their life. On this occasion, the nurse had refused because they felt the patient could potentially die in the transfer and this was not good end of life practice.

Nursing and medical staffing

- The SPCT provided support, advice, staff training and care to patients trust-wide. The team consisted of one WTE nursing team leader for palliative care and 4.8 WTE nurses. The Acute Oncology service is available Monday to Friday 9am-5pm. The Team is led by 1 wte Clinical Nurse Specialist and 2 Oncologists from the Cancer Centre at Royal Surrey County Hospital who provided a total of 6 sessions between them. Oncologists from the cancer centre at Royal Surrey County Hospital also have outpatient clinics at Ashford and St Peters hospital.
- Doctors and nursing staff told us that mandatory training was completed online within six weeks of starting with the trust. This induction did not include end of life care training but this was currently being considered for inclusion.
- Trainee doctors were provided with three hours of end of life training by the trust. Training was also provided to trainee doctors by the trust in breaking bad news. Junior doctors told us they found this helpful.

End of life care

Major incident awareness and training

- Some areas of the hospitals were able to describe what actions to take in the event of a major incident and how this would impact on patients receiving end of life care.
- Mortuary staff had additional facilities available in the event that the mortuary became full. The chaplaincy services were on call for any major incidents.

Are end of life care services effective?

Good

Patients identified as having end of life care needs were assessed and reviewed and had pain and other symptoms managed effectively. The SPCT was reported as being accessible and effective in supporting patients with complex end of life care needs. They reviewed patients within multidisciplinary meetings to promote coordinated, safe and effective care. The team was also supportive of staff training needs, with an effective programme for ward and department staff.

End of life care in the last hours or days of life was provided in line with national guidance. However, for patients with long-term conditions who may have been in the last year of life, assessment tools were not used to ensure that they were recognised consistently by staff throughout the trust. Discharge planning arrangements were responsive to support patients to be in their preferred place of care at the end of their lives.

Any concerns identified as part of national and local audits were reviewed and an action plan completed to address and improve the service. Shortfalls in care planning were being addressed by a pilot scheme to develop person-centred care planning.

Evidence-based care and treatment

- The SPCT followed national guidance, using NICE's Quality standard for end of life care for adults (2013). This was demonstrated in a number of ways, including patients being supported to make choices about their care, where they wanted to die, and good recording of treatment plans to meet their needs. We also saw a prompt service provided by staff in the bereavement office and mortuary. This provided practical and compassionate support to the bereaved. There was also a 24-hour chaplaincy service.
- Referrals to the SPCT were met within 24 to 48 hours. Referrals in the 2013/14 year numbered in excess of 1,000 and, of those, around 50% were cancer referrals. All targets for review were met. Each ward and department had access to a palliative/end of life link nurse and a resource folder for advice and information should the link nurse not be available.
- The Cancer Patient Experience Survey also identified shortfalls. The trust had reviewed the outcomes and an action plan was put in place.
- Local audits, including the Best Care Audit, was completed every two months. This was a snapshot audit of patients on one elected day to check nutrition, observations, skin integrity, medication, and that privacy and dignity being maintained. We saw this had been completed and that results were collated and displayed in some areas to demonstrate areas achieved and areas for improvement. The results went to the Best Care Surveillance Panel and the Trust Board. Action plans were produced as identified. These audits also supported the changes needed in practice, for example, on one ward the results had helped staff to promote the pilot for personalised care planning for end of life care.
- As part of its ongoing review system, the SPCT had identified actions for improvements within the trust's end of life pathway. For example, the need for personalised care planning. Newly developed care plans identified the trust's identified five priorities for care, these were to recognise, communicate, involve, support, plan and do. These actions followed recommendations in the Department of Health's End of Life Care Strategy (2008) and in Priorities of care for the Dying Person, from the Leadership Alliance for the Care of Dying People (2014).
- Quality and safety half days took place each month. On these days, mortality reviews took place and multidisciplinary learning was developed to report back to staff. However, at this time learning for end of life was not being considered.
- The trust responded to the Liverpool Care Pathway review in 2013. It stated that the trust would continue to focus on individualised end of life care based on the patients' and families' wishes. This would be guided by the trust's five key principles of good care. Each end of

life care plan would continue to be led by a named consultant and nurse and supported by the SPCT as required. Leaflets referencing the former Liverpool Care Pathway were, however, still on display in the hospitals. Senior trust staff told us that these leaflets would be removed.

Pain relief

- The ward staff would seek the support of the SPCT for advice around pain relief and symptom control. We saw this happening on wards and staff told us they found the SPCT to be accessible and supportive in this role.
- Management of patients pain was anticipated in advance with 'as required' medicines prescribed to patients who were identified as requiring end of life care. These were prescribed in advance to enable the management of any changes in patients' pain or symptoms without delay, such as having to wait for the pharmacy to deliver medicines. Staff told us the trust had 'hub' wards which stocked anticipatory medicines and these were accessible 24 hours a day. Guidance from the SPCT was available to doctors and nurses to ensure that anticipatory medicines were correctly prescribed and administered.
- Nursing staff used an assessment tool to provide a numerical score to identify the level of a patient's pain severity. There were also prompts for staff to identify when patients were not able to articulate their needs. We saw that this tool was consistently used to identify the treatment patterns to support patients with pain management.
- We observed staff asking patients about their pain and providing prompt medication. Staff advised patients to press the call bell if they had any further discomfort and to tell staff if they were not comfortable. On the surgical assessment unit (SAU) we saw a patient's request for pain relief was met promptly. The staff member further checked to ensure that the patient was comfortable.
- The trust had an adequate supply of syringe drivers for pain control and trained staff to set up this equipment. The syringe drivers were not set up outside the hours worked by the SPCT. Staff checked the equipment regularly to establish its effectiveness and recorded their findings. Changes in treatment were provided and monitored when pain control needed further adjustment.

Nutrition and hydration

- Specialist dietician support was available on all wards as required. Patients had been assessed using a malnutrition universal screening tool (MUST), which identified nutrition and hydration risks. Records showed that, following a MUST assessment, plans had been put in place to ensure the patient's comfort. As patients approached the end of their life these assessments were regularly reviewed and plans altered to meet any changing needs.
- Patients were provided with drinks and snacks. Relatives told us that they were offered food and drinks when visiting, both during the day and at night time.
- Mouth care was assessed and provided as needed. This was assessed as part of the daily nursing needs and patient records demonstrated that this took place to make eating and drinking as comfortable as possible.

Patient outcomes

- Patients benefited from discussions with nursing and medical staff about their treatment options and discharge plans. They were helped to feel central to the discussions and have their choices and preferences lead the decisions made.
- The trust had contributed to the National Care of the Dying Audit 2013/14. As a result of shortfalls identified within the audit report, an action plan had been produced with timescales for completion. The action plan identified that some timescales were ongoing into 2015. We saw from observation and discussion that some areas had now been addressed. These included the provision of a seven-day service by the SPCT, which was now being delivered.
- The preferred place of care and death was discussed with the patient to support their choices and preferences. The preferences were discussed at the specialist palliative care multidisciplinary team meeting. The Coordinated, Safe, Integrated (CoSI) model was being used. This demonstrated collaboration of community end of life care services for patients in the last six to eight weeks of life. It supported the rapid discharge of end of life patients from the hospitals to be cared for in their preferred place. This model had been recently established to consider referrals and working practice.

End of life care

- One occasion was identified that was not a positive outcome for the patient and their relative. We raised this outcome with the trust who acted promptly to ensure the situation was addressed. An investigation and learning was taken from this incident.
- The wards and departments measured patient outcomes by the use of Best Care Measurement and Accreditation Tool. Feedback was provided to ward staff as needed. We saw that some aspects of the Best Care measurement were not completed and these areas were assessed by the SPCT. This included the records related to care plan records and to preferred place of death.
- As a result of ongoing actions by the trust to meet demand for beds, two hospice beds were available in the community for transfers from the trust.
- Facilities available for relatives were shared with other services. We visited the A&E department and looked at the viewing facilities and relatives' room. These were suitable and appropriate facilities for relatives to spend time with a deceased patient. However, we noted that the relatives' room was also used as a psychiatric assessment room, which was not ideal.

Competent staff

- Specialist skills were being developed where needs had been identified. Aspen Ward had a specialist palliative nurse currently working on the ward. This nurse provided support to improve the clinical skills of the staff team and introduce the personalised care plan pilot.
- The SPCT provided regular and ongoing training related to all aspects of end of life care to staff teams and professional groups. It included training in the setting up of syringe drivers, getting the communication right and priorities for care of the dying person. Training half days had been provided by the trust. Nursing and medical staff commented that these were helpful. A hospital intranet site was available to ensure that staff had access to information and updates.
- Link nurses were identified on each ward and department specifically to champion end of life care, processes and policy. In the absence of the link nurse, information relating to end of life care was available consistently in every ward and department for staff to refer to.
- Staff throughout the hospitals said that the SPCT was exceedingly helpful, supportive and responsive.
- End of life patient care was monitored by the SPCT at ward level. If learning needs were identified, the SPCT provided bespoke training. Aspen Ward had been used to audit training for end of life care for nursing and medical staff. As a result, this information was used to develop further training needs for hospitals' staff. Local audits included an audit of designated beds, documentation, and service evaluation for seven-day working.

Multidisciplinary working

- Multidisciplinary working took place to ensure a continuity of support for patients with end of life needs. Patients receiving end of life care were discussed daily by the multidisciplinary team at the board rounds to ensure that all teams were clear of each patient's plan for care and treatment.
- Multidisciplinary meetings took place each Friday. At these meetings all patients receiving specialist palliative care support were discussed and a plan of care put in place. The support of therapists was included, such as an occupational therapist. A psychologist was available but they did not attend the multidisciplinary meeting. At the time of our inspection, 30 cases were discussed.
- We observed a handover and saw good team dynamics with offers to share out the work list to meet the heavy demand on the specialist nurses' time.
- The Ashford and St Peter's Hospitals NHS Foundation Trust had collaborative links with local hospices and the clinical commissioning group. There were examples of joint working which demonstrated the ongoing benefits to patients with access to designated hospice beds.
- The Choice research project, a joint collaboration with University of Surrey, was carried out in 2013and aimed to establish a toolkit to care for the dying patient in care homes. The research highlighted the supervision and support needs of carers in homes. The second phase of the research project had been funded to take place at Ashford and St Peter's hospitals. The aim would be to support the needs of patients to die in their preferred place of care with people who are familiar with their needs, to facilitate appropriate discharge, and to improve communication and collaboration.
- Collaborative working between the bereavement services, the mortuary and the chaplaincy services

supported relatives of patients who had died. The multidisciplinary working by these services together ensured that there was a continuity of care for bereaved relatives.

Seven-day services

- The SPCT was available seven days a week between 9am and 5pm. Out-of-hours services were available from the on-call doctors at the hospital, with telephone advice support available from a nearby hospice. This ensured that prompt expert advice was readily available.
- A rapid discharge service was available as part of the seven-day service. When a rapid discharge was prompted by the patient or staff, joint working between the ward, the discharge team and the SPCT took place. This was to enable the patient to go home if that was their preferred place of death. We saw on one occasion staff did not facilitate a transfer to a nursing home as the patient was too close to the end of their life for the transfer to be comfortable.
- A pilot was currently taking place on Aspen Ward to identify how rapid discharge could be improved before rolling out to the rest of the hospital.
- In response to an identified increased need, the availability of diagnostic facilities had been increased to seven days a week. This would support an earlier diagnostic facility for all patients.

Access to information

- Staff told us that electronic recording systems did not all link and so information sharing and access was not possible between some departments and specialties. Patients' end of life care records were in paper format on the wards and departments and recorded in electronic format by the SPCT. The SPCT could access the electronic systems used by the cancer teams and so could share information through that route. These routes were not accessible to ward teams and so the information they needed had to be completed by hand.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff considered the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards during multidisciplinary working. We attended board rounds on the wards which included a multidisciplinary approach to discussions about patient capacity and nursing and medical staff demonstrated an understanding of their responsibilities.
- Records identified when a patient lacked capacity to make a valid decision, and the decision-making process to ensure that patients' best interests had been served. Staff explained how best interest meetings would be held and when independent mental capacity advocates would be used to support patients' best interests.
- Staff completed online training for the Mental Capacity Act 2005 and its related Deprivation of Liberty Safeguards.

Are end of life care services caring?

Good

Patients and relatives told us about the compassionate and sensitive end of life care provided to patients by staff in all wards and departments. Patients and relatives told us that they were treated with dignity and respect at all times.

The SPCT was highly regarded by colleagues throughout the trust.

A range of services to support the emotional needs of patients and relatives was available throughout the trust. Patients and relatives told us they felt included in decisions and treatment plans.

The close working relationship between the nursing and medical staff, chaplaincy, bereavement, mortuary and porter services was evident to support patients and relatives.

Compassionate care

- Relatives spoke in the most complimentary terms about the nursing and medical staff. Nursing care was described as "brilliant" and "exemplary" and the SPCT as "outstanding in their support". We were also told about the kindness of ward clerks and other administrative staff.
- Patients and relatives were offered support with emotional and psychological pain through the SPCT, the chaplaincy service and ward staff.

End of life care

- We observed nursing and medical staff interacting with end of life patients in a caring and gentle way which protected their privacy and afforded them dignity. We saw non-clinical staff treating patients and relatives with the same empathy and respect.
- Most patients at the end of their lives were moved to a side room for privacy. One staff member described how a patient had asked to be moved back to the ward as they had felt isolated. Staff had facilitated this and provided support for the other patients in the bay when that patient died.
- Porter staff were respectful when transferring patients at the end of their lives. Portering staff were trained as part of their induction to treat all patients with dignity and respect. Transfers to the mortuary were done discreetly and porter staff ensured that the appropriate checks and procedures were undertaken.
- The chaplaincy department of the hospital was proactive in its support of end of life care. The chaplain and volunteers visited the wards daily, helping those patients who needed spiritual support. The chaplain was also present on the end of life steering group to ensure that the spiritual needs of patients continued to be in focus. The chaplain had also reintroduced the end of life care group for relatives to provide further support.
- Bereavement and mortuary services were provided in a compassionate and supportive way. We spoke with porters who took patients to the mortuary. They treated patients with dignity and respect. The teaching programme for porters included ensuring that they understood the importance of dignity and respect for the deceased patient.
- The mortuary staff were respectful and professional. Patients were treated with dignity and respect. The consideration of family members was managed to ensure as little distress as possible. Specific requests for viewings could be made. The mortuary staff ensured that those relatives with specific requests and religious beliefs were supported to the best level they could. The trust could accommodate people with specific lifestyle choices and customs.

Understanding and involvement of patients and those close to them

- Staff demonstrated a passion about the end of life care provided. Patients told us they felt included in decisions about their care and that staff were compassionate and sensitive to their end of life needs. We observed staff speaking with patients and their visitors with privacy, dignity and respect.
- Relatives told us they had felt included in discussions and supported with the right information to make informed decisions. They had also received explanations about the personalised care plans being trialled on one ward and were provided with literature about what to expect during a patient's deterioration.
- We were told by staff about a recent celebration which took place on a ward. This enabled a patient at the end of life to celebrate an important event before their death. Staff spoke emotionally of the effect this had on the staff.

Emotional support

- The chaplaincy services were available to support patients and relatives. Multi-faith rooms were available. The spiritual needs of patients were not routinely assessed as part of the admission process. There were plans to include this in the piloted personal care planning project. However, every patient, relative and staff member we spoke with was complimentary about the input of the chaplaincy service. Staff were confident in how to access a range of faiths on request to ensure that the right spiritual support was made available.
- Emotional support for patients and relatives was available through the SPCT, ward-based clinical nurse specialists, the chaplaincy team and bereavement services. Relatives were able to stay at the hospital overnight on camp beds if needed at the end of life.
- Some patients needed the support of their regular home carers. For example, recently a patient with a learning disability wanted their carer to stay, and arrangements were made for that to happen.

Are end of life care services responsive?

Good

All patients requiring end of life care could have access to the SPCT.

The SPCT was responsive to requests to support patients with complex end of life symptoms and care needs.

End of life care

Admission pathways could prove difficult for cancer patients with complex needs. Rapid discharge arrangements and relationships with the local hospice promoted a responsive service for patients.

Learning from patient questionnaires, complaints and feedback was used to improve services.

Service planning and delivery to meet the needs of local people

- The trust's website included information relating to palliative care. This included the staff available and their role. There was also a leaflet which told patients what to expect and provided useful information.
- There was a chapel, quiet room and a multi-faith room in St Peter's Hospital. The support of the chaplaincy staff was evident throughout the hospital. The prayer book showed these areas were well-used by patients, relatives and staff.
- In response to the need for timely discharge, there were two beds at a local hospice now available and fully utilised to support end of life discharges.
- Bereavement services provided one staff member for the St Peter's Hospital. When this person was not available, the service was supported by the Patient Advice and Liaison Service team. Some delays were caused by staff not promptly completing death certificates. However, in response, we saw on board rounds that when a patient was identified as being close to the end of life, a plan was implemented to ensure a timely completion of the certification needed.

Meeting people's individual needs

- The SPCT undertook an assessment of specialist palliative care needs, which included: symptom assessment and management; psychological needs; complex spiritual needs; complex social and advance care planning. This enabled the team to provide a care plan to meet people's individual needs. Auditing of end of life care was ongoing to ensure that the service provided met patients' needs.
- Food and drinks were supplied and open visiting was available on all wards for those patients approaching end of life or in need of family support.
- The trust had extended services to ensure patient understanding. The trust could provide interpreters for a variety of languages and information in larger print and an audio version. Further literature was also provided around communication between family members, and for use with staff and family members. Literature was available in an easy-read format to support anybody with a learning disability.
- Equipment and facilities were considered and available for palliative and end of life patients who needed bariatric (weight loss) support at admission, discharge and after death.
- Some delays occurred in access to death certificates because of delays in doctors' signatures. This may have caused distress to patients' families. However, trainee doctor handovers were focused to address any delays in completing death certificates over weekends should this be needed for religious or cultural reasons. For those patients with no known family, the bereavement staff made every effort to ensure that any family members were tracked, and if they could not be found, would organise the funeral arrangements.

Access and flow

- End of life care was provided by ward and department staff throughout the hospitals. The trust told us about increased overall demand for services. This included end of life services. As a result, the admission journey for some patients who received palliative care or had end of life needs was extended to include A&E, the medical assessment unit and the Medical Short Stay Ward. These pathways could prove difficult for cancer patients with complex needs. As no oncology unit was available, patients went to whichever ward was most suitable for them and the consultant visited them there. This meant that there was no admission process to avoid admission through A&E.
- Staff demonstrated a clear understanding of how to refer to the SPCT. There referrals were highlighted electronically, reviewed daily and responded to within 24-48 hours by the SPCT.
- Rapid discharge arrangements were in place. These were seen to be responsive to patients' needs and supported by staff to ensure they were safe.

Learning from complaints and concerns

- The SPCT undertook a patient satisfaction survey every year. The last survey had not been successful in that very few responses had been received and so very little specific learning had been gained. In one instance, further to comments received, more communication training had been provided in the appointment booking

office. To improve the situation, the SPCT had identified an alternative questionnaire format and were optimistic that, following the next round of reviews, learning and changes would be identified.

- Complaints in the trust were received by each division. As end of life care came under several of the different divisions – for example, surgery and critical care – any complaints relating to end of life care had to be filtered and forwarded to the SPCT. Any investigations were reviewed for themes and were discussed at the end of life steering group. Two complaints were ongoing and steering group minutes reflected the complaints issues identified on the agenda.
- As a result of complaints, changes in practice had taken place. This included the development of multidisciplinary board rounds. We attend two board rounds and saw that the multidisciplinary approach was used to ensure good communication.

Are end of life care services well-led?

Good

The end of life service provided by the SPCT was well-led. The team promoted an open culture of sharing knowledge and developing the skills of others.

The governance processes to monitor the quality of end of life care identified when there were shortfalls and the end of life steering group supported actions to be taken.

The SPCT demonstrated learning and changes in practice as a result of audits, incidents and complaints.

Vision and strategy for this service

- The trust end of life strategy (July 2014) set priorities for the present and future. The strategy set out the trust's commitment to deliver the best possible end of life care. Ashford and St Peter's Hospitals NHS Foundation Trust had an end of life steering group chaired by the directorate lead for end of life care and medicine. This group met quarterly and had representation from community providers, the clinical commission group and patients. The steering group enabled the integration and collaboration of hospital and community services. Work streams had been identified with lines of responsibility and target dates. We saw from minutes of these meetings how the National Care of the Dying Audit had been reviewed and a working party organised to review the findings. The role of the person to report back at the next meeting was agreed and timescales confirmed. Progress of action plans relating to end of life care was the steering group's responsibility and was a six-monthly agenda item.
- The SPCT planned to contribute to the trust's formal induction training sessions for new nursing staff.

Governance, risk management and quality measurement

- The SPCT maintained a record of audits and action plans relating to end of life care. Any pilots being undertaken, for example, the personalised care plan pilot, were monitored and reviewed within a planned timescale. Any identification for training to minimise risk was raised with the SPCT and bespoke training provided.
- Risks were identified and escalated to the Trust Board through the end of life steering group. Should a risk need to be added to the trust's risk register, an appropriate procedure was followed by the lead nurse for end of life and cancer services. Currently one risk had been highlighted around the need for increased consultant cover for palliative services. Actions had been taken and recruitment commenced.
- The SPCT reviewed risk and quality indicators such as incidents, audits and quality improvement programmes. There were standing agenda items for the end of life steering group. This information was documented in meeting minutes and a clear audit trail was evident of issues raised and actions taken.
- The trust had a direct line of information through performance review monitoring and divisional governance meetings. These fed in to a risk committee, quality and governance committee and patient experience committee. They, in turn, informed the integrated governance committee and ultimately the trust board. A patient story was presented to the board at each monthly meeting, and a recent presentation included end of life services.

Leadership of service

- The SPCT told us they felt well-led. Staff throughout the trust said that the SPCT was visible, approachable and easily accessible. All staff we spoke with on the wards and in departments valued the team and considered them to be a source of information and support.

End of life care

- Staff were aware of the chief executive (CEO) and the head of nursing. Most staff spoke positively of the trust board's presence and visibility in the hospitals. Some staff spoke very highly of the head of nursing. One described an occasion when the head of nursing worked on the wards alongside student nurses. SPCT members told us that clear lines of communication were open to the Trust Board via the divisional lead and end of life steering group. A non-executive director attends but is not a designate of the steering group.
- The clinical lead for end of life care and division lead for medicine were interim roles. Each ward and department had a link end of life care team member. These link nurses met monthly to discuss any concerns and issues and report back to the lead palliative care nurse. These roles ensured that changes in practice were embedded in their department or ward. A file of end of life information was also provided for staff to work from in each department and ward.
- Oncology services' leadership was divided between different lead roles and directorates. We spoke with the senior oncology staff and all were clear about the routes information took and how the system for reporting worked in the hospital.

Culture within the service

- Most staff we met were able to tell us the trust's values and we saw that these were available on the trust's intranet. We saw the culture of all staff providing palliative and end of life care was that of kindness, dedication and a will to provide a good experience for patients and relatives.
- Some staff were able to describe their duty of candour to their patients. They explained that they had a responsibility to be open and transparent and to accept responsibility if they made mistakes and, when required, apologise.
- Staff consistently told us that the trust supported them to be open and transparent. When new ideas from staff were raised to the trust they were considered. The CEO requested staff bring new thoughts and ideas for improving the trust's services to the Trust Board for consideration.
- Staff sometimes felt the emotional stress of providing end of life care. They told us that they looked after each other and that counselling support was available through the trust. A system of Schwartz Rounds (monthly one-hour sessions for all staff) had been implemented. These afforded staff from all disciplines across the hospital the opportunity to reflect on the emotional aspects of their work.

Public and staff engagement

- The end of life service had made changes in response to patient experience. The patient experience group raised an issue with the trust around early patient diagnosis which led to changes in day-to-day practice. This included SPCTs now being involved in board rounds on the wards which were to be updated on all patients with end of life needs.
- A patient and a lay representative were included on the end of life steering group. There was also an Improving Cancer Care action group at the trust and their views were sought to inform the trust of public perception of end of life and cancer care.

Innovation, improvement and sustainability

- The SPCT worked collaboratively with other services to improve end of life care for patients. For example, the team was working with a local hospice to ensure that sufficient consultant cover provided a joint method of care between the hospital and the wider community.
- A pilot had been undertaken to use an End of Life Toolkit as part of a Choice project (in collaboration with the University of Surrey) for use in both hospitals and the community. Following this pilot this toolkit was going to be rolled out to the rest of the wards and departments of the hospital. This was, however, not yet in place.
- There was ongoing work in A&E by the end of life link nurse to support witness resuscitation choices. This meant that relatives did not have to be excluded from resuscitation areas if that was what the patient and family wanted.

Outpatients and diagnostic imaging

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

Information about the service

The Ashford and St Peter's Hospitals NHS Foundation Trust provided an outpatient service of about 405,870 first and follow-up appointments over the previous 12 months up until November 2014. Around 250,000 of these were at the St Peter's Hospital site.

At St Peter's Hospital each outpatient service was located within one of four directorates and managed through that department. At Trust Board level outpatient services came under the medical directorate.

The majority of clinics were located within three main outpatient areas located on the ground and first floor near the main entrance of the hospital.

During our inspection we visited the outpatients clinics for rheumatology, orthopaedics, audiology, ear, nose and throat, physiotherapy, cardiology, respiratory, radiology, dermatology and phlebotomy. We met with 28 staff, including receptionists, booking staff, nursing staff, healthcare assistants, consultants and therapists. We spoke with 24 patients. We looked at the patient environment and observed waiting areas and clinics in operation.

We visited the diagnostic and imaging facilities, met with a range of staff and spoke with patients attending for a variety of different scanning procedures.

Summary of findings

We found that a safe environment for patients was maintained and that the required safety checks were being completed and recorded.

The outpatient waiting areas and clinic rooms were clean and hygienic.

Patients attending the outpatient clinics were positive about their treatments and consultations and the professionalism of the staff. Clinical staff were caring and compassionate in their approach to patients. Staff were treated with respect.

The trust was taking action and implementing changes to respond to an increased demand in some clinic services. Some additional clinics were being run and action was being taken to improve the patient experience with regards to appointment booking.

There were consistent processes to monitor the performance of the different clinic services and identify risks and ongoing concerns. There was an ongoing transformation plan for the outpatient service that was being implemented with the engagement of staff.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We found that a safe environment for patients was maintained with the required safety checks completed and recorded. The outpatient waiting areas and clinic rooms were clean and hygienic.

Patients attending the outpatient clinics were positive about their treatments and consultations and the professionalism of the staff.

Clinical staff were caring and compassionate in their approach to patients. Staff were treated with respect by each other.

The trust was taking action and implementing changes to respond to an increased demand in some clinic services. Some additional clinics were being run and action was being taking to improve the patient experience, including appointment booking.

There were consistent processes to monitor the performance of the different clinic services and identify risks and ongoing concerns. There was an ongoing transformation plan for the outpatients service that was being implemented with the engagement of staff.

Incidents

- There had been no reported serious incidents relating to the outpatients services in the previous 12 months.
- Staff we spoke with were clear about the process for completing the required form and reporting incidents. Some staff we spoke with commented that the form was too complex and could be time-consuming. Staff were aware of the box they were required to tick if they wished to receive feedback after reporting an incident.
- There was inconsistency in how staff felt information was reported back to them after reporting incidents. We were told of two examples, in the physiotherapy clinic and the ophthalmology clinic, were clinical staff said they received prompt feedback and guidance relating to reported incidents. However, three staff members we spoke with told us they had completed forms and received no feedback.
- Staff we spoke to in the diagnostic imaging department understood their responsibilities to raise concerns and record safety incidents and understood the process for doing this. We saw evidence of how reported incidents were dealt with. One incident, relating to the missed observation of a malignant renal lesion, had been investigated by the consultant radiologist and joint specialty lead in radiology, and a report completed. Recommendations were made and a debrief was provided to staff in the department. Staff we spoke with were aware of the incident and the action taken.

Cleanliness, infection control and hygiene

- We saw all the waiting areas for the outpatient clinics and also a selection of consulting rooms and treatment and scanning areas. All were clean and hygienic. Patients and staff we spoke with told us they thought the hospital was always clean and expressed no concerns about the risk of infection.
- Individual outpatient clinics had nominated infection leads who carried out regular audits of their respective areas. We saw samples of these audits in the diagnostic imaging area and the dermatology clinic. We saw that hand gel dispensers were readily available and there were signs advising about hand washing. Regular hand hygiene audits were also carried out, and we saw samples of these that showed scores between 96% and 100%.
- We spoke with the manager of the domestic cleaning staff who showed us the cleaning audits they carried out on a weekly basis of all areas of the hospital, including the outpatient areas. The manager of the team also completed a daily walk-around to check on cleanliness and hygiene standards. The audits were all available online for clinical or reception staff to check if they needed to. We were told how the staff rotas had been reorganised over the previous 12 months to ensure that waiting areas were cleaned at the most appropriate times. We saw there was an internal target of 20 minutes for cleaning teams to respond to a call for urgent cleaning. Cleaning and clinic staff told us this target was always met. Several clinical staff we spoke with told us the cleaning staff were “excellent” and were positive about how quickly the team responded to cleaning requests. We saw the training audits that showed the training and induction of cleaning staff was being completed and audited and was up to date.

Outpatients and diagnostic imaging

- In the diagnostic imaging department the lead nurse was responsible for infection control and hand hygiene audits. Records showed scores of 97% and 100% in the previous two months. There was also a schedule for the deep cleaning of the clinical areas.
- All clinical and reception staff we spoke with had completed infection control training. We saw that reception staff and clinical staff observed the recommended bare below the elbows policy for hygiene.
- Where toilet facilities were located in clinics, these were clearly signposted. We looked at a sample of these and saw they were regularly cleaned and that this was recorded.
- We saw that signs providing information about the Ebola virus were widely displayed through the outpatients waiting areas.

Environment and equipment

- We looked at a selection of resuscitation equipment and found that this was correctly serviced, cleaned and checked at regular intervals, with the required records completed. Staff who completed these checks confirmed they had undertaken the required training. The resuscitation trolleys were discreetly and securely stored and staff were aware of their location.
- There were appropriate facilities to dispose of sharps and clinical waste and these were being regularly emptied.
- Major building work was being undertaken in the diagnostic and imaging department and this was being managed effectively and safely. Areas being worked on were sealed off and clear signposting was in place. There were escalation procedures when staff needed the noise levels to be reduced to complete certain patient procedures such as ultrasounds. The manager of the department explained how the work was being managed in conjunction with the contractors, the estate department and the senior management of the diagnostic and therapies division. The operational manager confirmed that risk assessments covering the full range of the work being undertaken were used and reviewed on a regular basis.

Medicines

- The clinics we visited which stored medication had appropriate lockable facilities. We saw that the correct recording was being completed. Procedures were in place for the storing of controlled drugs where this was required, with the correct documentation.
- Patients we spoke with told us they received appropriate information about the medication they were prescribed and that any changes were explained to them.

Records

- Clinicians we spoke with told us that the medical notes were provided efficiently and were appropriately prepared for clinics. In the ophthalmology department, for example, we were told that, on average, they were only required to prepare one set of temporary notes a week.
- We saw there was secure storage for medical records in the outpatient clinics with lockable cabinets available behind the reception desks. Records were not transported in trolleys that protected confidentiality. The physiotherapy department kept their own set of patient records in a secure, non-clinical storage area, not accessible to patients. Staff took out the records they needed for their immediate appointments and returned them at the end of their clinics.

Safeguarding

- Information was displayed in the clinic areas about safeguarding, including details about the trust-wide team and the pathway for reporting safeguarding concerns.
- All the staff we spoke with told us they had completed safeguarding training, which was part of the required mandatory training for the trust. Managers in departments explained how they completed different levels of training depending on the role of the staff member. However, some staff we spoke with were unsure whether they had completed level 2 or level 3 child protection training. Nursing staff and reception staff were aware of the process to follow if they wished to report a concern.
- Patients told us they thought the hospital was a safe place to visit.

Mandatory training

- The completion of mandatory training varied between the different divisions but completion rates were all

above 80%. Staff were clear how their training was monitored and confirmed that managers gave reminders when training was overdue and needed to be completed.

Assessing and responding to patient risk

- Staff were present in all the waiting areas for clinics and able to notice patients who appeared unwell and needed assistance. If required, the staff member would arrange for a doctor to see the patient.
- Staff in the diagnostic imaging department knew who their radiation protection adviser and supervisor was for each clinical area. They explained how they would promptly report any concerns about safety with a line manager. We saw there were local rules for each area and where copies of IR (ME) R 2000 could be found by staff if required.

Staffing

- Staffing in individual clinics was organised by the relevant managing medical division. Each service was supported by reception staff, doctors, nursing staff and healthcare support workers. Staffing levels were maintained by the use of bank (overtime) staff.
- Staffing levels varied according to the clinics and bank staff were used to ensure the designated numbers were in place.
- Staff in the diagnostic imaging department told us that safe staffing levels were maintained.

Major incident awareness and training

- Throughout the outpatient area there were permanent signposts relating to major incident provision. The trust's plan for managing major incidents included utilising parts of the outpatient area.

Are outpatient and diagnostic imaging services effective?

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

We observed that patients were receiving effective care and treatment. Patients were provided with sufficient information about their treatments and the opportunity to discuss their concerns, care and treatment with clinical staff.

Information about national guidelines, trust policies and procedures were effectively disseminated through the department.

Evidence-based care and treatment

- Staff were able to access policies and procedures online and we were told how new practice guidance would be disseminated through line management. We were told that protocols, such as National Institute for Health and Care Excellence (NICE) guidelines were followed where appropriate.
- The lead nurses in the clinics explained how they received NICE and Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and then ensured this was passed through to the other nursing staff. Nursing staff told us how new practice guidance could also be disseminated through the specialist area they were working in.
- The diagnostic imaging department had integrated diagnostic reference levels into their practices as required by Ionising Radiation (Medical Exposure) Regulations 2000. The equipment in the department regulated these levels.

Competent staff

- Some clinics could be run by a clinical nurse specialist, including cardiology, dermatology and ophthalmology. For these clinics there were nurse protocols and competencies to follow. Two nurses we spoke with explained how they had been supported to complete the necessary training.
- There was a system for staff to receive annual appraisals and nursing and healthcare staff we spoke said they were up to date with these. There was no overarching training matrix for the outpatients department as this was monitored from within the individual specialties. We saw evidence that 100% of appraisals had been completed by staff working in the orthopaedic trauma clinic. In the diagnostics therapies division we saw that 80% of appraisals had been completed but that there was a plan to have all staff completed by April 2015.

- We spoke with reception staff and healthcare assistants who had recently completed their induction to the role. In the orthopaedic clinic there was a two-week induction for new healthcare assistants and staff said they were well-supported through this period. Reception staff explained how they undertook training during their induction period and that support was available if they encountered procedures they were unfamiliar with.
- Healthcare assistants were running the phlebotomy clinic and had been trained to do this role.
- In diagnostic imaging, there were policies and protocols for the use of machines. All staff underwent training in the use of each machine and there was a record of when refresher training was due and completed.

Multidisciplinary working

- We saw evidence of professional multidisciplinary working. In the ophthalmology clinic the lead nurse explained how, if a patient was assessed as needing a cataract operation, they would try and see them that same day to complete their pre-operation assessment. This meant the patient only had to return once for the operation itself.
- In a nurse-led urology clinic, we saw how the clinic worked in collaboration with local GPs. The clinical staff explained how, if a malignancy was suspected, they could arrange for the GP to organise tests, such as cytology, and then make the patient's clinic appointment which would include a magnetic resonance imaging (MRI) scan. This resulted in prompt diagnosis and, if required, earlier treatment. The senior nurse also worked in the oncology department which they said improved communication between the specialties. Staff working in the urology department told us they thought they worked well as a multidisciplinary and cohesive team.
- The radiology team described how they worked closely with the nursing staff on interventional treatment. There was also an office called the 'hot seat' where a radiologist was available to provide advice and guidance to members of the team on any arising clinical issue. In the imaging department, staff rotated working across the two hospital sites. This promoted team working as staff worked with everyone in the department over a period of time.
- An audiologist explained how they were able to access and speak to consultants and nurses working in the ear, nose and throat clinics, located close to the audiology clinic. Their experience was that different professionals all worked well together to meet the needs of patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act (2005) and Deprivation of Liberty safeguards were displayed on the noticeboards in the outpatient waiting areas. This provided a basic explanation for patients about the issues involved in these areas.
- We saw evidence from staff training records that clinical staff had completed training on mental capacity and Deprivation of Liberty Safeguards. Staff confirmed that they had completed training and undertaken regular updates.
- When appropriate, patients had completed consent forms prior to receiving treatments. Some forms were completed when the initial appointments were made and some when the patient attended the clinic. Patients we spoke with gave examples of how staff asked for consent before commencing any treatments or examinations.
- We observed that radiographers discussed processes with patients and asked them what area was to be scanned, gaining assumed consent.

Seven-day services

- The outpatients department was open between 8am and 6pm Monday to Fridays and there were occasional clinics being run on Saturday. Some clinics also occasionally stayed open until 7pm. These were additional clinics organised to help some specialties meet their referral-to-treatment time targets. For example, there had recently been additional urology clinics run. There was a trust-wide plan to move towards more flexible staff working hours and this would potentially provide more weekend clinics.
- There were trust-wide developments to move towards more six- and seven-day working, which would also provide opportunities to increase the capacity in some clinics.

Outpatients and diagnostic imaging

- Changes had been made to the provision of endoscopy clinics following a 40% increase in demand in some specialties. Seven-day working had been introduced in this area and there was also a plan to use a mobile unit on the Ashford Hospital site before January 2015.
- The trust had taken action to address a backlog of urology appointments. This had included seven-day working and recruiting additional consultants.

Access to information

- Patients told us that appointments were not rushed and they were allocated enough time with staff. Clinicians were informed about patients' medical histories and medical records were made available to them.
- Some, but not many, of the clinics displayed information about safety metrics, appointments completed and rates for patients not attending.
- Some patients we spoke with said they would like to see the information about waiting times more clearly displayed in the clinics.

Are outpatient and diagnostic imaging services caring?

Good

We found that the outpatients department staff working at St Peter's Hospital were caring and considerate towards the patients. We observed clinical staff, receptionists and volunteers interacting with patients with a caring and friendly approach.

We saw that staff and volunteers throughout the department treated patients, their relatives and visitors in a polite and respectful manner.

Compassionate care

- During our visit we spoke with 24 patients and all said they found the staff were caring and respectful. We observed staff interacting in a caring and considerate manner with patients. We saw that patients and relatives were greeted politely and respectfully when approaching reception desks.
- Patients we spoke with were positive about their experience of the outpatients clinics. We were told that reception staff were efficient and helpful. Patients commented on the professionalism of the clinical staff and how their treatments were discussed and explained. One patient we spoke with told us, "This is my fourth visit this year and I have been to two different clinics; both consultants were excellent". Another patient told us, "All the nursing staff running my clinic have been great, they really explain things well".
- Patients' confidentiality was respected. Private rooms were available in all the clinic areas if staff needed to speak patients about sensitive issues. We observed that consultations with clinical staff were conducted in private.
- We saw reception staff taking telephone calls relating to patients which could be overheard and so they were careful not to identify any private details and protected patient confidentiality.

Patient understanding and involvement

- Patients told us they felt involved in their care and were fully consulted about their treatment options. For example, in the ear, nose and throat clinic area, a poster promoted a course for patients run by the Macmillan nursing service. This was for patients who were recovering from head or neck cancer and called 'The road to recovery'. We observed a nurse explaining this information to a family, telling them who to contact if they needed further clarification.
- Patients told us how they could involve their relatives in discussing their treatment. We saw that patients could attend appointments with their partners if they chose and we observed this happening.
- We spoke with two patients in the waiting area of diagnostic imaging. They were positive about the care they had received from all the staff in the department. One patient told us they thought they had been "well looked after" by everyone, as they had been very nervous about their appointment.

Emotional support

- We found that patients' confidentiality was respected. There were a number of private rooms available in the clinic areas where staff could have sensitive conversations with patients when the need arose. Staff explained how they would ensure that the patient was in a suitably private area or room before discussing any distressing news. Patients we spoke with told us that conversations with clinical staff were conducted in private.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services responsive?

Good

We found the trust had taken action and implemented changes to respond to increased demand in some clinic services. This included coordinated action between the booking centre, the various clinics specialties and the management teams of the different divisions to reduce the referral-to-treatment times.

The trust had higher than the national average cancellation rates for appointments, both by patients and the hospital. Action was being taken to improve these rates.

The refurbishment and further development of the diagnostic and imaging service was improving the service for patients and would also, when completed, increase the capacity of this service.

Car parking was often a problem for patients, with limited spaces available from late morning onwards.

Service planning and delivery to meet the needs of local people

- Analysis done by the trust showed that of outpatient appointments cancelled by the hospital, 8% were cancelled with less than six weeks' notice. Action had been agreed as part of the outpatient improvement plan to improve these figures. Work was being done with the divisional teams and a monthly report to the executive board was being completed to monitor progress. Each specialty had a monthly performance review and any short-notice cancellations of clinics were now reported and discussed in these reviews.
- The trust received an average of around 13,000 referrals a month from GPs. An improvement initiative looking at the patient pathway found that, at times, patients were referred twice, as no initial confirmation was received of the appointment. An important part of the changes made to address these appointment issues was the creation of a centralised call centre for booking first-time appointments. This was located on the Ashford Hospital site and had a bespoke manager. The manager was involved when capacity problems were identified and worked in conjunction with the various directorates to organise additional evening or weekend clinics. Information, including a video presentation, was provided to GP practices about the changes to the booking system.
- A minority of the services operated their own booking systems, such as physiotherapy and audiology. Patients we spoke to in these waiting areas said the booking system had worked well for them.
- The trust had also introduced a telephone reminding service for appointments. This had helped to reduce the rate of patient non-attendance from 13% to an average in the last 12 months of 8%.
- We observed patients booking follow-up appointments with the reception staff on several clinics. Where possible, patients were offered flexibility with dates and times to accommodate their transport needs or other arrangements.
- We spoke with 24 patients and four relatives who were attending the outpatients department. None of the patients we spoke with had experienced any cancelled appointments and all were positive about how they had arranged their visits. One patient told us they were a regular visitor to the respiratory clinic and that the staff arranged their appointments at convenient times and were always helpful. Patients we spoke with attending dermatology, fertility, respiratory and cardiology and physiotherapy clinics all said they had not waited long for their first appointment. All were satisfied with the booking process and the written information they had received about their initial appointments. We spoke with four patients who had arranged to have more than one appointment on the same day. All said this had worked well and, though they had a long wait at times, they were pleased they had only to visit the hospital once.
- The urology clinic was recruiting an additional urologist and it was planned that the senior nurse would take over the day-to-day running of the unit. The role of the nurse was being expanded to include additional staff training for ward-based staff. The urology service had been reorganised and was now all located in one area. Staff were positive about the change and told us it had improved communication between staff and patients. Patients could receive quicker diagnosis and therefore start their treatments earlier.

Outpatients and diagnostic imaging

- The trust is a tertiary centre for limb reconstruction and we visited the pre-operation outpatient clinic which was nurse-led and run. The clinic sees about 50,000 patients a year. We were told there were plans to move the clinic to new premises but there was no date set for this.
- In the diagnostic imaging department there were targets for each modality that were internal trust targets set by the department. On the week we visited, nine of 16 modalities were not meeting these internal targets for reporting x-rays. A weekly meeting looked at a patient tracking list which listed the waiting times for image reporting for every patient. Reports could be reallocated between staff who had capacity.
- The diagnostic imaging department had extended its working hours to accommodate an increased demand on its services. Weekend working and evening working until 8pm was in place. An external provider was also being used to provide urgent overnight consulting for some imaging.
- Refurbishment and expansion of the diagnostic imaging department was being undertaken. A new interventional suite was due to be opened in January 2015 and an additional CT scanner was to be installed in March 2015. The new computerised tomography (CT) scanner will increase the capacity of the department. It was explained that the new technology associated with this equipment would negate the need for barium treatments and increase the range of cardiac treatments that could be undertaken. The department had a 10-year 'managed equipment plan' with an external provider. Staff we spoke with were positive about the improvements this was bringing for patients. All servicing, maintenance and equipment replacement was the responsibility of the external contractor. The contract included a guarantee of 98% working time for equipment and a commitment to complete repairs within four hours.

Access and flow

- Data showed that, of 356,723 appointments made during the year 2013/14, 11% had been cancelled by patients and 11% by the hospital. Data also showed that 5% of patients did not attend their appointments, which is 2% lower than the national average. There were about 250,000 first-time and follow-up appointments at the hospital.
- The trust was meeting the national target time for the 18-week patient pathway of referral-to-treatment time for outpatient services. The data showed there had been times over the previous 12 months when the trust had not met the target of 90% of patients attending their first appointment. There were systems to monitor this performance and to take action to address shortfalls. Weekly meetings were held between the booking centre manager and the performance management team, who collated the referral-to-treatment time data, and with the managers of the different medical specialties. There were also monthly meetings with the executive board where the managers of each medical division reported on their respective times.
- We saw examples of how extra capacity was created to address increased waiting times by running extra clinics, extending clinic hours and recruiting additional staff. Some increases were temporary and some permanent. There were also trust-wide developments to move towards more six- and seven-day working, which would also provide opportunities to increase the capacity in some clinics.
- Extra clinics had been booked in January for the dietetics clinic to reduce a 15-week wait for first-time appointments. There had also been individual contact with patients to establish reasons for a high rate of patients not attending in this clinic and hopefully reduce this. Changes had been made to the provision of endoscopy clinics following a 40% increase in demand in some specialties. Seven-day working had been introduced in this area and there was also a plan to use a mobile unit on the Ashford Hospital site before January 2015.
- We saw evidence of how the trust had taken action to address an identified problem with a backlog of urology appointments. This had included seven-day working and the recruitment of additional consultants. The backlog had been cleared and each patient who had been delayed in their consultation was investigated by the patient safety lead to capture any potential harm.
- The trust was not always meeting the target that people should be seen by a cancer specialist within two weeks of a GP referral. The data showed that, over the previous 12 months, between 94% and 97% of patients had been seen within the two-week target. However, the target for people waiting less than 31 days from diagnosis to first definitive treatment was being met.
- We found that the patient waiting times in clinics varied in the different clinics. On the day we visited, the clinics in physiotherapy, audiology, urology were running on

time but there was extended waiting times in the orthopaedic fracture clinic and the dermatology clinics, for example. Some clinics kept patients informed of the waiting time by using the electronic screens located in the waiting areas and others by the reception staff informing patients of the length of delay. However, not all clinics kept the patients informed of the ongoing waiting times. For example, a dermatology clinic due to start at 9.30am was 15 minutes late starting but patients were not informed of this or the reason for the delay. Patients we spoke with had varied experiences of waiting times. Some said staff informed them when appointments were running late but others said they were only told when the clinic was running "really late". Not all of the clinics used the electronic screens to inform patients of the delays.

Meeting people's individual needs

- Next to the reception desks in the main patient waiting areas were electronic checking-in stations for patients. The instructions for these machines were provided in several different languages and the system appeared to work effectively for the majority of patients. Occasionally receptionist staff were required to provide assistance.
- Patients and staff we spoke with consistently told us about the problems of parking. At certain times, usually late morning onwards, the patient car park could be full. Patients were also concerned about the cost of parking, which was made worst because some people came early for appointments to ensure they had time to find to somewhere to park. We saw there was a sign on the parking ticket machine advising disabled drivers to read the notice on the machine below. This information was to tell them how to claim their free parking. However, the notice was actually located on a wall a few metres away. This could be misleading for patients. Staff on the main outpatient reception desk told us that parking was the most frequent concern they had to respond to. We spoke with two patients who were using the disabled parking spaces. They told us they had visited many times and had always been able to find vacant disabled parking spaces. They said they understood how the free ticketing system worked.
- The signage directing patients was clearly visible and, as well as the reception desk staff, there were also volunteers around the main entrance to offer assistance to patients. At the top of the main escalator from outpatients, on the first floor leading to several waiting areas, there was also a volunteers desk that was attended for the majority of the day.
- Clinics displayed notices about the availability of chaperones for patients and there was a trust policy for this. However, training was not provided to staff on chaperoning. Chaperoning was routine in certain clinics such as colorectal or gynaecology, and could be requested by either the patient or clinician in others.
- Some patients we spoke with were unhappy with the delays in accessing the hospital transport after they had completed their appointment. Staff also told us this could be a frequent concern for patients. If a clinic had been running late, a patient may have a long wait until the transport was available. We observed staff explaining to patients when the transport would be arriving and ensuring they were comfortable and knew where they had to wait. We saw that staff ensured that people knew when the transport had arrived.
- All the waiting areas provided sufficient seating. There were magazines available and also information was clearly displayed on the noticeboards.
- Patients with a learning disability attending outpatients could be provided with a Hospital Passport, a document which contains key information about how the individual should be supported, the person's behaviours and likes and dislikes, information to help them through the appointment process.
- There were notices in the clinics informing patients about the Butterfly Scheme which was used in the hospital for identifying patients who may have dementia. Patients with dementia attending clinics were supported by carers or relatives and we observed reception staff interacting with patients and carers in an appropriate manner. There was, however, no training for outpatient staff on the subject of dementia to promote and develop their understanding.
- Translator services were available for patients and were advertised in the waiting areas. A need for this service could also be identified and a translator booked when a GP arranged an appointment.
- We saw a wide range of leaflets were available and displayed in all the clinics and we observed staff directing patients toward these. These provided information about treatments, conditions and support

groups in the community. We saw also that information was displayed about prescriptions, claiming benefits and transport costs. Information was also displayed about aftercare services and rehabilitation.
- One poster displayed by the trust was about shared decision-making. This provided guidance to patients about what their options were and how they could get the right support to make the decision that was right for them.

Learning from complaints and concerns

- The Patient Liaison and Advice Service had an office located in the hospital. Information about this service was displayed in the clinic waiting areas. Staff told us they would deal with a concern directly if they could by talking to patients but would direct to the service if this was required. Reception staff told us the most common issues patients raised directly with them were parking difficulties, both available space and the cost, and the delays waiting for hospital transport.
- The trust had recorded that 26 complaints had been made in relation to the outpatients service in the previous three months and these had been responded to within the required timescales. Operational managers reported back learning from complaints through their team meetings. Staff told us they received information about a complaint when it was made about an area they were working in.

Are outpatient and diagnostic imaging services well-led?

Good

Outpatient services were located within their own medical divisions and managed within these. We found that, at the clinic level, there were examples of good leadership and staff felt supported by their immediate line managers. Senior staff running clinics said they were well-supported by the senior managers within their medical division and were clear about the lines of accountability.

There were consistent processes to monitor the performance of services and identify risks and ongoing concerns. There was a transformation plan for the outpatients service that was being implemented with the engagement of staff. This was being monitored by through divisional managers and the trust board.

Staff was generally satisfied with the communication across the different medical divisions and felt the trust leadership communicated their information effectively to them. Staff told us they were approachable, and listened to staff.

Vision and strategy for this service

- The trust had an improvement strategy for the outpatients service. A project had been established in 2013 that had targeted a number of areas for work to be undertaken. These included improving the external website, standardising contact methods for making appointments, reducing the numbers of cancelled appointments and providing some customer training for frontline staff.
- Previous to this the corporate business plan of 2012 had included plans to begin implementing some standard processes for letter formats and appointment booking.
- In August 2014, following an analysis of information including data from complaints, further work was introduced to improve general communication, delays in patients pathways, waiting times in clinics and the provision of timely and appropriate information to patients about their appointment. This process had been driven by the trust's programme management office.
- An action plan detailed the steps to be taken in each area. For example, in regards to the administration process, a workshop was organised with the participation of over 50 staff from across the outpatients department. This meeting had taken place in November 2014 and produced ideas and actions to be followed up. A smaller project group was being formed from this meeting to take the ideas forward. We spoke with three staff who had attended this workshop and they were positive about the work completed.
- Other plans being implemented from the action plan included the introducing of the NHS Friends and Family Test in all clinics, which had been started in October 2014. A plan was also in place to reduce the number of cancelled clinics, this included the monthly review of

the data and reporting to the executive team. There was an initiative to monitor the patient waiting times in the clinics and also provide quality data information on noticeboards for patients in the waiting areas.
- Some clinic services also displayed information about their own vision and objectives. In the physiotherapy department, for example, information was displayed about their vision of "developing an ethos of personal responsibility".

Governance, risk management and quality measurement

- There were systems and processes to manage the governance across the services in the outpatient services and monitor the performance against established criteria. A performance management team produced weekly updates on the compliance with various national requirements including the referral-to-treatment times for the different specialties. This team met every week with the various service managers, administration managers and the central booking centre. The reasons for appointments not being booked were looked at and plans could be discussed to deliver additional clinics if required. The performance team had a proactive approach which could highlight issues and support the different specialties to deliver improved patient waiting times. The team produced a weekly trust-wide performance report which went to the trust deputy director.
- The executive board met with each of the 26 medical specialties every month, where they were reported to on a range of issues, including staffing, complaints, referral-to-treatment times and follow-up appointment ratios. The board received weekly reports about the compliance with the target of two-week cancer referrals
- Staff working in the outpatients department had not completed training on the recently introduced Statutory Duty of Candour but many were aware of this new legislation. Some staff told us they were aware of the legislation from reading the trust newsletter. Clinical and reception staff we spoke with told us they believed they worked in an open culture and that trust staff were open and transparent with patients over their treatments and care.
- There was a daily morning meeting for radiographers which looked at any recorded concerns or information. For example, staff who had worked overnight in the A&E department would provide the team with an update of ongoing work.
- There was a monthly governance meeting for the whole of the diagnostics directorate and the head radiographer also provided a weekly ongoing governance report for the radiography team.
- Within the diagnostic and imaging department there were regular management meetings for the senior staff. The directorate management held a weekly meeting to review overall performance and a monthly meeting to examine service needs. Staff were clear about the lines of accountability.

Leadership of service

- We saw evidence of good leadership and communication in the various clinics. There were regular staff meetings within the different specialties. For example, the orthopaedic trauma team held daily multidisciplinary meetings and there were weekly management meetings within the physiotherapy department. We were told that information was disseminated effectively through line managers and that staff were able to access email messages from the trust management.
- In the physiotherapy department, the senior staff met regularly with the manager and deputy manager. Senior physiotherapists told us they were well-supported and could voice opinions and raise concerns. The deputy manager said they felt the communication from the senior managers was effective and that trust messages were well-communicated.
- We spoke with a variety of healthcare assistants and were told they felt generally well-supported by the nursing staff and their managers. Staff working in the phlebotomy clinic told us they were encouraged in their professional development by their managers and supported to complete training.

Culture within the service

- The trust's values were well-displayed throughout the various outpatient areas and staff we spoke with were familiar with them. Several staff commented upon the support they received from colleagues and their immediate managers. Staff also made positive comments about the trust board members being open

and approachable. While the majority of staff were positive about the culture, they also commented about the pressure they felt under to deliver increased services and efficiencies. Several staff commented that this, coupled with staff turnover, were important factors affecting staff morale.

- Several staff we spoke with told us the problems of staff car parking affected their enjoyment of work. Staff arriving later in the working day sometimes could find no spaces and would have to pay to park in the public car park, or alternatively park a considerable distance from the hospital in residential areas. Staff also could be fined for parking in the non-designated parking areas. These issues, combined with the limited public transport available, were contributing factors to staff turnover.

Public and staff engagement

- Staff we spoke with said they felt the trust board kept them informed of the developments and issues that were ongoing in the organisation. Several staff commented that the information was there if staff chose to access it. Staff were given trust messages directly via email and there were opportunities to meet board members at 'sounding events', which were open forums for staff to raise issues with board members.
- As part of the plan to improve and develop the outpatient service, 50 staff had participated in a one-day workshop. We were told that the smaller working group developed from this would be required to report back the work in progress to all the staff who had attended the original workshop.
- The NHS Friends and Family Test was being extended into the outpatients service from October 2014.

Innovation, improvement and sustainability

- The transformation plan for outpatients was looking at a variety of areas that could be improved for the benefit of patients. This included appointment booking, waiting areas and customer training for staff.
- The diagnostic department was undergoing major refurbishment that was due to be completed by April 2015. The expanded department, coupled with the new equipment, much already in place, would be improving the service to outpatients.
- In the orthopaedic pre-operative assessment clinic, we saw how elective surgery followed a specific standardised pathway which culminated in reduced bed stay for patients. An enhanced limb recovery programme aimed to discharge patients having knee operations after four days and hip operations between two and three days. This was achieved through multidisciplinary working from the onset of the patient pathway, pre-operative preparation and the use of new equipment, such as a hip scanner.

Outstanding practice and areas for improvement

Outstanding practice

- Good joint working between the wards and departments, the bereavement services, chaplaincy services and the mortuary services to ensure as little distress as possible to bereaved relatives.
- Caring staff throughout the hospital who were seen to treat patients at the end of their lives and patients' relatives with dignity and respect.
- The trust had a proactive escalation procedure for dealing with surges in activity and managing capacity.
- The major incident procedures had been regularly tested internally and with external partners with reviews of learning being implemented.
- The trust had developed an Older People's Assessment and Liaison (OPAL) team which enhanced the care of the frail elderly by ensuring these patients were effectively managed by a specialist team early in their admission. Their interventions decreased the number of admissions of this group to specialty wards, and also contributed to fewer patients being readmitted. Patients and their supporters said they felt involved in care planning and discharge arrangements.
- The electronic patient record system in the intensive care unit (soon to be brought into the high dependency unit) was outstanding. Patients benefitted from comprehensive, detailed records in one place, where all appropriate staff could access and update them at all times.
- In critical care there was an outstanding handover session between the consultants going off duty and those coming onto shift. This included trainee doctors and made excellent use of the electronic patient record system.
- The dinosaur trail designed to distract children on their walk to the operating theatre had proven to be very successful. It meant children were not scared when they arrived at the operating theatre.
- The play therapy team who worked within the paediatric services were very enthusiastic about their work, were well-respected by children and their parents and staff. The team had won a £3,000 prize for innovative ways to brighten up the playroom.
- The children's ward staff worked hard, with the clinical nurse specialist to ensure patients with diabetes had a high standard of care and there was a well-established transition to adult services.
- The trust had a very detailed policy for use at times when patient safety needed to be maintained to enable treatment through applying 'mittens'. The policy provided staff with guidance on their use in line with the Mental Capacity Act 2005, from the assessment of the patient, recording the decisions and the continual review of decision and when to stop using them.

• The trauma and orthopaedic unit had set up an early discharge team to reduce the length of stay for patients with hip fractures. Patients had continuity of care from hospital into their own home as they had the same staff. This had reduced their length of stay in hospital.

Areas for improvement

Action the hospital MUST take to improve

- Take action to ensure medicines in medical care services are stored at temperatures that ensure they remain in optimum condition and provide effective treatment.
- Ensure that all trained paediatric nurses are up to date with medicines management training.
- Take action to ensure patient records are kept securely and can be located promptly when required.
- Take action to ensure the critical care department has sufficient numbers of suitably qualified, skilled and experienced nursing staff on the units and the outreach team to safeguard the health, safety and welfare of patients at all times.

Outstanding practice and areas for improvement

- Take action to ensure staffing levels on Ash Ward are such that they are able to meet the needs of their patients at all times.
- Take action to ensure theatres, anaesthetics and surgical wards have sufficient numbers of suitably qualified, skilled and experienced nursing staff to safeguard the health, safety and welfare of patients at all times.
- Ensure in the critical care department that there is a full range of robust safety, quality and performance data collected, audited, examined, evaluated and reported. The trust must ensure it has sight of this data, which follows the standards of a national programme, at board level.

Action the hospital SHOULD take to improve

- Ensure the security arrangements for accessing the paediatric area in the A&E department are adhered to in order to prevent unauthorised access.
- Ensure the layout of the A&E department waiting area enables sufficient visibility for staff to identify if a patient's condition deteriorated.
- Ensure the access/exit routes of the room used for psychiatric assessment in the A&E department are not obstructed to protect the safety of staff and patients.
- Follow up the recommendations from the maternity external review to provide an improved experience and outcomes for women and their babies from ethnic minorities and for families with greater social factors and stress.
- Ensure adherence to the trust policy on inappropriate movement of patients at night, in particular those receiving palliative care.
- Ensure those patients who receive palliative care and have complex needs do not have a protracted journey via several clinical areas on their admission to hospital.
- Report on and display in the critical care department incidents of all categories of patient harms. These should be reported in staff and clinical governance meetings and actions taken around any trends or performance improvement identified.
- Ensure in the critical care department that all investigations it carries out into serious incidents have action plans attributable to members of the team, and mechanisms for actions to be followed up and reported.
- Ensure in the critical care department that all clinical areas are able to be easily cleaned and free from dust and sticky tape on the walls in clinical areas. The critical care operational policy should set out what area is considered as the 'clinical area' and how staff should behave in relation to infection prevention and control in this area. This should follow the trust policy on infection control.
- Audit critical care recommendations for the Faculty of Intensive Care Medicine Core Standards and escalate areas where it does not meet the standards to the trust risk register. This should extend to: cover provided from allied health professionals, including the pharmacist, confidentiality of patient records in the high dependency unit (HDU), and the environment of the HDU.
- Ensure any secure areas, such as the clinical room in the HDU, are attended to immediately when security fails due to broken door locks.
- Ensure critical care has access to a practitioner skilled in advance airway techniques at all times.
- Monitor all critical care patients for delirium using a recognised tool.
- Look to provide patients in the critical care department with innovative services to contribute to their emotional support and wellbeing. Patients' and relatives' views should be sought to determine what patients want from critical care. Their views and opinions should be acted on and used to improve the service.
- Ensure that any policy used in the critical care department be approved by the relevant party within the hospital trust. Operational policies should be written in accordance with trust policies. The critical care operational policy should ensure statements around patient consent are made in line with current legislation and the Mental Capacity Act 2005.
- Consider how to improve the dementia-friendly design of its facilities.
- Ensure that medical care services consider how it formulates and records its strategy.
- Ensure negotiations remain ongoing with the local clinical commissioning group around designation of high dependency beds on Ash Ward.
- Ensure the skills mix on Ash Ward is such that the needs of children and young people with mental health needs can be effectively cared for and managed at all times.
- Ensure that all parents and staff are aware of the hot drinks policy when on the paediatric wards.

Outstanding practice and areas for improvement

- Ensure the inpatient observation charts include a section for ongoing pain assessment, including how a child is responding to pain relief given.
- Review the dispensing of medication on Wren Ward from their medication room directly to patients without the use of safe and secure storage facilities.
- Review the storage arrangements of the oxygen cylinders in the sluice area in recovery.
- Ensure that staff receive safeguarding training to meet their target.
- Review the use of the mobile privacy screen on Wren Ward to ensure privacy for patients.
- Ensure assistance is provided to visually impaired patients with their meals.
- Consider how they ensure that staff in A&E understand their responsibilities regarding the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards.
  - The provider is not currently doing something that we have identified as an area for improvement within a domain but which does not link directly to a regulation. The trust should consider:
- Alternative ways of improving the recruitment of permanent staff in A&E.
- How they ensure staff in A&E have protected time to attend required training.
- How they ensure that new staff, including overseas workers, have sufficient support and supervision during their probationary period.
- Ensuring that staff working in the A&E paediatric area undertake all routine checks of controlled drugs.
- The arrangements to enable staff in A&E to have meal breaks at times of high activity.
- How it ensures that hand hygiene requirements are met.
- How it can ensure that the registered nurse-to-patient ratios meet national guidance at all times in medical care services.
- How it ensures that 90% of stroke patients are admitted to an acute stroke unit.
- How it ensures patients with heart failure receive after-care that meets national guidance.
- How it provides out-of-hours provision for urgent endoscopy.
- How it meets the requirements of mixed-sex accommodation in the discharge lounge.
- How it can assist wheelchairs users while they are in hospital to remain independent by ensuring access to wheelchairs.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use services were not protected against the risks associated with because medicines were not stored in conditions that would ensure they remained effective and in optimum condition. Not all trained paediatric nurses were up to date with medicines management training which increased the risk of medication errors being made. Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of Medicines.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People who use services were not protected against the risks associated with unauthorised access to confidential patient records. Patient records were not securely kept and some were seen to be accessible to secure areas posing a risk Regulation 20 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Compliance actions

The provider had not taken suitable steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff in the critical care service, on the children's ward and in theatres, anaesthetics and on surgical wards to safeguard the health, safety and welfare of patients at all times.

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010: Staffing.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: People who use services and others were not protected against the risks associated with inappropriate or unsafe and treatment in critical care because of a lack of the effective operations of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided, and to identify, assess and manage risks relating to the health, welfare and safety of patents and others who may be at risk. There was no system to make changes to the treatment or care provided from an analysis of incidents that resulted in, or had the potential to result in, harm to a patient. There was no system to regularly seek the views (including the descriptions of their experiences of care and treatment) of patients and persons acting on their behalf to enable to the registered person to come to an informed view in relation to the standard of care and treatment provided to patients. Regulation 10 of the HSCA 2008 (Regulated Activities) Regulations 2010: Assessing and monitoring the quality of service provision (1) (a) (b) (c) (e).