

St George's University Hospitals NHS Foundation Trust

St George's Hospital (Tooting)

Quality Report

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

Ratings

Overall rating for this hospital

Requires improvement



Urgent and emergency services

Requires improvement



Medical care (including older people's care)

Requires improvement



Surgery

Requires improvement



Critical care

Good



Maternity and gynaecology

Good



Services for children and young people

Requires improvement



End of life care

Requires improvement



Outpatients and diagnostic imaging

Inadequate



Summary of findings

Letter from the Chief Inspector of Hospitals

St George's Hospital in Tooting, London, is the main hospital site of St George's University Hospitals NHS Foundation Trust. The trust serves a population of 1.3 million across Southwest London. A large number of services, such as cardiothoracic medicine and surgery, neurosciences and renal transplantation are provided and the trust also covers significant populations from Surrey and Sussex, totalling around 3.5 million people.

As well as acute services, the trust also provides a full range of community services to patients of all ages following integration with community services in Wandsworth in 2010.

St George's Hospital provides acute hospital services and specialist care for the most complex of injuries and illnesses, including trauma, neurology, cardiac care, renal transplantation, cancer care and stroke.

St George's University Hospitals NHS Foundation Trust employs around 8,536 whole time equivalent (WTE) members of staff with approximately 3,259 working at St George's Hospital. We carried out an announced inspection of St George's Hospital between 21 and 23 June 2016. We also undertook unannounced visits to the hospital on 2, 7 and 11 July 2016.

Overall, this hospital is rated as require improvement. We rated outpatients and diagnostic imaging as inadequate. We rated the emergency department, medical care, surgery, services for children and young people and end of life care as requires improvement. We rated critical care and maternity and gynaecology as good.

We rated safe as inadequate. We rated effective, responsive and well led as requires improvement. We rated caring as good.

Our key findings were as follows:

Safe

- Several areas of the hospital's estate that was in a state of disrepair. There was water ingress during heavy rain to several clinical areas we visited. Work had commenced to repair some of the affected areas, but the significant maintenance huge backlog, meant that this would take some time.
- Heating and power failures which had previously affected one medical ward remained on the risk register and had not been fully addressed.
- Some theatres were not fit for purpose. Theatres were sometimes closed due to electrical faults or unsafe temperatures. Sixteen of the 51 theatres needed to be completely refurbished. Since the inspection, we have been told by the trust, that the refurbishment of theatres 5 and 6 had been completed.
- The ED environment was aged old and this meant that some areas looked dirty, despite regular cleaning. Many parts of the department were extremely hot and uncomfortable.
- Children and young people with mental health conditions were cared for on Frederick Hewitt Ward, but an environmental risk assessment had not been carried out to identify ligature points and other risks to their safety.
- The storage of equipment and fluids in the ED within the major incident cupboard was unclear and created confusion about what was training equipment and what was 'live' equipment.
- Many staff were trained in safeguarding adults and children and there were policies and processes in place for them to follow. However, 53% of medical staff working with children and young people had not completed level three safeguarding training, which is a requirement for all staff working with children. Safeguarding training was identified as a risk on the services risk register. Access to training was a problem; there was no dedicated trainer and no safeguarding supervision for staff.
- There was variable adherence to infection control procedures and some medical and surgical staff ignored challenges from colleagues, which had a high impact on infection prevention and control.

Summary of findings

- Medicines were largely stored and managed appropriately, save for a few exceptions. For example, there were several examinations where radiographers gave contrast to patients despite PGDs not being in place.
- Mandatory training completion by staff was low in many areas.
- Records were well documented with fully completed care plans and legible entries that had been signed by the relevant staff member. However, there were instances where care records were not stored securely, increasing the risk of unauthorised access.
- Medical and nursing cover across the hospital was generally good, apart from in the paediatric wards.
- Most staff knew how to report incidents and there was evidence of learning from incidents being shared as well as changes to improve practice being made.

Effective

- There was a lack of formal mental capacity assessments and best interest decision making as required under the Mental Capacity Act, 2005 and some patients had decisions made for them that they were capable of making themselves.
- The Nursing Daily Evaluation Last Hour and Days of life document was a prompt sheet that was not backed up by either assessment or evaluation tools.
- Pain was assessed and patients told us their pain was managed well. However, pain relief was not always documented in records and there could be a delay to administration of analgesia when patients arrived within the emergency department.
- Information technology issues impacted on staff's timely access to information and as a result records were fragmented in some areas.
- Evidence based guidance was available and care was provided in line with the guidance.
- We saw multiple examples of effective multi-disciplinary team working however there were shortfalls in some areas including MDT working for those at end of life or where patients required in out from both medicinal and surgical practitioners. .
- All areas participated in national clinical audits and patient outcomes were measured. Many clinical areas showed positive results, particularly maternity and surgery.
- Outcomes for renal patients in relation to survival rates and transplantation were excellent and were some of the best in the country.
- A strong obstetric team focused on effective intrapartum care and staff used innovative and pioneering approaches to care with excellent outcomes. The maternity service was achieving year on year reductions in emergency caesarean sections.
- The maternity unit was strong in fetal medicine and had done pioneering work in non-invasive testing.
- There had been improvements in the appraisal process for nursing staff, but there were limited opportunities for training and development.

Caring

- Staff delivered care in a kind and professional manner.
- Although we observed and received some very positive reports of staff's kindness and caring attitude to patients, we also received some reports from patients about a lack of empathy from staff and poor communication.
- Patients were largely treated with dignity and respect.
- Most patients were positive about the care that they had received from staff and the way they had their treatment explained to them.
- Feedback from survey results showed high levels of satisfaction by patients and relatives with most of the services provided.
- There was sensitive support in place for bereaved parents of children.

Summary of findings

Responsive

- The trust had to temporarily cease national reporting of the RTT data. This was because, they could not guarantee the data they were reporting was robust and accurate.
- Children shared ward areas with other children of a different gender or age group. Parents were asked to sign a disclaimer confirming their acceptance that their child could share an area with children of a different age or gender.
- People were not able to access services for assessment, diagnosis or treatment when they needed to. The trust was not meeting national waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for the incomplete pathways.
- The trust was not meeting the urgent two week referral target for patients with suspected cancer and cancer waiting times on the whole were variable across the targets.
- Follow up appointments were not always made in a timely manner and 'Did Not Attend' rates were higher than the England average.
- Theatres were unable to meet demand. Cancellation of operations were frequent and some of these were not rebooked within 28 days.
- Bed occupancy levels in surgical wards were higher than the England average, with a steady increase over 2015.
- Patients sometimes had to wait for tests because of demand on ultrasound and MRI scanners.
- There were a significant number of patient moves at night, between the hours of 10pm and 6am, which caused disruption and anxiety to some patients.
- Although a hospital passport had been completed for patients with a learning disability, their care plans were not adapted to take account of their individual needs.
- Care of people living with dementia was variable. The butterfly scheme existed but the Dalby Ward environment had not adapted to meet the needs of people living with dementia.
- The ED was not large enough for the current throughput of patients and did not meet modern standards, which meant that in some areas, privacy and dignity of patients was compromised.
- There was not always a systematic approach to the management of actions and learning from complaints.
- Interpreters were sometimes used when patients were consenting to treatment and did not understand English, but at other times staff relied on relatives to interpret.
- Not all women currently received continuity of midwife care.
- There had been delays in access to some gynaecology clinics and procedures, although reductions in waiting times had been achieved over the previous three months by running extra clinics.
- curtains used to screen the beds on at least four of the medical wards did not preserve people's privacy.
- Some patients were unhappy with having to use of disposable utensils and plastic beakers.
- Parents were informed via text, when the child came out of theatre following surgery.

Well-led

- Leadership across several departments was weak, with many longstanding problems failing to be addressed within a timely manner. There was a lack of strategic direction for some of the services from the top of the organisation.
- We found a reactive rather than proactive approach to risk and environmental safety.
- Whilst there were named executive and non-executive directors, staff working within the palliative care team considered there was lack of executive strategic direction for the provision of palliative care. for the top of the organisation. The lack of multidisciplinary team meetings (MDT) with colleagues from medical and surgical departments and other allied health professionals was an area of concern.

Summary of findings

- An external review of Referral To Treatment (RTT) data quality at St George's University Hospitals NHS Trust (June 2016) found that due to a high number of unknown start times of a patient's referral journey, patients were prevented from being treated in chronological order. The trust was also inconsistent in achieving their two week targets for patients with suspected cancer.
- Following the inspection, the trust wrote to NHS Improvement and NHS England, to confirm their intention to temporarily cease national reporting of our RTT data. This was because, they could not guarantee the data they were reporting was robust and accurate.
- The risk register in several divisions, did not fully document all risks identified across the departments and mitigating actions were not always sufficient to address risks. Actions taken to mitigate the risks were insufficient and timescales to fully address the risks were unclear.
- Some staff felt able to approach their senior management team and felt well supported by their senior clinical staff. However, staff working with children and young people did not receive feedback from their appraisals and felt support was inconsistent.
- There was no evidence that a vision and strategy for maternity was being jointly developed with midwives and obstetricians.
- There was low morale among theatre staff and consultant surgeons. Some consultant surgeons were not working with a multidisciplinary approach and were not engaged in the divisional objectives.
- Black and minority ethnic staff felt that they were not given the opportunities that less experienced white staff had in some areas.
- Engagement of patients and the public in the improvement of services was evident.
- There were examples of the development of services and the introduction of new practices to take the service forward.
- We saw innovation across some areas, including participation in research, journal publication and use of social media to disseminate key information to staff.

We saw several areas of outstanding practice including:

- Outcomes for renal patients in relation to survival rates and transplantation were excellent and some of the best in the country.
- The outcomes achieved by the specialist medical and surgical services provided by the hospital.
- The effectiveness of maternity care delivered by the hospital.
- The responsiveness of the neonatal unit to parents whilst their baby was on the unit and the support provided by the outreach nurse.
- The involvement of children of varying ages on the interview panel as part of the recruitment process for ED paediatric nurses.

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

Importantly, the trust must:

- Ensure all premises and facilities are safe, well-maintained and fit for purpose.
- Ensure all care is delivered in accordance with the Mental Capacity Act, 2005, when appropriate.
- Review Improve all its governance processes, so that patients receive safe and effective care.
- Ensure the RTT data is robust and accurate so that patients are given appointments and treatment based on their needs and within national targets.
- Ensure serial numbers of prescriptions (FP10s) for prescribers are always monitored for use.
- Ensure staff radiographers only administer medication (contrast media) where appropriately authorised Patient Group Directions (PGDs) or valid prescriptions are in place.
- Ensure the fit and proper persons' requirement regulations for directors is always complied with.

Summary of findings

- Ensure the paediatric ward environment, staffing and training requirements are suitable for treating and caring for children and young people with mental health conditions.
- Ensure medicines are stored in an appropriate manner, by keeping cupboards locked when not in use.
- Ensure the process for decontamination of nasoendoscopes is always compliant with guidance.

In addition, the trust should:

- Maintain patient privacy, dignity and confidentiality at all times.
- Review the fluid storage within the ED major incident cupboard to ensure that training equipment is not stored with 'live' equipment.
- Ensure staff consistently follow guidance related to the prevention of healthcare associated infections with specific regard to hand hygiene.
- Ensure the equipment stored on Pinckney Ward is cleaned and there are systems in place for monitoring the cleanliness of equipment returned to the ward.
- Ensure all staff caring for children receive level 3 safeguarding training.
- Ensure the process for investigating serious incidents is timely and undertaken by people trained in investigation so they understand the root causes of an incident and identify measurable action.
- Minimise the cancellation of operations and when this cannot be avoided, they are rescheduled within 28 days.
- Reduce the moves of patients to wards that are not appropriate.
- Ensure there are robust arrangements in place, which staff are conversant with, in relation to the recognition and escalation of deteriorating patients.
- Ensure divisional and trust priorities are shared by personnel of all grades and professions who work together to promote the quality and safety of patient care.
- Address the low morale among theatre staff and consultant surgeons.
- Replace damaged furniture in patient/clinical areas so that they can be thoroughly cleaned.
- Ensure that all patients within the ED 'streaming' area are assessed within a private area.
- Ensure staff can observe the patients whilst they are waiting in their outpatient departments.
- Ensure patient electronic records are not easily visible or their paper records are not easily accessible by the public.
- Improve the percentage of telephone calls answered by staff in the outpatient department are within the service level agreement targets.
- Communicate effectively with patients when outpatient clinics overrun.
- Ensure there is sufficient diagnostic equipment (including cystoscopes) to supply day surgery, main theatres and endoscopy.
- Ensure staff are appropriately inducted to the clinical areas to which they are employed to work.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

We rated this service as requires improvement because:

- SStaff did not use observe appropriate security in using computers.
- The design and use of accommodation in some areas did not protect patients' privacy and dignity, or the confidentiality of patient discussions with clinicians.
- No skin assessments were completed for patients, including those in the department a long time who were at risk of pressure sores.
- The storage of equipment and fluids within the major incident cupboard was unclear and created confusion about what was training equipment and what was 'live' equipment.
- The new rapid assessment and triage (RAT) system had been implemented in a very quick timeframe and this meant there was a disconnection between how senior managers saw the process working to how it was operating day to day.

However;

- The department had a strong audit and research programme with participation in a number of national research studies and evidence of improvement and learning following audits.
- Major trauma patients outcomes were good and the department performed well in a trauma peer review.
- There were multiple examples of effective multi-disciplinary team working.
- Staff reported they felt well supported by their department managers and senior clinicians, especially with a consultant in the department 24 hours a day.

Medical care (including older people's care)

Requires improvement



We rated this service as requires improvement because:

- The environment and supporting infrastructure within some parts of medical services was

Summary of findings

unsuitable/unsafe and environmental issues on some wards impacted on staff's ability to meet patients' individual needs. Environmental issues also impacted on staff's ability to protect patient's privacy and dignity.

- Feedback from patients on the kindness and compassion of staff was predominantly good, but we also saw examples of patients' privacy and dignity not being respected and were given examples of a lack of empathy and poor communication by some staff.
- Medicines were not stored in accordance with the provider's medicines management policy, and therefore posed a risk to patient safety. People's rights were not always protected under the Mental Capacity Act 2005 because when patients did not have the capacity to make some decisions for themselves, there was no evidence of a two stage mental capacity assessment or information about how the best interest decision was made.
- Processes to identify and assess patient's individual risks and respond to their individual needs were not fully implemented. There was an open culture of incident reporting and staff received some feedback from incidents and complaints. However, action plans from these did not always fully address the issues and were not comprehensive.

However, we also found:

- Outcomes for renal patients in relation to survival rates and transplantation were excellent and were some of the best in the country.
- Good multi-disciplinary working and collaboration with external agencies and commissioners to improve services.
- Practice was evidence-based and the service participated in a full range of national clinical audits. Results indicated good performance in relation to the majority of these.
- Patients were given information and explanations to enable them to understand the plans for their care and treatments and participate in their care.

Summary of findings

- Although the service faced challenges in the recruitment and retention of staff and this contributed to challenges in achieving and maintaining staff competency, action was being taken to mitigate the impact of this.

Surgery

Requires improvement



We rated this service as inadequate because:

- Some theatres were not fit for purpose. Theatres were sometimes closed due to electrical faults or unsafe temperatures. There were also water leaks following rain in some theatres, wards, pre-assessment unit and the day surgery unit.
- Theatre air handling units (AHU) were at risk of failing intraoperatively due to the age of the plant. This was on the divisional risk register and rated as 'extreme'.
- Two of the theatres in St James' Wing (5 and 6) were closed at the time of our inspection for refurbishment, including electrical repairs and the installation of laminar flow. Sixteen of the 51 theatres needed to be completely refurbished.
- Since the inspection, we have been told by the trust, that the refurbishment of theatres 5 and 6 had been completed.
- The system for managing theatre stock was not effective and this resulted in items running out before theatre staff had ordered replacements. Theatre staff spent time looking for items in other parts of the hospital and sometimes surgeons or anaesthetist did not have their preferred equipment. The equipment purchase and replacement programme had been affected by budget cuts.
- Some medical and surgical staff ignored challenges to their infection control practices.
- The processes for reporting and investigating serious incidents (SIs) were slow and did not always identify factors that contributed to incidents.
- The trust had temporarily ceased national reporting of the RTT data. This was because, they could not guarantee the data they were reporting was robust and accurate. The surgical division made additional checks to limit the risk of losing track of patients, but some patients were not receiving treatment within the expected

Summary of findings

time from referral. There were sometimes additional delays when patients had to wait for tests because of demand on ultrasound and MRI scanners.

- Theatres were unable to meet demand. Cancellations of operations were frequent and some of these were not re-booked within 28 days.
- Patients sometimes had to wait for tests because of demand on ultrasound and MRI scanners.

Critical care

Good



We rated this service as good because:

- We saw good evidence of learning from incidents and varied methods of disseminating learning points, including the 'Big 4' and work based social media. Learning from serious incidents was shared across the units.
- The leadership team demonstrated appropriate responses to issues identified, such as gaps in the critical care service specification standards (D16) 2015, a review of the current outreach provision and increased in-house training opportunities for staff.
- Suitable processes and development opportunities were in place to ensure nursing staff working on the units were competent. We also saw training and learning opportunities for doctors on CTICU and GICU and feedback from these staff members was positive.
- We saw staff following evidence-based practice via specific clinical guidelines across the ICUs, for example the
- The ICUs had a comprehensive audit programme in place to ensure audits were completed at appropriate intervals to monitor quality and safety. We also saw evidence of suitable responses to address audit findings, for example with regards to reducing pressure ulcers.
- There were minimal non-clinical transfers out of the ICUs and few patients were discharged from ICU out of hours. Performance in this area was better than the national average for GICU and CTICU.
- Patient and relative feedback was very positive about the care provided across the ICUs and

Summary of findings

staff were frequently described as considerate and respectful. Relatives told us they felt suitably involved in patient care and hospital feedback forms showed most relatives were as involved as they wanted to be in decisions about their loved one's care.

- We saw some specific examples where staff anticipated and met specific patient needs, such as nursing a patient in accordance to their religious beliefs on GICU and supporting a patient through a marriage ceremony on CTICU.
- ICNARC data demonstrated that patient outcomes, including mortality and readmission rates, were as expected. Good outcomes were also achieved for patients who had their chests opened on the unit in emergencies.

However;

- We were concerned about a potential culture of under reporting incidents. This was due to low incident numbers, staff feedback and minutes from the morbidity and mortality meetings that indicated incident reports were not always completed when they should have been. This had not been identified as an issue by the leadership team.
- The risk register did not fully document all risks identified across the units and mitigating actions were not always sufficient to address risks.
- The leadership team did not identify oversight of the satellite areas as an area for concern, despite us identifying some safety concerns in these areas such as poor completion of resuscitation trolley checks on CTICU.
- Arrangements for doctors' inductions on NICU were not robust and were not addressed when concerns were raised by staff. Feedback about teaching opportunities for doctors working on NICU was not positive.
- Processes for managing patient risk on the hospital wards and providing critical care support were not optimised. Patients had to

Summary of findings

become sufficiently unwell to trigger a National Early Warning Score of six or more before a referral to the critical care team would be triggered.

Maternity and gynaecology

Good



Overall we rated maternity and gynaecology services as good although we judged some aspects of the services to be outstanding:

- Year on year reductions in key indicators for maternal outcomes.
- The acute gynaecology service offered a highly effective and timely service in acute gynaecology and early pregnancy.
- There was outstanding performance in relation to supporting women who had pregnancy loss.
- The service provided safe and effective care in accordance with recommended practices.
- There were well-developed care pathways in maternity services for women identified as being 'at risk' because of medical conditions or vulnerability and the service had staff with expertise in several specific conditions of pregnancy.
- Staff were confident about reporting incidents and said learning from these was shared with staff.
- Midwives and doctors worked well together as a team without hierarchy.
- There were clear pathways for all pregnant women to access the right services for their needs, with excellent access to specialist midwives.
- Staff demonstrating compassion and patience towards women.
- Staff were conscious of the need to protect the dignity and privacy of women in all areas of the service.
- Antenatal clinics were available at many locations in the community thus minimising women's need to travel.
- There were many good examples of pioneering work and innovative practices such home monitoring of hypertension in pregnancy, using a mobile phone app.

However:

Summary of findings

- Not all women received continuity of care from midwives.
- Leadership required improvement as there was no evidence that midwives were being involved in developing the strategy for maternity in line with evolving national developments.
- Midwives felt concerns they had expressed about the management of the service were not listened to at executive level or board level.

Services for children and young people

Requires improvement



We rated this service as requires improvement because:

- There was a high level of staffing vacancies on the neonatal unit and paediatric wards, which meant the service had high use of agency and bank staff. Agency staff were not able to carry out all the procedures undertaken by permanent staff and contributed to delays in caring for patients.
- Children and young people with mental health conditions were cared for on Frederick Hewitt Ward, but an environmental risk assessment had not been carried out to identify ligature points and other risks to their safety.
- 53% of medical staff had not completed level three safeguarding training, which is a requirement for all staff working with children. Safeguarding training was identified as a risk on the services risk register. Access to training was a problem; there was no dedicated trainer and no safeguarding supervision for staff.
- There was no pharmacy service available for paediatric oncology patients out of hours or at weekends for children admitted as emergencies or whose condition required changes to their medicines.
- Equipment stored in the Pinckney Ward storeroom was not routinely checked. Equipment could be returned or removed without checking if it had been cleaned.

Summary of findings

- Staff were not always able to access clinical information about a patient whilst records were being transferred across to the new electronic patient record system resulting in delays providing children with their medicines.
- Nursing staff did not feel supported by their leaders. They had not received feedback from their appraisals and felt support was inconsistent. They told us the culture did not feel open and staff were sometimes reluctant to raise issues.

However:

- Children were monitored to identify any deterioration in their condition.
- The results of investigations into incidents were discussed in departmental and governance meetings and action was taken to follow up on the results of investigations
- Staff could access clinical guidelines and policies which were regularly updated and based on national guidance.
- The service contributed to a wide range of national audits and undertook local audits on the quality of services provided.
- There was effective multidisciplinary working between teams based in the trust and with other organisations and networks.
- Overall levels of mandatory training were good and staff were supported with training.
- Parents and families all spoke positively about the care provided and the support they received.
- Governance structures were in place at ward level through to the new divisional structure and beyond to the board.

End of life care

Requires improvement



We rated this service as requires improvement because:

- We found the palliative care team to be highly skilled and knowledgeable; however we found them to be a generalist service not a specialist palliative care service. They reviewed all dying

Summary of findings

patients, but did not provide specialist palliative care. The palliative care team and ward staff told us that the palliative care team did not provide training to ward staff within the hospital to enable the ward teams to look after non-complex patients without support from the palliative care team.

- Numbers of patients being referred into the palliative care services had increased year on year and which made the service unsustainable unless they provided a specialist services..
- Whilst incidents were reported, the staff weren't always able to locate incidents on the datix system to show us.
- Patient records were not securely stored.
- We found no evidence that patient pain assessments scales were used.
- The palliative care out of hours service provided by Trinity Hospice, did not have a formal service level agreement in place.
- The end of life care strategy was an action plan not a strategy and there were no clear pathways to achieve the results detailed within the document.
- The 'nursing daily evaluation last hour and days of life' document was a prompt sheet, which was not backed up by either assessment tools or any evaluation tools to show whether the prompt had been addressed.
- There was lack of strategic direction for the palliative care for the top of the organisation. The lack of multidisciplinary team meetings (MDT) with colleagues from medical and surgical departments and other allied health professionals was an area of concern.

However

- There was an open and transparent culture within the service. Incidents were mostly reported and learning was shared.
- Patients were treated with dignity and respect and staff were caring and supportive. The relatives we spoke with were happy with the care that they and their family members were receiving.

Summary of findings

- Anticipatory medicines were prescribed in a timely manner and were available when required by patients.
- 85% of patients on fast track discharge were able to go to their preferred place of care last year.
- The Macmillan Cancer Centre offered advice and support to patients with cancer and their relatives.
- The spiritual centre provided for people of faith or those of no faith, remembrance services were held annually and services of many faiths were held on a regular basis in the centre. The chaplain attended both the end of life programme board and operational groups, which demonstrated the trust recognised the importance of religious and spiritual input to the delivery of the end of life care service.
- The trust had appointed an end of life non-executive director one month prior to our inspection.

Outpatients and diagnostic imaging

Inadequate



We rated this service as inadequate because:

- An external review of Referral To Treatment (RTT) data quality at St George's University Hospitals NHS Trust was published in June 2016. This found that due to a high number of unknown start times of a patient's referral journey, patients were prevented from being treated in chronological order. The trust was also inconsistent in achieving their two week targets for patients with suspected cancer.
- Following the inspection, the trust wrote to NHS Improvement and NHS England, to confirm their intention to temporarily cease national reporting of our RTT data. This was because, they could not guarantee the data they were reporting was robust and accurate.
- There were several examinations where radiographers gave contrast to patients despite PGDs not being in place.
- The systems in place for the prevention of healthcare associated infections with specific regard to hand hygiene, were not being consistently followed throughout the outpatient

Summary of findings

department. Monthly clinic hygiene and cleaning audits were completed by the contracted cleaning provider, however, the results did not reflect the cleanliness of the areas we inspected.

- The design, maintenance and use of facilities and premises did not keep people safe at all times. Some of the areas were cramped and very busy.
- Staff were not able to observe the patients waiting in their departments.
- Staff struggled to maintain patient privacy and confidentiality, mainly due to the lack of space and overcrowding of certain clinics.
- There was limited audit of patient waiting times for clinics and all the clinics we attended over-ran.
- Staffing levels had been critically low and the outpatients had been running at approximately 50% vacancy rates. However, the staffing structure had been reviewed and vacancy rates were much improved in outpatient administration areas. Availability of records for outpatient clinics had improved since the last inspection although we found the records were easily accessible by the public during clinic sessions, often left in unsupervised areas.
- The introduction of the Electronic Data Management System had ongoing issues and extra capacity was needed to ensure further roll-out.
- Trust level Did Not Attend (DNA) rates (9%), were consistently worse than the England average (7%), between September 2014 - August 2015.

However:

- Most staff had completed mandatory training.
- Staff were aware of their responsibilities within adult and children safeguarding practices and good support was available within the hospital.
- Staff followed consent procedures and had a good understanding of the Mental Capacity Act 2005.
- Staff were committed to delivering good care, but morale was low and they felt under pressure.

Summary of findings

- Staff were caring and involved patients, their carers and family members in decisions about their care.
-

St George's Hospital (Tooting)

Detailed findings

Services we looked at

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

Detailed findings

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Background to St George's Hospital (Tooting)

St George's Hospital, Tooting, is one of two acute hospital locations of St George's University Hospitals NHS Foundation Trust, which we visited during this inspection. The other registered hospital location we visited was Queen Mary's Hospital, Roehampton.

St George's Hospital has 995 beds. The hospital is in the London Borough of Wandsworth and the lead clinical commissioning group is Wandsworth, which co-ordinates the commissioning activities on behalf of the other local clinical commissioning groups such as Merton and Lambeth.

Our inspection team

Our inspection team was led by:

Chair: Martin Cooper, Medical Director

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

The trust was visited by a team of 62 people, including: CQC inspectors, analysts and a variety of specialists.

There were consultants in emergency medicine, anaesthesia and intensive care, obstetrics and gynaecology, radiology and neonatal care. The team also included nurses with backgrounds all the specialties we inspected, as well as a midwife, an infection nurse and a student nurse. There were also specialists with board-level experience and three experts by experience.

How we carried out this inspection

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

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

- Is it well-led?

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

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery

Detailed findings

- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These organisations included the clinical commissioning groups, NHS Improvement, Health Education England,

General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch. We also received information from the trust's council of governors.

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

Facts and data about St George's Hospital (Tooting)

Context

- St George's Hospital, Tooting, is based in the London Borough of Wandsworth and serves a population of 1.3 million people.
- The hospital offers a range of local services, including: an emergency department, medicine, surgery, critical care, maternity, paediatric services and outpatient clinics. The hospital is also a major trauma centre and provides specialist services in neurology, cardiac care, renal transplantation, cancer care and stroke.
- In the 2011 census, the proportion of residents in Wandsworth who classed themselves as white was 71.4 %.
- The health of people in Wandsworth is varied compared to the England average. Deprivation is lower than average, however about 19.2% children live in poverty.

Activity

- The hospital has approximately 941 beds including 57 critical care beds and 67 maternity beds.
- The hospital employs 3,259 WTE staff.
- There were approximately 656,511 outpatient attendances at St George's Hospital between July 2014 and June 2015.
- There were approximately 146,908 attendances to the emergency department in 2015/16.
- There were 1,448 deaths at the hospital between April 2015 and May 2016

Key intelligence indicators

Safety

- Between May 2015 and April 2016, there were 129 serious incidents including seven never events reported to STEIS.
- Trust wide, a large number of pressure ulcers were regularly identified each month using the safety thermometer, with 234 throughout the reporting period, March 2015 to March 16. 20 of these cases meet the SI criteria.
- Trust wide, four cases of MRSA, 39 of MSSA and 33 C diff cases were reported at the trust between March 2015 and March 2016.
- There were 44 falls and 92 CAUTIs reported to the patient safety thermometer.

Effective

- The SHMI for this trust for October 2014 to September 2015 was 0.91 and within expected limits.
- The HSMR for this trust for January to December 2015 was 87.5 and better than expected. The HSMR for emergency admissions at weekends was 91.0 (as expected) and for emergency weekday admissions was 87.0, (better than expected).
- There were two mortality outliers in this trust.
 1. Cardiac pacemaker or defibrillator introduced through the vein
 2. Coronary atherosclerosis and other heart disease
- Both are being followed up by CQC.

Caring

Detailed findings

- In the CQC inpatient survey 2014, this trust performed about the same as other trusts in all 12 questions.
- In the friends and family test results for May 2016, 95% of inpatients recommended the hospital with a 30.6% response rate.
- The number of written complaints has decreased since 2010/11, and remained fairly consistent, aside from a reduction in 2012/13, which saw the lowest number of written complaints in the five year period.

Responsive

- Between April 2013 and August 2015, 6,640 experienced delays in the transfer to their care.
- Bed occupancy at the trust, between April 2015 and March 2016 was 95.5%.

- The trust has temporarily ceased national reporting of its RTT data, because, at present, it cannot guarantee the data they are reporting is robust and accurate. This means that the data will not be included in the national data set.

Well-led

- Staff sickness absence rates in this trust for the period between January and December 2014 averaged 3.4%.
- Results from the NHS staff survey in 2015, showed that this trust had a similar performance to other trusts for eight questions and performed worse than other trusts in 24 questions. The overall engagement score for this trust was 3.7, which was slightly lower (worse) than the national average of 3.78.

Inspection history







This is the second comprehensive inspection of St George's Hospital. The first being in February 2014.

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	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Outstanding	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at St George's University Hospital has over 150,000 patient attendances per year and serves a population of over 1.3 million across Southwest London. The department includes a team of consultants and matrons who are supported by a team of registrars, junior doctors, nurses, emergency nurse practitioners (ENP) and medical assistants as well as some allied health professionals and support and administrative staff. It provides a 24-hour, seven day a week service.

The department is a designated Major Trauma Centre for the South West London and Surrey trauma network and also a Hyper Acute Stroke Unit (HASU), facilitating thrombolysis (the breaking up of the clot that has formed) where appropriate.

The department consists of a eight bedded resuscitation room, 21 'majors' cubicles, of which 10 are curtained and 11 side rooms. There is an ENP led Urgent Care Centre (UCC) with nine curtained examination areas, five side rooms, and an ophthalmic suite. There is a nine bedded clinical decision unit (CDU) and an additional area within the UCC footprint with nine chairs that is designated as CDU2. The waiting room has a triage area where there are five curtained cubicles. Children are cared within a separate paediatric ED that has a children's waiting area, treatment cubicles, a three bedded children's 'majors' area and a five bedded paediatric assessment unit (PAU). The department has co-located x-ray and CT scanning and some blood testing is carried out in the department hot lab.

Adult patients have a brief discussion with a senior nurse prior to registration providing early assessment and appropriate streaming of patients. Children and young people register and then proceed to the paediatric area where a nurse will triage them. Between April 2014 and February 2016, 21% of ED attendances were patients between birth and 16 years old and 79% were 17 years and over. The ED department treats approximately 400 patients per day, of which 23% are admitted to the hospital and the number of attendances has risen for the past two years.

During our inspection, we visited ED over three days during our announced inspection and one weekend night as an unannounced inspection. We visited paediatric ED, the UCC and the CDU. We saw patients being treated and we spoke to over 30 staff including doctors, nurses and allied health professionals. We spoke with 17 patients and relatives, interviewed seven senior managers and reviewed 21 patient records as well as information provided by the trust and the public.

Urgent and emergency services

Summary of findings

We rated this service as requires improvement because:

- Staff did not use observe appropriate security in using computers therefore compromising patient confidentiality.
- The design and use of accommodation in some areas did not protect patients' privacy and dignity, or the confidentiality of patient discussions with clinicians.
- Skin integrity assessments were not completed for patients, including those in the department for long periods of time or those who were at risk of pressure ulcers.
- The storage of equipment and fluids within the major incident cupboard was unclear and created confusion about what was training equipment and what was 'live' equipment.
- The service had established an additional waiting area called CDU 2 that was supported by the trust commissioners, however it did not comply with the definitions outlined by NHS England for a Clinical Decision Unit and patients could be left waiting in this area for over five hours.
- The new rapid assessment and triage (RAT) system had been implemented in a very quick timeframe and this meant there was a disconnection between how senior managers saw the process working to how it was operating day to day, where privacy and dignity was sometimes compromised.

However;

- There had been some improvement in performance against the four hour target and for the last quarter, levels were higher than the England average.
- The department had a strong audit and research programme with participation in a number of national research studies and evidence of improvement and learning following audits.
- Major trauma patients outcomes were good and the department performed well in a trauma peer review.
- There were multiple examples of effective multi-disciplinary team working.

- Staff reported they felt well supported by their department managers and senior clinicians, especially with a consultant in the department 24 hours a day.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



We rated safe as requires improvement because:

- Staff did not use personal protective equipment appropriately or close the door of a side room where a patient requiring isolation procedures was staying.
- Some patient chairs within the department were ripped which meant they were unable to be cleaned properly and therefore were a potential source of infection.
- Many staff did not make sure they used IT securely and by leaving access cards unattended in computers and this left patient details visible on computer screens across the department.
- None of the patient records we reviewed contained a record of completion of a skin assessment; this included patients who had been in the department a long time.
- Patients unable to walk were not provided with a medical escort when they went to X-Ray or CT. This meant patients were left unobserved in the corridor outside this area.
- The storage of equipment and fluids within the major incident cupboard was unclear and created confusion about what was training equipment and what was 'live' equipment.

However;

- There was 24 hour consultant cover within the department.
- Nursing staff numbers in the department were good with only 9% vacancies.
- Staff knew how to report incidents and there was evidence of learning from incidents being shared as well as changes to improve practice being made.
- All the records we checked for children attending the department had a safeguarding assessment completed by the triage nurse.

Incidents

- There had been no never events reported for urgent and emergency care between May 2015 and April 2016. Never events are serious, wholly preventable patient safety incidents, which should not occur if the available preventative measures are implemented.

- Urgent and emergency care reported 315 incidents between 1 December 2015 and 31 March 2016, 292 of these were reported as no or low harm. There were 21 incidents reported as moderate harm, one as high harm and one as extreme harm. We reviewed incident investigations of seven serious incidents that occurred during 2015. Most of these included appropriate action planning and explanation of how shared learning was cascaded to all staff.
- Policies and procedures were in place for reporting incidents. Staff could demonstrate how to report incidents using Datix, an electronic reporting system.
- Incidents were reviewed by one of the department's matrons, who would close the incident and email the person who raised the concern with the outcome. If an incident required investigation by another department the matron would allocate the Datix to that department. We were told it was sometimes difficult to receive feedback on the outcome if the incident raised was investigated by another department.
- Learning was shared during twice daily staff handover meetings and within a communications folder that was available at all times. The matron compiled a monthly thematic review and produced memos reminding staff about incidents that were displayed on noticeboards and in the communications folder. Incidents were also discussed at clinical governance meetings, held every two months and we saw presentations prepared for these meetings that detailed this.
- We were told consultants discussed mortality and morbidity at departmental clinical governance meetings held every two months. Notes were not taken of these meetings so it was unclear who had attended and how information from them was communicated to those that were not there. We were provided with presentations of two of the meetings and mortality and morbidity was not listed in these so we could not confirm what discussions had taken place. Divisional managers also told us that doctors attended divisional mortality and morbidity meetings when relevant however we were not able to identify from minutes provided when this had happened.
- An example was given of practice being changed following an incident of patients not having ID bands put on. As a result of the incident, the receptionist gave the patient an ID band when they booked into the department and plans had been made for an ID band printer to be set up in the ambulance handover point.

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- A member of staff in CDU told us of an improvement that had taken place following a patient who had deteriorated in a room where they were unable to be observed from the nurses' station. The department had now introduced a form that needed to be completed in order to determine the level of observations a patient required. We were shown an example of a completed form and told that appropriate level of supervision would be arranged if required.
- Staff understood 'Duty of Candour' and their responsibilities related to this. They said that they would direct the patient or relative to a senior clinician when needed.
- Duty of Candour was included within trust induction. Senior nurses or consultants within the department undertook the responsibilities for speaking to patients or relatives as required. We saw duty of candour actions documented in all of the investigation reports that we reviewed.

Cleanliness, infection control and hygiene

- We were told that there were three cleaners within the ED that were available 24 hours a day; we saw cleaners present in the department when we inspected. They undertook general cleaning of the department throughout their shift, with more thorough cleaning conducted when the department was less busy. We were told that if a cubicle had been used for an infectious patient, a specialist team were contactable 24 hours a day and would be contacted through a telephone helpdesk.
- Patients within the waiting area told us 'It's clean. I saw them clean this morning.'
- At the beginning of each shift, each cubicle was cleaned by the nursing staff allocated to it and we saw a record of this was completed. This included the trolley and equipment.
- Each area of the department had a checklist that was to be signed off each hour to show the areas have been cleaned. When we looked at this checklist we found multiple gaps present where this had not been completed.
- We observed staff of all grades cleaning the cubicles between patients. Although gloves were worn for this, aprons were not, which is not in line with best practice.
- Clinical areas at the point of care looked generally clean, however there were some areas, such as the wall of the ambulance assessment area and the floor in the paediatric waiting room that appeared dirty, due to some marks that were visible. As we observed regular cleaning in the department, it is possible that these were scuff marks that could not be removed by regular cleaning.
- Staff completed annual training for infection prevention and control. Compliance for completion was 69% for nursing and medical staff and above 96% for non-clinical staff.
- There was good availability of personal protective equipment (PPE), hand gel and sufficient hand washing facilities. We observed most staff washing hands or using hand gel between patients.
- Hand hygiene audits were carried out regularly and were displayed on an infection control notice board. Results from October 2015 to March 2016 showed that the correct hand hygiene technique had been used by staff observed in this audit 99.5% of the time.
- As part of our inspection, we observed all sharps bins were signed and dated, however none were partially closed when not in use which was contrary to best practice guidance. All sharps bins in areas accessible by children were placed high up and out of reach.
- A PPE and Isolation audit was carried out by the department and results from October 2015 to March 2016 showed that in seven episodes of being observed, 100% of staff put on gloves and an apron when caring for patients with an infection risk. However, when we observed one side room being used for a patient needing extra infection control precautions, identified by a sign on the door, we saw the door of the cubicle left open and staff went in and out without putting on gloves or aprons beforehand. This was not in line with infection prevention and control policies.
- It was reported that toilets were checked on an hourly basis for cleanliness. However, there were no check sheets that demonstrated this within the toilets and we found bodily fluids in two separate toilets at different times during the inspection. We highlighted this to staff and action was taken to clean these areas straight away.
- We were told that the play specialist was responsible for cleaning and rotating the toys within the paediatric areas. However, the play specialist was only in the department three days per week and there was no record or schedule of when the cleaning occurred.
- Chairs within the main waiting area were metal and therefore were able to be cleaned regularly. However, within the designated mental health cubicle and the

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paediatric waiting area, there were some chairs where the fabric had been ripped, exposing the foam beneath it. This meant that they would be unable to be thoroughly cleaned and therefore a potential source of infection.

- Equipment we observed within the department was visibly clean and some had 'I am clean' stickers attached, although use of these stickers was not consistent in all areas. For example within the paediatric areas although trolleys were visibly clean, stickers had not been placed on all of these.
- The sluice areas within the department were clean and had no visible stains. However there was no visible checklist of when they had been last cleaned.

Environment and equipment

- Some areas of the department, such as the resuscitation area and UCC were suitably sized and fit for purpose. However the ambulance assessment cubicles were cramped, and it would be difficult to fit multiple staff around a patient if they required emergency resuscitation.
- During the inspection there was some heavy rain and, despite the department being on the ground floor, there was a corridor area where there were two ceiling leaks. The area had been cordoned off and warning notices put up as well as buckets to catch the water.
- We were told that the department was constrained by the space that it had and this meant that it wasn't always the ideal environment. We were also told that there was often a delay for fixing problems when they were reported. We saw signs up around the department highlighting problems that had been reported, such as a cubicle with no door handle that had been reported a month before our inspection and the water machine in the waiting room being faulty.
- During the inspection, the sluice in the resuscitation room broke and caused a significant leak. This was reported as an emergency and was repaired by the estates team within a few hours.
- Most cubicles within the 'majors' area had access to suction and oxygen, however two cubicles within the ambulance assessment area did not. This could lead to a delay in treatment, if portable equipment had to be sourced in the event of a patient deteriorating. We were told by nurses within this area that they would swap patients between cubicles if there was a requirement for a patient to have access to oxygen.

- There was a designated separate children's waiting area accessed by a corridor from the main waiting area. Access was by reception to the corridor and then with a buzzer system from the paediatric nurses station.
- The department had one psychiatric assessment room available. This room had two doors and panic alarm available within it and was visible from the nearby nursing station. The chairs within this were heavy and therefore would be unable to be lifted or used as weapons. The room met the standards required to be accredited by the Royal College of Psychiatry following a review in October 2015.
- We were told that there were often more than one mental health patient within the department and therefore another cubicle would be used. This could mean that the patient was waiting within an area that was not suitable for their needs; however we were provided with guidance that staff should follow when assessing the suitability of a cubicle which would mitigate the risk.
- There were two waiting rooms within the department that were designated for relatives who were accompanying critically ill patients.
- All mattresses and trolleys that we saw were clean and free from damage.
- It was reported on the trust risk register that there were risks to patients remaining on a trolley for long periods, due to lack of hospital beds, if they had to wait for admission. We were told by nursing staff that patients could be put on a bed if they had to wait a long time in the department, however we did not observe any patient on a bed during our visit, even if they had been in the department for a long time.
- Resuscitation equipment was checked daily as per trust guidance however the equipment and trolley were visibly dusty despite a checklist.
- A medical technician was based within the department and carried out daily checks on ventilators and the blood gas machine. Drug administration pumps for the resuscitation room were serviced annually by this technician. Other equipment was checked by the medical engineering department when they were received by the trust and stickers were placed on them for asset tracking and a date of when it was last serviced. We saw some equipment had 'N/A' (not applicable) recorded for the date it was last serviced and we were told that this was for equipment where the company providing it, had advised that further servicing

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was not required. We checked the service manuals for two of these items. The manual recommended for a device used to take patients observations that an annual calibration was required but a record of this was not available. In another service manual for a machine which is used for taking an electrocardiogram (an electrical trace of a person's heart), it stated that preventative maintenance is recommended to be performed every 12 months and we found that a record of this being completed was not available.

- We were informed by staff of difficulties with the IT system; there were reported problems of printers not working and a number of old computers that required replacement. There was a strategy for IT and plans to implement an increase in use of electronic records. This had been delayed a number of times, due to cost and the current plan was for it to be rolled out in August 2016. However, this required new hardware to be installed prior to its implementation.
- We were told that the staff in the department were used to dealing with downtime caused by IT system failures; a recent example was given of one lasting three and a half hours shortly prior to the inspection. There had been no patient safety incidents caused by this failure.

Medicines

- We found medicines were mostly stored safely within cupboards that were labelled clearly detailing contents within. However, a cupboard in the paediatric ED department (near the nurse's station at reception) did not have a label detailing the contents within. We also found the door to the treatment room in paediatric majors was unlocked, along with a medicines cupboard within the room. This meant medicines were not stored in accordance with the provider's medicines management policy.
- We found the treatment room in the adults' 'majors' was not clean and tidy at the time of inspection. However, we did not find any medicines lying around, and the area used to prepare medicines was fit for purpose.
- Keys to the Controlled Drugs (CD) cupboards were held by registered nurses. We found Controlled Drugs were correctly documented in the CD register. However, the recordings of daily checks were not always done in a consistent manner within the CD registers and the CD register books were in very poor condition.
- Discharge medicines were stored appropriately in a lockable medicines cabinet within majors. Trust data provided showed that waits for To Take Out (TTO) medication were on average, 32 minutes in October 2015, which was within the trust target of 60 minutes.
- Medicines for internal and external use were stored separately, as were oral and intravenous medicines.
- We found controlled stationery, such as stock order books, FP10s and controlled drug registers were stored securely and there were arrangements in place to monitor their use.
- Rectal diazepam was stored in unsecured drawers within the ED (Resuscitation area). Staff told this was so it could be accessed in a timely manner for patients being treated for emergency seizures and showed us a risk assessment that was put in place for this storage.
- Fridge and room temperatures were monitored on a daily basis and within an acceptable temperature range. Staff were aware of the actions to take if the temperature went out of the range required of 2-8 degrees Celsius. We saw evidence of the recording of this on the logging sheets for those containing regularly used medication. However, a fridge and freezer located within the resuscitation department for medication related to clinical trials had several gaps during June 2016 on the logging of daily check sheets.
- Nurses and pharmacists provided information on medicines to patients. Additionally, the pharmacist was in charge of performing medicines reconciliation, and data showed that more than 85% of patients had a medicines reconciliation done within 24 hours.
- Staff had access to British National Formulary publications (BNFs) as well as all policies/information relating to medicines management (including the antimicrobial formulary), which were found on the intranet.
- We saw that the allergy statuses of patients were routinely recorded on medicines charts.
- Staff understood how to recognise and report medicines safety incidents. Even though they could not demonstrate a recent example, staff were aware of the dissemination of learning from these incidents, including by email and through a dedicated member of staff in charge of medicines management in the department.
- We found the department was staffed by a dedicated pharmacist between 9am and 5.30pm Monday to Friday.

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Additionally, staff were able to obtain medicines and support from an on-call pharmacist seven days a week. Pharmacy times were clearly displayed on the TTO cupboard in majors.

- Staff training had been provided on the safe use and handling of medicines, along with competency assessments for prescribing, dispensing and administering medicines. Staff were able to inform us that regular audits on the safe storage of medicines were undertaken in order to improve patient safety. Other audits that were performed included omitted/delayed doses and quarterly CD checks.
- Some nurses were able to administer medicines by patient group directive (PGD). New PGDs were being developed by the department pharmacist for pain relief at triage and in the UCC. All nurses who were authorised to administer PGDs, had a competency booklet which we saw.

Records

- Paper records were stored in a screened area that had an administrator located nearby at all times for security.
- Records were a mixture of electronic and paper. Information reported in the safeguarding committee minutes in February 2016 indicated that there has been an issue with paper records going missing from the department. This was also referred to within the clinical governance meetings and reminders had been given to staff to reduce the occurrence of this happening. The risk was recorded within the directorate risk register and the plan was for the trust to change to an electronic record system later in the year.
- We saw many occurrences of smart cards being left in computers when they were not directly attended by the member of staff. This meant that there were computer screens with patient information visible to people passing the screen. We raised this with the matron on the day of our inspection and these cards were removed. However, when we returned later that day we found that cards continued to be left in computer stations across the department. We were told by staff that removing the cards meant that they had a significant delay to returning to the screen they had previously been on and so they did not comply as it took too much time.

- Patient's notes for those waiting for assessment were left in a plastic holder in a corridor outside an assessment room within the triage area. These notes contained personal clinical information and could be accessed by anyone walking past.
- There were areas to record skin assessment within a patient's notes; however this had not been completed on any of the records that we checked. This included records for a patient who had been in the department for over eight hours. This could mean that a patient's existing pressure ulcer may not have been identified or their risk of developing a pressure ulcer identified. A documentation audit for May 2016 identified a third of patients who had been identified as requiring a risk assessment had not had one documented which may have meant that this wasn't assessed when it should have been.
- We saw mental health risk assessments completed for patients attending with an acute mental health episode.
- We noted a patient had an allergy recorded in their notes; however they did not have an allergy band on their wrist to alert staff to this.
- We observed some blood sample bottles that had been left in a cubicle. They had not been labelled and were left within the cubicle for at least an hour. We observed a blood sample taken from a patient and saw the samples were not labelled at the patient's side but in a different room which increased the risk of incorrect labelling and was not in line with blood transfusion guidelines.

Safeguarding

- Details for children that were on child protection plans for the local boroughs were entered onto the electronic system by the ED administration team weekly so that they automatically flagged when they attended the department.
- All children attending the department had a safeguarding assessment completed by the triage nurse. We looked at 10 sets of records and all of these had a safeguarding section completed and signed. If there were any concerns raised from this assessment, then a further form was completed and passed directly to social services if required.
- Information about children attending the department who had a social worker or a child protection plan was passed onto the safeguarding team to inform them of their attendance in the ED. Additionally, a weekly

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meeting was held with staff from multiple agencies to discuss all children that had attended the department where there were concerns or where the child was known to social services, to ensure that information was shared appropriately.

- There was annual training for safeguarding adults and children. Compliance rates for completion of safeguarding adults were 69% for doctors, 76% for nurses and 92% for administrative and clerical staff. Administrative staff had completed safeguarding level 1 for children and were 92% compliant. Clinical staff were all required to complete safeguarding level 3 training, however only 29% of nursing staff were compliant for completion, although doctors had a better rate of compliance of 66%. Recent safeguarding training held within paediatric ED had included female genital mutilation (FGM). Additionally the Trust training programme included PREVENT training (to identify those at risk of radicalisation) and child sexual exploitation.
- All staff we spoke to had a good awareness about safeguarding procedures, including FGM and were able to tell us what they would do if they had a concern.

Mandatory training

- Mandatory training was completed via a mixture of online 'e-learning' packages and face to face training.
- Subjects covered included conflict resolution, equality and diversity, fire safety, health and safety, information governance, and moving and handling.
- Compliance for mandatory training was between 60% and 100% for most areas, however moving and handling patient compliance was very low with only 14% of doctors completing it and 55% of nurses.
- Staff had annual resuscitation training appropriate to their role. Compliance for each staff group was 81% for non-clinical staff who completed basic life support, 71% for nursing staff who completed immediate life support and 71% for junior doctors who completed advanced life support.

Assessing and responding to patient risk

- A rapid assessment and triage (RAT) system had been introduced into the department nine months ago, however it had been modified in the last three weeks to involve a senior nurse. Patients who walked into the department were seen by this nurse for a brief discussion regarding their condition and a pulse rate and oxygen level check for some conditions. This was

known as 'streaming'. The patient was categorised using the Manchester Triage System (MTS) and allocated into a priority category. The MTS is a widely used clinical risk management tool to manage patient flow. Immediate priority patients were taken straight to the resuscitation area. Very urgent priority patients were placed onto chairs directly outside the assessment area to be seen for further assessment within 10 minutes and other patients were sent to book in at the reception desk and wait for further assessment, including clinical observations and blood tests if required by the triage nurse or were seen by a practitioner within the urgent care centre. The 'streaming' process had been brought into reduce the risks around the length of time that patients were waiting to be seen on arrival. Staff we spoke to said they felt this was working well.

- Staff told us that when it was busy it could be challenging to undertake blood tests and electrocardiograms (ECG)s for patients presenting with suspected acute coronary syndrome in the best practice target time of 10 minutes. We reviewed four sets of notes for patients attending with chest pain and found that two of these were over this time, one of which had their ECG taken at 19 minutes.
- We were told by the service management team that patients were not sent away from the ED without a further assessment or referral to an alternative care pathway directly following this initial 'streaming'. However, during our inspection we saw one patient told to return to another hospital department in the morning without any additional assessment. A blue form was completed by the 'streaming' clinician and the patient would be recorded on the computer after they had left the department. This could mean that the patient's condition was not fully known and the patient could deteriorate after leaving the department.
- After the 'streaming' by the senior nurse on arrival in the department, some patients were assessed as not requiring treatment in the ED and were referred to a GP. The person conducting this role was called a navigator and was not a clinical member of staff. The service did not audit whether patients re-attended following use of this service, however a monthly meeting was held with the providers of the out of hours GP service that patients were referred to during evenings and weekends where any issues of inappropriate referral could be raised, although we did not see any reference to the navigator service within the minutes we reviewed.

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- Following a further assessment, some patients were categorised as requiring treatment within the 'majors' cubicles. However, it was reported that frequently, cubicles were not available and consequently these patients were asked to wait within the waiting room. We saw this during the inspection when there were up to 15 patients in the waiting room area awaiting a cubicle.
- We were told that a risk assessment had been completed regarding this patient group. Mitigation described to us was that a consultant would prioritise review of blood results, the nursing staff would repeat observations every two hours and that patients would alert the receptionist if they felt unwell. The receptionist would inform the triage nurse to review them.
- There were 17 black breaches (times when an ambulance has to wait over an hour to hand over a patient) reported between March 2015 and March 2016. Three weeks before we inspected an ambulance RAT area had been introduced within the 'majors' area. This consisted of three cubicles and two side rooms where patients could be assessed and then moved into another area. We were told that since implementation of the ambulance handover assessment area, even without the IT support that had been requested, there had been an improvement to the 15 minute handover times from 30% to above 50% of handovers from ambulances completed within 15 minutes..
- The ambulance RAT was staffed by a nurse and a medical assistant and we were told that this worked well if the flow of patients to other cubicles within the department was possible as it would mean that each patient had an initial assessment quickly. However, if there was no space to move patients from this area, this took additional time as patients required nursing care and could mean that there was nowhere available for ambulances to offload their patients. We saw two patients within this area who had been there over two hours and another patient who was receiving treatment was sat on a chair in the corridor to wait for a cubicle to be available.
- When patients were being transferred for diagnostic testing, for example to X-ray or CT scan, they were not routinely escorted and, if they required assistance, were assisted by a porter. The patient would then wait outside the X-ray room for retrieval by a porter back to the ED. We observed several patients waiting in this area and none were reviewed during this time by nursing staff. One patient was identified by a doctor as requiring transfer to the resuscitation area due to their blood results, and was moved there by the doctor.
- The department recorded early warning scores (EWS) within the notes when observations were taken and this was monitored by documentation audits. Levels for May 2016 indicated that this had not been applicable to record in 53% of patients, 35% had it recorded appropriately and 12% hadn't which meant some patients were at risk of signs of deterioration not being seen.
- A sepsis pack had been introduced by the new pharmacist to the department. This was specifically for neutropenic sepsis and included all the medication required for this group of patients attending the department in order that prompt treatment could be given. The packs were stored in an adjoining ward, however there were plans to have a suitable storage area put in the treatment room so that they would be more easily accessible.

Nursing staffing

- Planned and actual staffing levels were displayed prominently within the department. Staffing was between 16 and 26 registered nurses (dependent on time of day) and between one and six medical assistants.
- Bank and agency staff use had been at an average of 20% over the period April 2015 to February 2016. We were told that this had now decreased as current vacancies were at 9%, which was the best it had been for a number of months and we saw very few agency staff present in the department over the inspection. The vacancies included six new medical assistant posts that funding had been agreed for in April.
- Nursing staff turnover was between 12 and 15% and the main reasons for leaving were reported to us as relocation to another area of the country, promotion opportunity elsewhere or some staff saying the type of work wasn't suitable for them.
- Rotas were planned eight weeks in advance which made it easier for the matrons to identify and fill gaps. Agency and bank staff were used to fill these gaps and we were told the bank staff were normally ED staff completing overtime shifts. We were told that agency staff worked regular shifts within the department and completed a trust induction prior to commencing work.

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- Nursing handovers occurred at the beginning of the morning shift and at the beginning of the night shift. Staff were allocated roles each day at this meeting and had a local handover for each patient from the nurse they were taking over from.
- Only senior nurses with more experience were used for 'streaming' and assessment roles.
- Shortfalls in staffing were identified and adjustments were made as required. Handovers were organised, thorough and fully attended.
- Between three and seven nurses were rostered in the paediatric ED over the 24 hour period with the shifts planned to provide more staff over the peak hours. We were told that there was always a senior registered sick children's nurse on shift and some of the other nurses were adult nurses that did a three month rotation within the paediatric ED. Paediatric ED had not used bank and agency staff since June 2015. We were told that staffing in the paediatric department could be challenging between 1am and 8am when there were only three nurses, if the paediatric 'majors' area had patients in it. However, staff were able to ask for support from the main ED if required.

Medical staffing

- The service provided consultant cover 24 hours per day, seven days per week which followed the February 2016 National Institute for Health and Care Excellence (NICE) guideline for Major trauma: service delivery.
- Consultant cover in the paediatric department was normally provided by the main ED consultant, although there were sometimes cover by a paediatric consultant. Additionally there were registrar level paediatric doctors available within the ED.
- No middle career doctors were employed in the ED in comparison with an England average of 13% of total medical staffing. However 31% of the doctors employed were consultants; which was significantly higher than the England average of 23%.
- Locum doctor use had been at an average of 12.5% over the period April 2015 to February 2016 with the highest amount recorded at 22% in January 2016.
- We observed one medical handover during the inspection where key information was passed on to those attending. Handovers were conducted at the beginning of every shift and were led by the lead consultant for the outgoing shift. Doctors were allocated

to a specific area of the department. They then went straight to these areas and got a direct handover about each patient from the doctor they were taking over from in that area.

Allied Health Professional and Support Staffing

- The department had a dedicated pharmacist who was available between 9am and 5.30pm Monday to Friday.
- The department employed nine physiotherapists, five occupational therapists and two technicians to provide specialist support to the department.
- There were up to four porters based within the ED during 8am to midnight and two between midnight and the morning. They provided the ability to move patients and also change gas cylinders within the department.
- The administration team had 16 staff, three apprentices and no vacancies. As part of their duties they had between three and six staff available for reception duties each day. The receptionist covered the main desk in the waiting room and also a desk within the 'majors' department, where ambulance patients could be booked in.

Major incident awareness and training

- The department had a copy of the major incident plan and action cards were available for staff to use in the event of a major incident.
- During the handover at the beginning of each shift, we observed nursing staff were allocated their role in the event of a major incident.
- The department had a major incident cupboard that contained equipment to be used if there was a major incident. We checked this during our visit and found out of date equipment and fluid bags in all four of the boxes that we checked. There had been a signature to state that the boxes had been checked on 31 March 2016, however one of the fluid bags had an expiry date of 2014 and the other two of 2015, meaning that there had been no check of these dates. This could mean in the event of a major incident, essential items would not be available or would be sub-optimal. We raised this with the senior nurse in the department at the time who assured us that it would be dealt with urgently. We were later informed by the provider that there was some equipment within the major incident cupboard that was used for training. We were not able to clearly identify which equipment was training equipment and which was for use in the event of a major incident and this had not been stated when we had spoken to the lead nurse.

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- Emergency medicines stored within the major incident cupboard were within date. It was recommended that they were kept in an area that did not exceed 25 degrees, however there was no method of confirming that the cupboard did stay below this temperature.
- Major incident training was provided on a monthly basis and we saw a poster advertising future dates. All staff were required to attend this on an annual basis and this was monitored by the practice educator nurse.
- A security office was based in the main hospital reception and security cameras in operation within the waiting area and the rest of the department were operated from there.
- During the night, hospital security staff attended the department and staff told us that they could request urgent attendance if required.
- All nursing staff we spoke to, including agency staff, were able to explain the actions that they would undertake in the event of a fire in the department.
- Senior managers told us that winter planning had started being discussed in the hospital for the winter 2016/17, however the ED was not yet involved in those meetings.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated effectiveness as good because:

- The department had an annual audit program that followed up previous Royal College of Emergency Medicine (RCEM) audits or measured against other national guidance. We saw evidence of improvements made in re-audits.
- The department had a dedicated research team that meant that patient's suitability for research trials could be determined early and there was participation in a number of national research studies.
- Data regarding outcomes of major trauma patients showed that the hospital had a high number of unexpected survivors attending with significant injuries.
- We saw multiple examples of effective multi-disciplinary team working.

However:

- Pain relief was not always documented in records and there could be a delay to administration of analgesia when patients arrived within the department.
- Most nursing staff had limited knowledge of the principles of the Mental Capacity Act (2005) and we saw no capacity assessments documented within records where this would have been appropriate.

Evidence-based care and treatment

- Clinical pathways followed included those for management of sepsis, and fractured neck of femur. The guidelines we reviewed included a review date and all were within that date. The clinical governance meeting had a standing clinical update agenda item where key points from guidelines were highlighted.
- We reviewed a sample of patient notes for people who had attended ED, which mostly showed patients had received care in line with relevant National Institute for Health and Care Excellence (NICE) guidance.
- The trust was a Hyper Acute Stroke Unit (HASU). A specialist hospital team were paged when a patient within the time frame for treatment was expected into the department. This team met and assessed the patient within the resuscitation room on their arrival.
- The trust had performed lower in some areas of the Royal College of Emergency Medicine (RCEM) audits than other hospital trusts. For example, in the 2013/4 audit of severe sepsis and septic shock, the trust performed worse than average on most measures. For example, only 66% of patients had full observations documented in their notes, 26% had antibiotics administered in the ED and only 58% had blood cultures obtained. The RCEM target for all these was 100%. However the evidence of serum lactate (a marker for infection within the blood) measurement being taken was at 94%, which was higher than in other trusts. The trust had produced an action plan in response to these findings and undertaken a snapshot audit in June 2016. In response to the measures above, improvements had been made in all areas. For example, 100% had a full set of observations undertaken in the department, 87.2% had blood cultures performed in the ED and 82.5% of patients had antibiotics administered within an hour.
- The department had undertaken a peer review against the London Quality Standards (LQS) for Emergency

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departments in May 2016. It had met the standards in 28 out of 32 of the standards and partially met three standards. An escalation plan was in place for the area they had not met for access to formal diagnostic reports.

Pain relief

- We found that pain scores were not always documented in records. One patient we spoke with who had pain relief recorded and analgesia administered, stated that the initial assessment of pain had been good, however when the pain had returned, the staff had not responded and they had threatened to make a complaint before they were given further pain killers. One record we looked at within the paediatric ED did not have a pain score, but the patient had been given analgesia.
- In order to get pain relief for patients waiting in the 'streaming' to triage area, nurses obtained it from the 'majors' area of the department, which could mean a delay in administration. However, following the inspection, the trust informed us that there was a medication cupboard in the triage area, which was used for the storage and administration of medicines covered by PGDs. This cupboard was not highlighted to us, and we did not see staff use this cupboard during the inspection.
- Pain scores were not documented within the 'streaming' assessment. Pain was assessed during the following assessment.
- Patient Group Directives (PGDs) were provided so that nursing staff could administer certain medicines such as analgesia without a prescription. We were told that these had recently been revised and consequently there were only a few staff that could use these to administer pain relief. A doctor was allocated to the assessment area for certain periods of the day; however there was still a delay to arranging the prescription and then moving to a different area to collect it.
- We observed a patient who had walked into the department and who was visibly in pain. They were seen by the 'streaming' nurse and then went and booked in via the reception. It took 25 minutes from their arrival in the department to be brought some pain relief medication.

Nutrition and hydration

- A housekeeper was employed within the department and one of their duties was to offer food and drink to patients waiting within the 'majors' and CDU areas of

the department. However, there was no schedule for this being completed and we were told this was done when it was noticed that patients had been present for a long time.

- Some nursing staff that we spoke with were unaware there was a housekeeper within the department, however we were told that this was a new role.
- We observed drinks and sandwiches being brought to patients in 'majors'. Nurses we spoke with said they would offer food and drink appropriate to patient's needs however on another day some patients we spoke with within the 'majors' department had not been offered any food or drink, including those that had been in the department for a few hours.
- Sandwiches were available within the CDU 24 hours per day for patients in CDU or the ED.
- The paediatric department had sandwiches and cereal available for patients and for breastfeeding mothers. Cold drinks were available for patients waiting and staff said they were able to call the kitchen if they needed to for additional food requirements.
- No food was offered to patients within the waiting room area. There were also no vending machines for food within the waiting room area. Patients were directed to shops within the main hospital; however these closed at 9pm.
- There were hot and cold drink vending machines available in the waiting area. The water fountain was out of order for the length of our inspection; however, on asking at reception, patients waiting were directed to jugs of water available by the ambulance entrance.
- No drinking water was available in the resuscitation area of the department. Staff said that they would fill jugs of water from CDU or the paediatric department.
- We observed a patient asking for some water in the 'majors' area. A medical assistant was fetching one for them when a nurse intervened and stated that the patient was 'nil by mouth'. The patient had not been aware of this and this information was not clearly marked within the cubicle.

Patient outcomes

- The hospital was a major trauma centre and the department contributed to the Trauma Audit and Research Network (TARN) data collection. In the 2015/16 annual data, the department had levels above the national average for most senior doctor treating patients with cardiothoracic injuries, where 87.8% were

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seen by a consultant at the department compared to 66.5% nationally. In addition in the year 2014/15, the hospital had 0.6 additional survivors out of every 100 patients, which meant an additional six people would have been expected to survive at this hospital for every 1000 injured patients treated.

- The department had achieved 19 out of the 23 reception and resuscitation measures in the National peer review report for trauma services in 2015 which gave it a measure of 83%. This was higher than the average national measure of 77%.
- The department took part in the Royal College of Emergency Medicine (RCEM) audit cycle. In the 2014/15 Mental health in ED audit, the trust only met one of the two fundamental standards required, with none of the development standards being achieved. However three of these were in the upper 25% of all trusts.
- Other RCEM audits results showed the department to be performing worse in some areas than other hospitals. For example in the 2014/15 initial management of the fitting child audit, however the department had undertaken a re-audit the following year and improved in these areas to the required standard of 100%.
- The service conducted internal annual audits where the standard was based on the National Institute of Clinical Excellence (NICE) and re-audits of previous RCEM topics, for example head injury and asthma in children. Each audit had a lead consultant and one or two audit doctors.
- Audits were discussed at clinical governance meetings and we saw presentations provided to this meeting including recommendations for how to improve care in these areas, including an audit for VTE prophylaxis in CDU. The audit had been repeated and shown significant improvements for patients having a VTE risk assessment completed (from 16% in September 2015 to over 50% in February 2016) and an improvement for patients having a 24 hour review (from 0% in September 2015 to over 70% in February 2016.)
- Nurses we spoke with were aware of the audits and research and told us of ones being undertaken within the department. For example in paediatrics, we were told of a paediatric sepsis Commissioning for Quality and Innovation (CQUIN) that they would start at triage and the ECLIPSE paediatric seizure medication trial.
- The hospital had research nurses based within the ED and they attended major trauma and stroke handovers by the ambulance crew to ensure early identification of

suitable patients for trials that were being undertaken. All staff that we spoke to had an understanding of research that was being done within the department. Current trials being participated in included the 'CRASH 3' and 'HALT-IT' trials, which both involved giving a medication to assist blood clotting to patients with specific conditions, the major trauma patient experience research study which aims to understand the experience of care and the 'BEST' trial, evaluating a new method of taking blood tests for patients with suspected heart attacks.

- Patients making an unplanned return with the same condition within seven days between December 2015 to March 2016 averaged 6.8%. This did not meet the England standard of 5% for this measure however it was better than the average percentage for English hospitals.

Competent staff

- There was one part time practice educator for nurses within the department who was supported by a recruitment nurse with responsibility for new staff joining the department. This practice educator had ten shifts each month to manage the training needs of 150 staff members. One day of face to face training was organised for nursing staff to attend and included mandatory training as well as a maths test and outside speakers.
- New starters to the department had a trust and local induction provided where competency books were provided. Five study days over the first year of employment were provided for these staff to develop their skills in working in different areas of the department.
- Early morning teaching was organised most days within the department between 8am and 9am and included topical updates, resuscitation refreshers, specific procedures or new equipment, and information about research trials. Staff were encouraged to make suggestions for topics and it was led by the consultants or other specialists when required. Four staff members per day were encouraged to attend this so that cover across the department could be maintained.
- Nursing staff had the opportunity to apply for university accredited courses and funding for the next year had been applied for to continue this. Examples of courses offered and attended by staff included, foundation in emergency practice, care of the acutely unwell patient and trauma care.

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- Medical assistants had one team day per year and additional study days for learning new skills.
- Clinical supervision was not carried out regularly by the educator but they would undertake this as requested or required. For nurses learning the triage role, there were three periods of supervision prior to commencing that role.
- Doctors we spoke with felt well supported by a high level of consultant cover within the department. They described a good level of teaching and supervision.
- Appraisal rates for the division for April 2015 to March 2016 were 66% for nursing staff and 63% for administrative staff. All staff we asked had received an appraisal within the last year.
- Student nurses within the department were allocated a nurse to work with for the duration of their shift.
- Four nurses in the department had completed their revalidation to practice as required by the Nursing and Midwifery Council. We saw signs that asked nurses to be aware of the dates that they were due for this in order to access early support from the practice educator.

Multidisciplinary working

- We observed a handover in the resuscitation room to the major trauma team. A tannoy and bleep was used to contact members of the team including the estimated arrival time of the patient, so they were ready to meet them. This team consisted of specialists from around the hospital including anaesthetics and orthopaedic and general surgery. The team signed in on paperwork and were led by an Emergency Medicine Doctor. We observed that all members of the team had clear roles that ensured a methodical approach to the assessment and treatment of the patient.
- There were links set up with acute oncology services so that patients presenting to the department undergoing chemotherapy could have direct access to that team.
- Patients attending with acute mental health needs could be referred to mental health services 24 hours a day.
- A consultant led monthly group was held with community healthcare providers to discuss frequent attenders and plan alternative pathways for them.
- Staff working in the department 'Hot Lab' reported good links with the rest of the ED team and were pleased that their work was viewed positively by the department.
- A Safe Treatment and Rehabilitation (STAR) team consisting of an occupational therapist, physiotherapist

and social worker screened patients in the 'majors' area and visited patients in the CDU in order to facilitate an earlier but safe discharge back into the community. The recent addition of a dedicated pharmacist meant that patients could be assessed by them as part of the team where appropriate. We were told of three examples when the pharmacist had worked with other department professionals in the assessment of patients and their intervention in the treatment had meant the patient had a better long-term care experience, such as discharge avoidance or reduced re-admission.

- A charity called Redthread provided youth workers who were contactable via a bleep system for young people between the ages of 11 and 25 who were victims of violence and exploitation. There were posters and leaflets around the department explaining their purpose.
- A play specialist had recently been employed with the paediatric ED. Reports from staff were very positive and an example was given about a child with autism who had required treatment. With the support of the play specialist, the assessment could be undertaken in a calm environment that meant that it was achieved more quickly, and procedures such as scans could be done without the need for mild sedation, making for a more positive care experience for the child.
- The 2015 national peer review audit for 2015 highlighted the good interaction between ED and radiology as an area of good practice.

Seven-day services

- The main ED and children's ED were open 24 hours a day, seven days a week. The department 'Hot Lab' that provided fast access to certain blood results was open daily between 11am and 7.30pm and outside of this time blood samples would be sent to the main hospital laboratory that was open 24 hours.
- There was easy access to the CT scanner and X-ray, as they were located next to the department and these services were available 24 hours a day.
- A dedicated department pharmacist was available between 9am and 5.30pm Monday to Friday. Additionally, staff were able to obtain medicines and support from an on-call pharmacist seven days a week.
- ED consultants were present for 24 hours each day.

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- The child and adolescent mental health service (CAMHS) was available between 9am and 7pm Monday to Saturday. There was access to psychiatric liaison outside of these hours.

Access to information

- Staff were able to access local policies and procedures on the intranet.
- Patient records were held in the department for two weeks, and therefore were available if a patient re-attended within that time. After two weeks, the records were taken off site and scanned so that they were available electronically.
- The administrative staff could enter clinical information about a patient electronically if requested by a doctor. This included if a patient had any safeguarding concerns or additional needs.
- Patients discharged directly from the department had a letter sent electronically to local GPs.
- The introduction of a dedicated department Hot Lab for blood tests had reduced the time taken for results and access to staff for urgent results was reported as being much easier.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff sought consent from patients prior to undertaking any treatment or procedures and documented this clearly in patient records where appropriate.
- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to clearly articulate how they sought informed verbal and written consent before providing care or treatment.
- Most nursing staff we spoke with did not have a good understanding of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. One said that they might look up information on the intranet, however two said that they had not received any specific training.
- Most nursing staff were unable to explain the five key principles of the Mental Capacity Act, however they were able to discuss best interest decisions and we were told this was usually completed by the doctors.
- Doctors that we spoke with reported specific training they had undertaken on the mental capacity act and were able to explain the principles. They reported they would document the capacity of a patient within the

patient notes; however we saw no documentation regarding capacity of patients within any of the records that we looked at for patients that we would have expected it.

Are urgent and emergency services caring?

Good



We rated caring as good because:

- Most patients we spoke with were positive about the care that they had received from staff and the way they had their treatment explained to them.
- We saw many occurrences of staff delivering care in a kind and professional manner.
- There was sensitive support in place for bereaved parents of children.

However:

- Some nurses carried out initial assessments of patients in the entrance lobby which meant that other patients could hear and see what was being discussed.
- The accommodation was not large enough in areas for the current throughput of patients and modern standards, which meant that in some areas, privacy and dignity of patients was compromised.

Compassionate care

- The Friends and Family Test (FFT) is a method used to gauge patients' perception of the care they had received. Patients who completed the survey reported whether they would be likely or very likely to recommend the ED to their friends and family. The results for March 2015 to February 2016 were below the England average with rates ranging from 78% to 86% of patients recommending the service with a response rate of 23%.
- We spoke with 17 patients during our inspection and most were positive about the care they received and said, 'They are friendly here,' and 'They are caring, lovely people.'
- We saw letters and cards with thanks from patients who had been treated in the department.
- We observed most staff providing compassionate care to patients and supporting their carers and relatives.

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- However, within the 'streaming' area, patients were not always taken into a curtained bay to have a discussion regarding their care. We saw a nurse ask a patient questions in the open reception area where other patients could hear what was being discussed, although other staff members used curtains to maintain privacy and dignity during assessment and treatment.
- Within the ambulance assessment area, we observed assessment of patients being undertaken that could be overheard by all other people within the room.
- We asked the senior ED team about the issues regarding privacy and dignity and they recognised that there was an issue in some areas, however said that this should be mitigated by use of curtains and that there was a strict policy that all treatment and assessment should be in clinical space and not in corridors.

Understanding and involvement of patients and those close to them

- Patients told us that staff explained treatments and results to them. One patient told us, 'They do explain everything properly here and the doctors are very clear and it is very busy usually but they don't rush you.'
- In the A&E survey in 2014 the department performed in line with other trusts for all measures, including for family and others close to the patient having opportunity to talk to doctors and being provided with information.
- Within the Clinical Decisions Unit (CDU), there were noticeboards with information about support services available from external organisations such as Age UK and community pharmacists.
- Within the children's waiting area there were some laminated posters on the wall warning about potential accident risks for children. These posters had pictures on as well as limited writing in English and were suitable to advise parents of accident prevention at home.

Emotional support

- We saw staff providing emotional support and reassurance to patients and their families.
- A butterfly box was used within the paediatric ED for families where a child died in the department. This included information leaflets and contact numbers, a blanket and teddy bear. Additionally a lock of hair could be arranged to be given to the parents and the nurse who was involved in caring for the child would go with the parents to view the child's body.

- A nurse told us how she had been supported after caring for a child that had died in the department. This included a debrief that day and then a follow up meeting with everyone who was involved from the team as well as the bereavement support service. She said that there was regular follow up from this team.

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

Good



We rated responsiveness as good because:

- A hospital wide flow programme had identified actions across the hospital that were needed to support the delivery of the four hour target and improve patient flow. There had been some improvement in performance against the four hour target and for the last quarter, levels were higher than the England average.
- A dedicated 'Hot Lab' had recently opened within the department and provided fast access to blood results.
- A play specialist had been employed within the paediatric ED and there were plans to increase this post to cover seven days of the week.
- A dedicated department pharmacist had been employed and this had reduced the medication waiting time for patients being discharged.

However:

- There was nothing within the department to support patients living with dementia. Staff relied on carers attending with the patient to support their needs.
- The service had established an additional waiting area called CDU 2 that was supported by the trust commissioners, however it did not comply with the definitions outlined by NHS England for a Clinical Decision Unit and patients could be left waiting in this area for over five hours.
- There was no information displayed about waiting times and the process for assessment was not clear to patients entering the department, particularly if they could not read English.

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- The department was consistently below the England average for patients that left the department without being seen. There was no display of waiting times in the department and information about this was not routinely provided by staff when the patient arrived.

Service planning and delivery to meet the needs of local people

- The trust provided 24 hour accident and emergency services for children and adults in the local boroughs and additionally for patient's suffering a stroke or major trauma from across South West London, Surrey, Kent and Sussex.
- The design for a new building to expand the current CDU had been agreed and the department was waiting agreement of funding for this improvement.
- The hospital had built a helipad which opened in 2014 so that patients with major trauma could be brought to the hospital by air ambulance. The ED supported the facility for the air ambulance team to request the patient be taken straight to the CT scanner where required.
- The department had a new 'Hot Lab' that had been in place since March 2016. This was open during the hours of 11am and 7.30pm and provided testing of blood samples solely for the ED department. This had shortened the length of time that patients were waiting for their results and also meant that quality improvements were made, such as patients suspected of having neutropenic sepsis were only given antibiotics when neutropaenia was confirmed by the lab. It was hoped that this would reduce unnecessary blood tests for patients as the quick turn-around meant that blood tests could be requested once a patient had been assessed.

Meeting people's individual needs

- Hospital records were marked with a colour coded sticker system for patients in specific categories. These were red for children, blue for patients over the age of 65, yellow if they had returned within three days and green for patients with suspected sepsis.
- There was the ability to record clinical alerts for patients on an electronic system so that if the patient re-attended the department, their needs could be easily identified. This was done by administration staff at the request of the consultants and there was a trust policy that related to this. Examples were provided of patients

who frequently attended the department or had previously been known to have methicillin resistant Staphylococcus aureus (MRSA). MRSA is a type of bacteria that is resistant to many antibiotics.

- Some patients were known to attend the department frequently. One consultant had responsibility for these patients and held a monthly group with other ED consultants and the community teams so that they could try to identify alternatives to ED for these patients.
- Patients attending with acute mental health needs were assessed using a risk assessment matrix. Referral to a mental health team could be made 24 hours a day and a member of the team attended the department to assess the patients to see if they required admission. If admission to a mental health hospital was required, we were told that there could often be a lengthy delay, although we were not provided with details of this time. We were told that sometimes the patients waiting might be looked after by a registered mental health nurse (RMN) although this was reported as rare. If it was identified that they required admission to a medical ward, an RMN was requested to accompany them. We observed a patient who was requiring admission and although a bed was available, they needed to wait for availability of an RMN.
- Children and young people with acute mental health conditions could be referred to the Child and Adolescent Mental Health Service (CAMHS) between 9am and 7pm Monday to Saturday. Outside of these times the on call psychiatric liaison team would be called to assess the patient. If required, they would be admitted to the paediatric assessment unit and nurse staffing would be flexed to ensure that they had one nurse allocated to care for that patient or, a parent could stay with the child.
- Information about interpretation services was available on noticeboards of the CDU.
- All staff we spoke to were aware of the translation services that they could access if required. A memo in the communications book highlighted learning from a complaint to inform staff that signing interpreters could be booked from the translation service for patients who were deaf.
- We saw some leaflets available in reception entitled 'Staying well this winter' that were available in many different languages.
- There was no method of clearly identifying patients attending the ED with a learning disability. There was a

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strong reliance on carers to assist staff and care for patients. Staff reported that they had no specific training for patients with a learning disability, however they said they could access specialist nurses 9am to 5pm Monday to Friday if there were specific issues. We observed a patient with a learning disability attend the department during our visit. The patient did not have a carer present and was refusing some observations. Despite the passport they had with them stating that best interest decisions would be required and to contact the learning disability liaison nurse, there was no documentation of capacity or a record of contact of the specialist nurse in the notes when we reviewed them.

- We spoke to several nursing staff about identifying patients living with dementia and were told this was done as they entered the department when a patient had a dementia passport, where it was written in their notes. As of May 2016, 76% of ED staff had completed additional dementia awareness training, however there was no specific adjustments that were made for this group of patients within the ED. There was a reliance on carers accompanying the patient to assist them. We were told that there were specialist dementia nurses available within the trust between 9am and 5pm Monday to Friday. However it was reported they were contacted rarely, when difficulties with assessment or treatment occurred.
- Patients undergoing current treatment of chemotherapy attending the department were able to be 'fast tracked' through the department in order to reduce the risk of infection.
- The environment of children's ED was child-friendly with a play area within the waiting area. There was a separate room for teenagers to wait. There was a TV in the area for patients to watch, should they want to.
- The service employed a play specialist within the paediatric ED. We were told that this person had facilitated creating an environment where children, particularly those with additional needs, were able to have a calm care experience and nurses told us it was much easier to treat patients when this person was in the department. The play specialist was only in three days per week, however there was a business case being made for additional resource due to the success of this role.

- There were a variety of menus available for patients to choose from who were staying in the Clinical Decisions Unit (CDU). This included menus for specific dietary requirements, such as allergies and intolerances as well as vegan, halal, kosher and Asian vegetarian options.
- The paediatric department had a room for teenagers attending the department that was separate to the paediatric waiting room. This had a sofa and a television. Whilst we were in the department, we saw the room being used for a young baby to have a quieter environment as there were no teenagers that required the room.
- The department was noticeably hot in a number of areas. There did not appear to be functioning air conditioning or fans available in some areas of the department making it an uncomfortable environment for staff to work in and patients to wait in. Patients told us the heat was extremely unpleasant.
- The main waiting room and walk in entrance to the department was next to the ambulance unloading area. This meant that patient's being unloaded from ambulances could be viewed by others waiting within the department or entering or leaving the service

Access and flow

- Delivery of services within ED depended on the number of patients attending the department and the flow out of those who were referred to other parts of the hospital or discharged. A detailed external review had been undertaken and from this a hospital wide flow programme had been put in place to support ED staff to improve the four-hour performance target and flow throughout the hospital and beyond.
- Between March 2015 and January 2016, the performance against the four-hour ED waiting time was consistently below the target of 95% (between 89 and 94%) and additionally below the England average. One business plan objective for 2016/17 was to hit the target of 95% by the end of September 2016. The most recent data available for April to June 2016 showed the hospital had improved to 92.5%, which was above the England average, with three weeks in that quarter where the target was achieved..
- The trust target was for 95% of admitted patients to have a bed within four hours after the decision to admit them had been made. We were not provided with data that showed how many patients had to wait over four hours; however data we were given found that 70% of

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patients that breached the four-hour performance target were admitted patients. We also saw some patients had been in the department for over eight hours on the days of our inspection. We were provided with details of a patient that had taken over 12 hours to be admitted after the decision raised and this had been escalated appropriately as a serious incident.

- A hospital site escalation meeting was held three times a day and was chaired by the head of operations or the head of nursing. It was attended by the matron for the emergency department and other matrons, departmental leads, service and site managers and the estates department. The agenda was set for the morning meeting and looked at overnight issues and hospital performance including the ED. Updates from wards were shared including bed state, planned discharges and staffing were discussed. Actions were given to each area in order to facilitate patient flow from the ED. A senior nurse who attended this meeting said that the meeting was useful and added that communication happened throughout the day if required and not just at these times.
- The hospital had launched some inter-professional standards as part of a flow programme in the last two weeks to reduce length of stay in the emergency department. These standards set clear expectations of all departments within the hospital for what was required by them to assist in the flow of patients. We were told that there had been improved responsiveness by other departments in referring patients to specialities requiring admission since this launch and data we were provided with showed a reduction in median time to referral of six minutes over the last three months.
- The walk-in rapid assessment and triage (RAT) area had some signs telling patients to wait, unless they were a child, when they could go straight to reception and book in. There were four chairs in this area. It was not completely clear to patients that arrived what the process was, as the chairs might contain others in the queue or patients waiting for transport home. The signs were all in English and therefore it would be difficult for patients who do not read English well to understand the process. Although when we observed the initial streaming process it was carried out quickly, no times were given for the waits for the next nurse assessment or wait to see a doctor.
- An area in the UCC was designated as CDU2. This area consisted of eight upright chairs and was open from 12.30pm until 1am and patients were left in the care of a medical assistant, supervised by the UCC nurse coordinator. The hospital had a policy on this area which stated that it provided additional seating area for patients who had an expected stay of less than four hours before they were admitted/transferred/discharged. Patients entering this area were classed as being admitted to the CDU and therefore would no longer count towards the Emergency Department performance measure of four hours from arrival to admission, transfer or discharge. This room did not satisfy the definitions defined by NHS England for admission. We asked the senior team about this and were shown evidence that this had been agreed by the Clinical Commissioning Group (CCG) as a suitable provision before a new expanded Clinical Decision Unit was built. We saw guidelines for the unit that stated this was for patients with an expected discharge time of less than four hours. However, evidence from an external review showed that between April 2014 and September 2015, although the majority of patient stays in CDU2 were less than five hours, 12% of stays were between five and 12 hours and 8% over 12 hours. . At the time of the inspection we did not see any patients being cared for within this area
- There was information on the department walls explaining each area of the department and in the waiting room that explained the pathway through the department dependent on severity of condition. However there was no information displayed about approximate waiting times. We were told that a board had been purchased with the intention of displaying this information, however it had not yet been put up.
- We observed some patients being given information about approximate waiting times when they booked in with the receptionist. Further updates were not given out routinely, however further times would be given to patients if they asked the reception staff. However, we spoke with 10 patients waiting at another time and none of them had been informed about an estimated waiting time.
- An administrative role called a navigator had been introduced in 2012 within the department. Patient's attending with conditions that could be seen within an alternative primary care setting such as a GP or Dentist would be 'streamed' on arrival at the department to see

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this person. Between 9am and 5pm an appointment at a GP or Dentist would be booked for them and from 5pm to midnight Monday to Friday and 1030am to midnight on Saturday, Sunday or Bank Holidays, patients could be referred to an out of hours GP service located on the hospital site. Between June 2015 and May 2016 an average of 300 patients per month attending the department had been discharged by the navigator, which was about 2% of those who attended the department.

- This navigator service also offered the opportunity for patients who were not registered with a GP to be registered at a local surgery.
- We were told patients attending as a major trauma call would have a record set up prior to their arrival as 'unknown adult' in order to ensure they would get direct access to urgent diagnostics and treatment as required. Their details would then be updated once they were known.
- The introduction of a new pharmacist post had improved waiting times for To Take Out (TTO) medicines for patients being discharged from 244 minutes in January 2014 to 32 minutes in October 2015.
- The percentage of patients leaving the ED, indicates where patients are dissatisfied with the length of time they have to wait. The department was worse than the England average and had fluctuated between 2.1 – 3.7% (September 2013 – December 2015), compared to 1.5 – 2.8% for the England average.

Learning from complaints and concerns

- We saw one information poster and one leaflet available in the reception area that directed patients and carers to the Patient Advice and Liaison Service (PALS), however these were only visible if you were to stand at the reception desk.
- Between April 2015 and March 2016, the Urgent and Emergency Service received 95 complaints. The majority of these were in relation to the clinical treatment they were given.
- The trust aimed to respond to 85% of complaints within 25 days, however between April 2015 and December 2015, only 64% of the complaints had been responded to within this time. Complaints had taken over 25 days to be responded in 35% of cases however, 47% of these cases had an extension agreed with the complainant.

- However, between January 2016 and March 2016 this had improved with 83% of complaints closed in 25 days and 100% of those that were over 25 days had an agreed extension. At the end of March 2016 there were 13 complaints still open
- The ED had undertaken a review of the response to complaints and there was an initiative introduced that aimed to achieve a local resolution by working closely with patients. This had been successful. We were told that for non-medical complaints, the general manager would contact the complainant within five days and try to resolve the issue. For medical complaints there would be a meeting to review these once per week and the clinical governance lead doctor would telephone the complainant and would follow this up with a letter if that was required. An offer would be made of having someone from the executive board sign the letter. We were told that if a complainant wanted a face to face meeting, this would be arranged and when this was done, staff reported that most patients were then happy with the resolution.

Are urgent and emergency services well-led?

Requires improvement



We rated well-led as requires improvement because:

- There was a disconnect between how senior managers described the 'streaming' process and the practice we observed during the inspection.
- There were regular meetings of the senior department and divisional clinical and managerial staff, however it was not clear how much key information was cascaded to staff in order to improve services and this meant that although we saw minutes where an issue was discussed, the practice was still occurring when we inspected.
- The decision taken by executive management to implement additional elements of the Rapid Assessment Triage (RAT) process with limited engagement of staff prior to the changes meant that procedural change was not fully embedded prior to the implementation.

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- Some staff did not know about how data for the friends and family test was gathered so they were not able to inform patients of this.

However:

- Staff felt able to approach the ED senior management team and felt well supported by their senior clinical staff.
- The senior management were undertaking a full consultation of the new RAT processes in order that feedback and suggestions from staff could be gathered in planning changes to it.
- Children were part of the interview panel for paediatric nurses applying to the department.

Vision and strategy for this service

- Senior managers told us the ED strategy for the next few months was to embed the recent changes they had made with respect to the processes of triage and assessment of patients. They intended to undertake a full consultation with staff about the changes that had happened and use these to improve what they were doing. They recognised that the new rapid assessment and triage (RAT) process had been brought in extremely quickly with limited consultation and they wanted to ensure that staff were involved in its ongoing review and improvement.
- Their vision for the future was to have the completion of 'CDU 3' alongside the new Surgical Assessment Unit (SAU) due to be completed in July 2016. This would create more space within the department to better provide for the number of patients attending.
- A further vision was to integrate the UCC with the minor injury unit located at Queen Mary's Hospital so that staff could work in both areas and to establish a business case for a consultant nurse for primary care.

Governance, risk management and quality measurement

- A number of meetings were held within the division and department that senior managers attended. This included a monthly emergency directorate meeting attended by senior nurses and consultants as well as the senior management team. This group discussed performance, incidents, staffing and complaints amongst other items.

- The senior management team met every week and alongside the topics discussed at the monthly directorate meeting also reviewed policies and pathways for sign off.
- An ED performance meeting was held every week with executive and divisional managers as well as the senior team. This meeting focussed on the ED performance and actions relating to the ongoing flow programme.
- We were told that key information from these meetings could be passed onto staff by email or at handovers; however we were told by some staff that feedback about performance and improvements only happened at a directorate level.
- A clinical governance meeting was held every two months and we saw presentations prepared for this meetings. Discussions included incidents, complaints, updates to clinical guidelines and audits and research. There were no notes taken of these meetings so it was unclear who attended and how information was cascaded to staff that were not present.
- We saw one issue that had been discussed in the January directorate meeting, of patients being left outside the CT scanning area. We observed unescorted patients outside X-ray and CT, including a patient who was moved to the resuscitation area. This was observed five months after the issue had been highlighted and therefore it was not clear what the outcomes of this discussion was and how they were shared with staff as it was still occurring.
- The department had risks identified on the divisional risk register and these did reflect issues within the department that we found on inspection such as patients having to wait in the ED and patient records being misplaced. However, one risk was listed as poor availability of beds for patients having to wait within the department could lead to increased development of pressure ulcers. Despite this risk being identified in March 2015 none of the records we saw had a skin assessment recorded including patients that were in ED during our inspection for prolonged periods; therefore there was not suitable mitigation in place for this identified risk.
- There were some examples where the senior managers did not appear to have a complete understanding of the practices undertaken in the department. For example, they told us that patients were not sent away or referred from the ED directly 'following the initial 'streaming' and

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we saw a flowchart which stated that all patients would receive an additional assessment following 'streaming' from the triage nurse or within the UCC. However; during our inspection we observed a patient who was directed at streaming to return to another hospital department the following morning without an additional assessment. Senior staff also told us that they were aware that there were privacy and dignity issues within the department and said that this was mitigated by a curtain in the 'streaming' area. They told us they had a strict rule that treatment and assessment must be in clinical space however we observed senior 'streaming' nurses speaking to patients about their condition in the entrance alongside other patients.

Leadership of service

- We were told that the Director of Nursing visited the department and that there were open forums available with the trust board that staff were able to attend.
- We observed senior clinical staff assisting staff by working clinically at busy times.
- We were told that staff were welcome to attend the monthly directorate meeting, however it was acknowledged that it was difficult for staff to attend during their working day.
- The daily nurses handover was used as a time where information could be shared from the communication folder as well as tasks allocated for the day which included which staff should undertake medication checks. Additionally a uniform check was carried out to make sure that staff were complying with standards of infection prevention and control and were smart in their appearance.
- Most nurses and doctors we spoke with felt well supported by the senior clinical staff within the department.
- Some staff reported that they did not feel that the board understood what the main concerns were that impact on the delivery of high quality care and reported that there was a disconnection between them and senior managers outside of the department. A recent example was the sudden decision to implement changes to the Rapid Assessment and Treatment (RAT) system by the senior team when the planned support that the ED had requested to support the delivery was not in place.

Culture within the service

- The hospital had recently relaunched their 'Inter Professional Standards' in March 2016 and these were

laminated and on display within the department. We were told that the introduction of these standards had decreased the delay in doctors from hospital specialties assessing patients for admission.. The standards were being reinforced from the medical director downwards and embedded in inductions and Standard Operation Procedures (SOPs). These standards were viewed as positive by all the staff we spoke with and said that it had improved the flow of patients.

- Consultants we spoke with said it was a good place to work with little friction as there were 'no big personalities'.
- Senior staff told us that they were proud of their staff and their ability to embrace change.
- A compliments board was maintained in the staff area that had positive feedback from patients about their care. We were told that individual compliments were passed on to the relevant staff member.
- Work experience students occasionally observed within the department. They were given an induction and at the end of the experience received a certificate from the service.

Public and staff engagement

- The service collected feedback from patients using a text message system. We did not see any signs in the department explaining this at the beginning of the inspection and some staff were not aware that this service existed and therefore did not ask patients to respond to it. However later in our inspection, more posters had been put up highlighting this service. There was an aim in the business plan to achieve a 25% response rate and the current levels were at 23%.
- Patients who were treated as part of the major trauma pathway were invited to take part in a patient experience study that was looking to explore the physical and emotional impact of the trauma they had suffered.
- We were told that a number of compliments about the service were received on social media during broadcasting of the television documentary show '24 hours in A&E' that was filmed in the department. This feedback was monitored by the Patient Advice and Liaison Service (PALS) and was passed on and shared individually with staff.

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- The service had a children's interview panel as part of their recruitment process for paediatric nurses. This involved one child aged under seven, one child aged between eight and 12 years old and one teenager asking questions to the prospective nurses.
- Following a Listening into Action engagement event, an ED staff council was held each month which involved multiple staff groups, including consultants, doctors, nurses, medical assistants and administrative and support staff. This provided an opportunity for staff to raise their ideas for improvement for discussion. There was also a suggestions box that staff could use to suggest ideas or raise concerns.
- Junior staff reported that they felt able to raise concerns with the local leadership team.







Innovation, improvement and sustainability

- The recent employment of a department pharmacist had reduced the time taken for dispensing of prescriptions for discharge within the clinical decisions unit from an average time of three hours and 40 minutes

to 17 minutes. This innovation had assisted with flow of patients within the department. The pharmacist was also awaiting final qualification to becoming an independent prescriber, so that they could see and treat suitable patients attending the department. This was in line with recommendations from a study conducted by a pilot study from Health Education West Midlands.

- A nurse within the department was a shortlisted candidate in the post-registration learner of the year category for the 2016 Student Nursing Times Awards for implementation of the INSIDE tool (to aid in person-centred care for patients with learning disabilities); however we did not see evidence of this being used when we observed care of a patient with learning disabilities therefore the knowledge was not embedded throughout the department.
- The development of the work with a youth service which aimed to support victims of high risk crime (funded by Mayor's Office for Policing) was viewed positively by staff within the department.

Medical care (including older people's care)

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

Information about the service

Medical services at St George's University Hospitals NHS Foundation Trust included acute and general medicine, care of older people and a full range of medical specialties including cardiology, oncology, clinical haematology, gastroenterology, and renal services.

There were a total of 36,630 admissions to medical services between September 2014 and August 2015.

We visited the following wards: Richmond (acute medical unit), Allingham, Dalby, Belgrave, Buckland, Marnham, Caesar Hawkins, Rodney Smith, and the Heart Failure Unit.

We spoke with 58 staff in addition to meeting with the senior managers for the medical and cardiovascular division. We also spoke with 29 patients and 10 relatives. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. We reviewed care records and attended handovers. We reviewed other documentation from stakeholders and performance information from the trust.

Summary of findings

We rated this service as requires improvement because:

- The environment and supporting infrastructure within some parts of medical services was unsuitable/unsafe and environmental issues on some wards impacted on staff's ability to meet patients' individual needs. Environmental issues also impacted on staff's ability to protect patient's privacy and dignity.
- Feedback from patients on the kindness and compassion of staff was predominantly good, but we also saw examples of patients' privacy and dignity not being respected and were given examples of a lack of empathy and poor communication by some staff.
- Medicines were not stored in accordance with the provider's medicines management policy, and therefore posed a risk to patient safety.
- People's rights were not always protected under the Mental Capacity Act 2005 because when patients did not have the capacity to make some decisions for themselves, there was no evidence of a two stage mental capacity assessment or information about how the best interest decision was made.
- Processes to identify and assess patient's individual risks and respond to their individual needs were not fully implemented. There was an open culture of incident reporting and staff received some feedback from incidents and complaints.

However, we also found:

Medical care (including older people's care)

- Outcomes for renal patients in relation to survival rates and transplantation were excellent and were some of the best in the country.
- Good multi-disciplinary working and collaboration with external agencies and commissioners to improve services.
- Practice was evidence-based and the service participated in a full range of national clinical audits. Results indicated good performance in relation to the majority of these.
- Patients were given information and explanations to enable them to understand the plans for their care and treatments and participate in their care.
- Although the service faced challenges in the recruitment and retention of staff and this contributed to challenges in achieving and maintaining staff competency, action was being taken to mitigate the impact of this.

Are medical care services safe?

Inadequate



We rated safe as inadequate because:

- On Buckland Ward, there was ingress of water during heavy rain, affecting the safe use of equipment. Heating and power failures which had previously affected the ward remained on the risk register and had not been fully addressed. Following the inspection, the affected roof had been repaired and the water ingress had stopped. The affected beds were not being used. We were told that the relocation of the renal unit had commenced and expected to be concluded by October 2016.
- Other environmental issues were identified. For example, an uninterrupted power supply was required on the acute dependency unit on Richmond Ward, as patients requiring ventilation were placed on the unit, and this was not in place. The trust had introduced a range of mitigating actions to protect patients from the risk of harm until such time that an appropriate power supply could be installed.
- In addition, there were no bedside night lights on Dalby Ward; the use of extension leads to power portable heaters and the poor condition of the floor in clinical areas on the ward increased the risk of falls.
- Medicines were not stored in accordance with the provider's medicines management policy, and therefore posed a risk to patient safety.
- The percentage of staff who had completed patient moving and handling training, resuscitation training and infection prevention and control training were low.
- The use of the early warning score to alert staff when a patient's condition was deteriorating and required appropriate escalation when the score indicated it was not consistent.
- There was variable adherence to procedures which had a high impact on infection prevention and control such as peripheral cannula care.
- Care records were not stored securely, increasing the risk of unauthorised access.

However:

Medical care (including older people's care)

- Staff were aware of the procedures to safeguard vulnerable adults and a good level of support was available from the trust safeguarding lead nurse.
- Staff were encouraged to report incidents and were able to tell us of actions that had been put into place to reduce the incidence of falls and pressure ulcers. Some learning had occurred from serious incidents.
- There were challenges in the provision of adequate numbers and skill mix of medical and nursing staff. However, action was being taken to recruit and support staff to mitigate the risk.

Incidents

- No 'Never events' were reported for medical services between May 2015 and April 2016. 56 serious incidents were reported during the same period. Of these, over 50% related either to a health care acquired pressure ulcer or issues related to delays in diagnosis. We reviewed the root cause analyses (RCAs) related to both of these issues and found an analysis of the contributing factors had been undertaken and actions were identified to reduce the risk of similar incidents occurring in the future.
- Lessons learned from serious incidents had been communicated to staff and in most instances, systems had put into place to reduce their recurrence. For example, following a root cause analysis relating to a healthcare associated infection, issues were identified with documentation, aseptic non-touch technique and handwashing. Training had been put into place for staff to address these issues. Following an incident related to an unidentified power failure in March 2015, which impacted on a patient receiving non-invasive ventilation, staff had received training and a new set of safety checks had been put into place. However, the underlying issue which was that the unit did not have an un-interrupted power supply had not been addressed at the time of the inspection.
- Serious incidents were reviewed at the divisional governance board and incidents were discussed at the directorate and care group meetings.
- Staff were clear on how to report an incident and told us incident reporting was encouraged to enable learning to occur. Temporary staff such as agency nurses and student nurses were aware of how to report incidents.

Some healthcare assistants told us they did not enter incidents onto the electronic reporting system themselves. However, the nurses they reported the incident to, entered it for them.

- Staff said they were provided with feedback from incidents and learning from incidents was shared widely. Some wards had recently introduced nursing and healthcare assistant 'huddles', which were held daily and were used to discuss all incidents and concerns.
- Staff were aware of the "Duty of Candour" which ensures patients and/or their relatives are informed when they are affected by something which went wrong and given an apology. We saw an example of an incident which had occurred and where the duty of candour actions had been completed.
- Morbidity and mortality meetings were held monthly and individual patients were reviewed. The guidelines from the Royal Society of Medicine were followed and a proforma was used to ensure a structured approach. Meetings were attended by consultants, junior medical staff, and other members of the multi-disciplinary team

Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to pressure ulcers, patient falls, venous thrombo-embolism (VTE) and catheter associated urinary tract infections.
- Safety thermometer data was collected by the trust on a monthly basis and reported on the nursing score card which was monitored at the trust board and at the divisional governance meetings.
- In April 2016, seven medical wards reported harm free care below the national average of 94%, with four of the wards reporting levels below 90%, indicating a higher than average number of patient harms were reported on these wards.
- Staff told us of initiatives to reduce pressure ulcers and falls which were beginning to produce reductions in these harms. However, the national data available for the period March 2015 to March 2016, did not show evidence of a downward(improving) trend.

Medical care (including older people's care)

- When we reviewed the data for individual wards, we did not find any clear trends in pressure ulcers and falls, except on Richmond Ward, where there were a lower number of falls in the second six months of 2015/2016 than in the first six months of the year.
- Harm free care was below 85% on Allingham Ward between November 2015 and January 2016 and improved between February 2016 and May 2016, following additional support provided to the ward.
- Data on performance in relation to the individual harms such as pressure ulcers, were displayed on noticeboards within the ward environment, although the overall safety thermometer score wasn't displayed. The results were published on the trust's intranet.
- A patient having renal dialysis told us staff did not clean the dialysis lines for the required time and they had spoken to someone about it. The staff had been apologetic and thanked the person for reminding them.
- Patient Led Assessments of the Care Environment (PLACE) results for 2015, indicated that all the medical wards and units scored highly for cleanliness with scores of over 95%, with the exception of Belgrave Ward which scored 86%.
- Patients were generally satisfied with the level of cleanliness of the ward environment, although one patient said the cleaning could be more thorough.
- We found the environment was visibly clean in most wards, but we found some bathrooms and toilets were not clean on Rodney Smith and Dalby wards.
- Staff told us they could raise concerns about the level of cleaning with staff from the cleaning contractor and they responded to concerns. The ward manager of Allingham Ward said they had been allocated an additional cleaner in the middle of the day to address cleanliness issues. However, we were told that on Rodney Smith Ward, a separate person was allocated to clean the toilets and did not start work until 12 midday. This was in addition to the morning cleaner, who was responsible for all cleaning in the morning.
- We checked the linen room on Rodney Smith Ward at 9.30am and found there was very little linen in the room. We talked with staff about this and were told staff were delayed in replacing bed linen in the morning when linen ran out as the delivery arrived at any time between 9am and 12.30pm. Staff could ring for additional linen if they required it out of hours and it was provided, but had to wait for the delivery in the morning.
- Infection prevention and control performance was discussed at the divisional governance board and actions identified when performance was below target.
- Performance in infection prevention and control audits were displayed on ward infection control notice boards along with the number of methicillin resistant *Staphylococcus Aureus* (MRSA) and *Clostridium difficile* (C diff) infections. This data was up to date.
- There were 10 cases of C diff in medical services between July 2015 and March 2016.

Cleanliness, infection control and hygiene

- Audit data provided by the trust indicated that hand hygiene compliance was variable in medical services and low levels of compliance were found during trust audits in January 2016. For example, Belgrave Ward reported only 50% compliance in January 2016 and Dalby Ward's compliance was reported as 76%. Following action to improve the scores, Belgrave Ward reported 100% compliance in June 2016.
- Patients told us staff sanitised their hands prior to caring for them and we observed good levels of hand hygiene during the inspection.
- We found personal protective clothing and equipment was readily available and placed strategically in all clinical areas. We observed the correct use of PPE during the inspection.
- A series of audits to assess level of compliance with clinical procedures which have a high impact on the prevention of infection were completed monthly. Trust data from these audits indicated variable compliance with these procedures. In particular, the actions to minimise infections associated with venous cannula care were poorly adhered to. For example, audit results for January 2016 indicated a compliance of only 63% on Belgrave Ward and 62% on Charles Pumphrey Ward.
- During our inspection, we found venous cannula surveillance records were in place but these were not always fully completed and it was sometimes unclear when the cannula had been changed. This meant we could not be sure that cannula sites were being checked daily or that cannulas had been changed at the required intervals. Both of these are important for the prevention and control of infection.

Environment and equipment

- The medical wards had secure access and visitors used an intercom to gain entry. This enabled staff to monitor people entering and leaving the ward.

Medical care (including older people's care)

- Safety checks had been completed for each bay and side room by nursing staff on a daily basis.
- We found the environment on Buckland Ward which cared for renal patients and those requiring renal dialysis to be unsafe and unsuitable. There had been heavy rain on the day we visited the ward and we found water leaking from the ceilings and down the walls in the bay areas where patients were having renal dialysis. Bays had been closed for patients and a bed pulled away from the wall. There was water ingress around the electrical socket still being used for a dialysis machine, increasing the risk of fire and electrical shock. We were told the issue was reported to the estates/maintenance department at 7am, however, they did not attend the ward until after 12 midday.
- Following our announced visit, we wrote to the trust and informed them that if they did not immediately address the water ingress into Buckland Ward, we would take urgent enforcement action against them. The trust responded and informed us that they had taken action to stop the water ingress. An unannounced visit by CQC to the ward on 11 July 2016, revealed that the affected bed areas were cordoned off and not being used. There was no evidence of water ingress despite it having rained a few hours earlier and had been raining at the time of the visit. Walls of affected areas were dry. The matron as well as two bands 6 and 7 nurses, stated that as far as they knew, the water ingress had been repaired and there had been no recent water leaks on the ward. A job requisition log was seen, which indicated that electrical socket tests by the affected beds, had been carried out by the estates department on 24 June 2016 and these were passed as 'OK'.
- It was reported to us that Buckland ward was very cold in the winter and during previous winter there had been no heating on the ward. The temperature was reported to be 11 degrees Celsius on one occasion. The issue was escalated to the estates department and the health and safety officer; and permission had been given to use portable heaters. However, this caused a power failure which affected people receiving dialysis. Patients receiving dialysis on Norman Tanner Ward, the Knightsbridge dialysis unit and the acute dialysis unit, had to have their dialysis stopped for safety reasons. The back-up generator for the area allowed patients to be removed from dialysis safely, but their dialysis had to be interrupted. The trust told us following the inspection that action was taken to determine the issues and long term plans were being developed by the division and estates team, in association with the trust board to ensure such issues did not arise in the future.
- The acute dependency unit (ADU) on Richmond Ward did not have a mains power supply system that would alarm in the event of failure. We were concerned that interruptions to the power supply could occur in such circumstances. However, we were told by the trust following the inspection, that in the event of mains failure, the hospital had backup sockets which were also located on Richmond Ward and the ADU. These backup sockets were supported by a backup generator, therefore, there would be a power supply in the event of mains failure.
- A risk assessment completed by the trust in August 2015 concluded that due to the classification of Richmond ward, an un-interrupted power supply was not mandatory, but the dependency of patients cared for in this area was such that an uninterrupted power supply was needed. Some actions were implemented to mitigate the risk, however, the coroner issued a notice to the trust in March 2016 requiring improvements to be made. The trust had recently updated the risk register and were putting plans in place to address this.
- The environment on Dalby Ward needed refurbishment and there were several issues which had the potential to impact on patient safety. Dalby Ward was designated primarily for the care of older people and those living with dementia. There were no bedside night lights, increasing safety risks due to reduced visibility for patients at night and reducing the ability of staff to monitor the patients without using the main ward lights. The main ward lights had to be used when staff needed to provide assistance to patients at night, increasing the disturbance to other patients. In addition, there were insufficient electrical sockets behind the beds and extension leads had to be used. We were told there had been no heating for two weeks in the winter and portable heaters had been supplied, but these increased the risk of slips, trips and falls. The floor was in a poor condition in the bays and toilets making it difficult to keep clean. During the inspection, we observed soiling on the floor in a shower room and one of the bays.

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- The macerator used to dispose of bedpans and similar disposable items was not working on Dalby and Rodney Smith Wards. Staff had reported the issue to the maintenance department, but they remained unresolved. On Dalby Ward, the issue had been reported 12 days prior to our visit. A member of staff from maintenance had visited six days later but it remained unresolved. The ward sister told us the macerator on Rodney Smith Ward had been reported on numerous occasions over several months, but remained out of use. As a result, alternative arrangements had to be used to dispose of items which increased risks associated with large amounts of bulky and hazardous waste.
 - We found other examples of maintenance issues which were ongoing. Staff reported a very slow response from the maintenance department and issues which remained unresolved for long periods such as call bell faults and faulty bedside lights.
 - We checked eight pressure relieving mattresses and found four of them had not had regular electrical safety checks.
 - Resuscitation equipment on each of the medical wards had been checked at least daily and the stored items were secure. However, they were cluttered and untidy, which might impact on ease of access when needed in an emergency situation.
 - The resuscitation trolleys also had a 'hypostop' box. These boxes are brightly coloured for instant recognition and contained all the equipment to treat hypoglycaemia (low blood sugar levels in diabetes). It is good practice to have them available on all wards, where people with diabetes may be cared for.
 - We reviewed the incident investigation report in relation to a hospital associated grade three pressure ulcer. This identified there had been a delay in obtaining a pressure relieving mattress for the patient and identified that staff should escalate if they could not obtain a mattress in a timely manner. Most staff we spoke with told us they were able to obtain pressure relieving mattress the same day they requested them, but two people said they sometimes were told there was no stock and had to wait 'a day or two.' They said they could escalate if urgent. Staff were not aware of a target time for the supply of a pressure relieving mattress.
- medicines trolleys were immobilised (chained to the wall) when not in use. Most of the medicines storage facilities were locked when we checked. However, on Richmond Ward, we found that two cupboards (one containing medicines for cardiac arrest) were unlocked during the inspection. We also found a patient's bedside locker containing their medicines, unlocked on Rodney Smith Ward. This meant that medicines were not stored in accordance with the provider's medicines management policy, and therefore posed a risk to patient safety.
- On Allingham Ward, the treatment room was tidy, with no medicines seen lying around unnecessarily. However, it also contained space where junior doctors and other staff went in and out. This meant that it was difficult to maintain secure access and there was a risk of distraction for nursing staff who were preparing medicines.
 - There was no separate treatment room for day case chemotherapy patients on Trevor Howell Ward, as medicines were stored in the same room as they were administered to patients. However, all medicines cupboards were locked when not in use and there was good oversight of them.
 - Maximum/minimum refrigerator temperatures were recorded on a daily basis for the medicine refrigerators. The process of recording room temperatures had recently been implemented by the trust and was not always in place on the medical wards.
 - Controlled drugs were correctly documented in the controlled drugs register and daily audits were completed.
 - We observed administration of medicines on three wards and saw medicines were being administered safely. Staff checked the medicine charts and the identity of the patient prior to administration.
 - Patients told us staff checked their name and date of birth prior to administration of medicines. Most patients we spoke with said staff explained their medicines to them when they administered them.
 - Allergies were recorded on the medicine charts and we saw evidence of input by the pharmacist on these. There were supplementary charts for specific medicines such as insulin and warfarin.

Medicines

- Keys to medicines cupboards, trolleys and patient bedside lockers were held by appropriate staff and

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- Staff competencies for continuous medicines management and training updates were done by the provider. However, we found that this was done on an ad-hoc basis, depending on the individual needs of nursing staff (and not in a formalised regular process).'
 - Staff had access to the latest version of the British National Formulary (BNF), through the trust's intranet (as well as paper based), in addition to all policies/information relating to medicines management (including the formulary).
 - Staff understood and demonstrated how to report medicine safety incidents. This was then escalated and fed back for learning through various channels, such as medicines safety newsletters, memos and face-to-face meetings.
 - Allingham Ward had reported a high level of medicines errors and the matron told us they were about to undertake a medicines management review in conjunction with the pharmacist. They identified the shared treatment room as a possible factor in relation to the medicine errors, in addition to the high levels of agency nurses, staff competency in the use of intravenous pumps and the storage of medicines in more than one place.
 - A patient told us that when staff had not been given them their medicines on two occasions one day, the error had been identified and two senior staff came to see them, apologised and tell them of the action they had taken as a result. They said that after this incident their medicines were, "Spot on."
 - Pharmacists were in charge of performing medicines reconciliation and data showed that more than 85% of patients on Richmond Ward had a medicines reconciliation done within 24 hours. This was above national standards and the provider's own target.
- they were stored behind the nurse's station which provided some restrictions to access, but on other wards they were stored in the ward corridors increasing the possibility of unauthorised access.
- Nursing risks assessments, care plans and charts for recording observations and regular monitoring activities were kept by the bedside in folders. The medical notes contained a multi-disciplinary record of care provided on a daily basis.
 - Patient's individual records were dated, timed and signed, and the designation of the person making the entry was identified. Of the 10 records we reviewed, seven were legible and clear but there were some legibility issues with three of the records we reviewed. We observed that when a student nurse had made entries in the records, they were not always countersigned by a registered nurse as required.
 - Risk assessments had been completed to assess each person's nutritional risk, their risk of developing pressure ulcers, and falls. When bed rails were in place, a risk assessment had been completed to ensure they were used safely.
 - Records of assistance with re-positioning of patients, intentional rounding, and other required interventions were generally consistently documented, but we found the three records we reviewed on Rodney Smith Ward were completed sporadically.

Safeguarding

- An adult safeguarding flowchart was available to provide guidance for staff on the action to take if they identified a safeguarding concern. The adult safeguarding policy was under review.
- Adult safeguarding training was mandatory for staff. The training records indicated that a total of 77% of staff in the medical and cardiovascular division had completed adult safeguarding training. 85% of nursing staff had completed the training, but only 57% of medical staff were recorded as having completed training. However, data quality issues were identified by ward managers and matrons, which reduced the percentage of staff recorded as having completed training. Compliance with training may therefore have been higher than the records indicated.
- 54% of medical and dental staff and 81% of nursing staff had completed level 2 safeguarding children training.
- Staff were able to identify the potential signs of abuse and the process for raising concerns. A student nurse

Records

- A combination of paper and electronic records were in use. An electronic system was being rolled out and had been introduced into specialties in the Atkinson Morley Wing initially and here some parts of the record were stored on the electronic system and others were paper based. Other areas used paper based records.
- Care records were stored in open trolleys on most wards and on the one ward we visited which had lockable records trolleys, they were unlocked. On some wards

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told us they had raised a concern with the nurse in charge and ward manager. Action had been taken by the ward manager in response and the student felt it had been dealt with appropriately.

- Staff were aware of the name of the adult safeguarding lead nurse and all concerns were escalated to them. Staff told us they were provided with advice and support as needed.
- We saw a record of a safeguarding review on admission for a patient with a plan of action and a record of the review by the safeguarding lead.

Mandatory training

- Staff identified data quality issues which negatively affected the rates of completion of mandatory training reported by the trust from their mandatory training database.
- We were told by staff that new staff were frequently recorded as not having completed training when they had completed it during induction. We were taken through the data for two wards by staff and shown that some staff who had been appointed but not yet started work were recorded on the database as not compliant. When reviewing the data and looking at only those staff who were on the duty rota, the levels of compliance with training were very high for subjects other than moving and handling and resuscitation. Therefore, we were satisfied that a higher number of staff had completed most mandatory training than had been reported by the trust.
- Data supplied by the trust indicated mandatory training completion was variable amongst staff groups and for specific topics for the medical and cardiovascular division. Less than two thirds of medical staff were recorded as having completed any of the individual mandatory training topics. Over 80% of nursing staff were recorded as having completed all mandatory training topics except moving and handling training, resuscitation training and infection prevention and control.
- Within the medical and cardiovascular division, compliance with infection prevention and control training was 69%, patient moving and handling training was 55% and only 47% of staff had completed basic life support training. These low compliance rates were of concern given the importance of competence in these areas to the safety of patient care.

- Most mandatory training was delivered using e-learning and compliance was higher for completion of these topics than for patient moving and handling and resuscitation, which was delivered face to face.
- Ward managers and matrons told us it was difficult to book staff onto moving and handling and resuscitation training as there were not enough sessions to accommodate all staff requiring the training.

Assessing and responding to patient risk

- Processes were in place within the acute medical unit (Richmond Ward) to ensure urgent or unplanned admissions were seen and assessed by a consultant within 12 hours of admission.
- An acute dependency unit had been opened within Richmond Ward to enable level 2 critical care patients to be accommodated within the ward. This was staffed by dedicated staff with relevant competencies.
- An early warning score (nEWS), was used to ensure prompt identification of patients whose conditions were deteriorating. We found nEWS had been recorded with each set of observations, but the frequency of the observations was not always in accordance with the triggers identified within the nEWS protocol.
- In addition, we did not always find a record of escalation (as dictated by the protocol) of the nEWS when the score should have triggered escalation. This meant we could not be sure a patient's deteriorating condition was reported and action taken to prevent further deterioration.
- The trust had conducted six monthly audits of the implementation of nEWS. The latest audit completed in January 2016 indicated variability between wards in the correct use of the score. The score was calculated correctly in only 20% of cases on Allingham and Marnham wards and there had been an appropriate response when nEWS was triggered in under 20% of cases on these wards. This added to the concerns we identified during the inspection that staff were not always responding to signs of deterioration in patients' conditions.
- We saw there was a display board on Allingham Ward with information on the correct use of nEWS. A matron told us of the work that had been done and the additional training provided to improve use of nEWS.
- When a patient's condition required escalation, the pathway was to contact the on-call junior doctor for the ward. There was no critical care outreach team in place.

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Staff told us the doctors responded promptly to escalation whenever possible, and if they were busy with other patients, they would ask the staff to contact the senior doctor. On Dalby ward (a care of the elderly ward), we were told staff sometimes found it more difficult to achieve a timely response to escalation and when this occurred they would go straight through to the on-call consultant who was very responsive. However, a process which required staff to contact more than one person on occasions to achieve a review of the patient, was likely to have a negative impact on the timeliness of the response.

- The assessment of patients for risk of venous thrombo-embolism was monitored through audits undertaken by the trust on quarterly basis. The results of the audits indicated the percentage of patients who were appropriately assessed on the medical wards increased in the last quarter of 2015/16, in comparison to the first and second quarters of the year.

Nursing staffing

- Nurse staffing requirements had been reviewed using a recognised tool (Shelford tool) and acuity and dependency data provided by the wards. The results were not felt to accurately reflect the numbers of staff required to cover the rota and a decision was made to work towards a nurse: patient ratio of 1:8. The ratios on nights were based on professional judgement.
- The staffing review had resulted in an increase in nurse staffing on some medical wards and on the wards we visited, staff told us the increased staffing levels better reflected the requirements of the wards.
- However, there were high vacancy levels on some medical wards. Trust data for April 2016 indicated a vacancy rate of 53% on Allingham Ward and vacancy levels of 30% and above on Amyand Ward (43%), Marnham Ward (30%) and Caesar Hawkins Ward (31%). There were also high vacancies on the Heart Failure Unit due to the expansion of cardiology services and the opening of the unit. The trust was mitigating the risks through a recruitment plan and by moving staff around to meet the needs of patients.
- At the time of the inspection, Allingham Ward's vacancy rate was 51% and the matron felt staffing issues had been a major contributory factor in the ward's low performance in the key quality performance indicators monitored by the trust over the previous months.

However, due to the increased input of the Matron, provision of support to the overseas nurses and a concerted recruitment drive they felt the situation was improving.

- The trust had recruited staff from overseas in an attempt to reduce vacancy levels and these staff required additional support in the initial stages. Staff to provide support and preceptorship to these nurses had been put into place.
- The impact of high vacancy levels was, to some extent, mitigated by using bank and agency staff. Trust data indicated that the majority of shifts were filled by the use of temporary staff. Some specialist and acute medical wards had been able to secure the same agency staff on a regular basis, improving the continuity of care and the effectiveness of the staff.
- However, staff also reported increased pressure as agency nurses were not allowed to carry out some tasks for which a competency assessment was required, such as administering intravenous medicines. This increased the demands on the permanent staff. We were assured by the trust that ward staffing was managed each day by the matron, employing a number of different measures, to ensure that large numbers of agency staff were not deployed in one specific area but were spread out across the division.
- A patient reported they had missed their medicines on two occasions one day. They said the shift was, "Very agency heavy." The issue had been identified by the nurse on the following night shift.
- Patients on Buckland Ward commented on the staff being very busy and they having long waits for attention. For example one patient said, "The nurses are very busy and sometimes when you call the bell, it can take them a long time to come. It takes 15 minutes or so sometimes." Another patient said, "Staff do what they can. It gets busy in here and they run around trying to get everything done for us, hooking us up to all the machines. The nurses do look after me, even if it does take a while to get them."
- Patients on other wards also commented on staff being busy, but felt they generally received reasonably prompt attention.
- Agency staff were given an orientation to the ward but they did not have any competency assessment or other induction. They were not allowed to give intravenous drugs as this required a competency assessment.

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Medical staffing

- The trust told us the service was working towards achieving full compliance with London Quality Standards requiring consultant work patterns to be designed to meet the demands for consultant delivered care, senior decision making and leadership on the acute medical unit, across extended day working, seven days per week.
- Acute medical consultants were present week days on the acute medical unit (Richmond Ward) and at weekends, acute or general medicine consultants carried out morning and evening ward rounds.
- Ambulatory care was covered by a consultant Monday to Friday with on-call consultant support at weekends.
- Caesar Hawkins Ward began as an overflow ward before becoming a short-stay ward. Junior doctors felt well supported. The consultant performed a daily ward round in addition to their duties in the acute assessment unit, ambulatory care and as physician of the week duties. Consultants covered for colleagues who were scheduled to do outpatient clinics.
- On the other medical and care of the elderly wards individual consultants conducted ward rounds two, three or four days a week. As a result, individual patients were not always reviewed by a consultant every day. However, there was a consultant presence on most wards Monday to Friday. AMU, Marnham, Allingham, haematology including Ruth Myles Unit, cardiology (CCU and Belgrave), Ben Weir and Buckland wards had weekend consultant ward rounds.
- In general, consultants were available on-site between 8am and 6pm, with the exception of AMU which had consultant cover 8am to 10pm.
- Medical staffing skill mix indicated the trust had a higher proportion of registrars than the England average, but a lower proportion of junior and middle career doctors.
- Junior doctor cover was variable with some teams reporting good levels of medical cover and others reporting low levels at times, resulting in delays to discharge medication and response to requests for medical review.
- At nights, medical cover was arranged around the wings of the hospital and it was reported by medical staff as being "Busy, but manageable." Nurse practitioners prioritised the calls for the junior doctors and carried out routine duties to enable the doctors to focus on patients requiring review.

- The medical and cardiovascular division were undertaking a review of the medical workforce provision at night. They told us it was, "Time to refresh and review medical cover."

Major incident awareness and training

- A major incident and resilience plan was in place dated October 2015.
- Staff had an awareness of the action to be taken in the event of a major incident and we noted there was a folder on each ward with fire procedures and the major incident plan.
- Staff were aware of the requirements for evacuation in the event of a fire and we were told of an incident in 2015 when a ward had had to evacuate patients due to a fire alert. The nurse in charge had been given an award by the trust in recognition of the effective way they had managed the situation.
- However, one of our inspectors was present on Marnham Ward when the fire alarm sounded. After initially sounding intermittently, the bell became continuous. The inspector did not observe any action or evacuation in response to the alarm and appeared to be the only person to leave the area.

Are medical care services effective?

Requires improvement



We rated effective as requires improvement because:

- People's rights were not protected under the Mental Capacity Act 2005 because when patients did not have the capacity to make some decisions for themselves, there was no evidence of a two stage mental capacity assessment or information about how the best interest decision was made.
- Information technology issues impacted on staff's timely access to information and as a result records were fragmented in some areas.
- Although meal time champions had been introduced and were working well on some wards, we observed a patient who required assistance to eat, was not given the opportunity to eat at two meal times.

However, we also found:

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- Outcomes for renal patients in relation to survival rates and transplantation were excellent and were some of the best in the country.
- Evidence based guidance was available and care was provided in line with the guidance.
- The service participated in national clinical audits and patient outcomes were measured. Outcomes were comparable to other similar services for most audits with the exception of the national diabetes audit.
- Pain was assessed and patients told us their pain was managed well.

Evidence-based care and treatment

- Staff were aware of National Institute for Health and Care Excellence (NICE) guidance relevant to their specialty and had access to the guidance via the trust's intranet.
- Local protocols and guidelines were in place and were based on NICE guidance and the guidelines we reviewed were up to date. An assessment of the service's compliance with NICE guidance relevant to medicines and care of the elderly, (such as chronic obstructive airways disease, acute and chronic heart failure and neutropenic sepsis), had been undertaken by the service. Dates to review progress when issues were identified, had been agreed. The assessment had been discussed at the divisional governance board.
- The service participated in the south west London HIV network group, which was established to provide a clinical expert forum to review medication regimes in line with NICE guidance.
- We saw there were good nutritional guidelines in place and we were told national gastroenterology guidelines were in the process of being developed and the team had compared their practice informally with the draft guidelines in order to identify any areas for improvement.
- Dementia and delirium pathways had been developed based on best practice and these along with assessment documentation and care plans were being rolled out in a staged process with training and education. A dementia and delirium team were available to drive implementation of the pathways and provide training for staff to encourage the development of best practice.

Pain relief

- We found a pain assessment was carried out alongside the vital signs observations of patients and was

recorded on the observation cards. We found it was well completed on most wards except Richmond, where the pain scoring had been missed on many of the observations.

- Patients told us their pain had been well-managed and staff checked on their pain regularly. One person said, "You're asked quite often." Another person said, "I have been given pain medication when I have told them about my pain levels, so that's all superb."

Nutrition and hydration

- Nutritional screening (MUST- the malnutrition universal screening tool) was undertaken for all patients on admission and the score was reviewed at approximately weekly intervals throughout the patient's stay in hospital.
- Fluid charts to record patients fluid intake and output when in use were not consistently completed, and therefore it was not possible to ascertain whether patients were receiving adequate fluids. For example, one person's fluid chart indicated they had received a total of 320 mls of fluids on one day and 650 mls on another day. Staff told us patients received fluids, but recording this was an issue. However, we could not be certain patients were receiving adequate fluids.
- Food charts were in place when patients were at high nutritional risk and we found most of these had been completed consistently.
- There was a multi-disciplinary nutrition team which reviewed patients requiring enteral and parenteral nutrition (tube or intravenous feeding). The full team carried out a multi-disciplinary ward round twice a week and saw patients each day. The team had an active focus on teaching and protocols had been developed and implemented.
- The wards within medical services had a recent focus on improving nutrition. Boards on each ward gave details of each patient's dietary requirements and the assistance they required. Red trays were used to highlight those patients in need of support at mealtimes.
- Wards allocated one or two staff as meal time champions each day and they worked with the ward hostesses to distribute meals and ensure patients received assistance with their meal.
- We observed the distribution of the lunchtime meal on Allingham, Belgrave and Rodney Smith wards. We saw

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meals distributed very efficiently and effectively on Allingham and Belgrave wards, patients received support as necessary and adapted utensils were used to allow patients to be as independent as possible.

- However, on Rodney Smith Ward the nursing staff and hostesses worked less closely together and some people did not receive the help and support they required. For example, at 9.20am, we observed a patient's full bowl of porridge on their bed table away from their bed. The patient appeared to be asleep and due to their circumstances, would have needed full assistance with their meal. We checked at intervals and staff did not attend to the patient or offer them their meal. At 10.10am we saw it had been removed by the hostess and when we checked, they told us it had been removed as it was cold. The patient did not receive their breakfast, nor was it flagged to staff that they had not. We observed the same patient at lunchtime for approximately 15 minutes after their food was served and no one attended the patient to provide assistance. We talked to the nurse in charge about this and they said breakfasts were served by the hostess and staff normally assisted patients with their breakfast when they came out of handover. They told us the patient was very reluctant to eat or drink. However, from our observations, the person was not always given the opportunity to eat.
- Patient feedback on the quality of food was extremely variable. For example one person said, "The food is diabolical." "The meals are tasteless and I don't feel I can eat them." "If you are hungry you have to force yourself to eat the food." This patient was identified as being nutritionally at risk and was prescribed nutritional supplements. However, most patients felt the meals were adequate and some were very complimentary. For example, one person said, "The food is amazing; very tasty and hot and the presentation is wonderful."

Patient outcomes

- The trust participated in all the national audit programmes relevant to the service.
- Outcomes for renal patients in relation to survival rates and transplantation were excellent and were some of the best in the country. The hospital had a survival advantage compared to the majority of other units for acute haemodialysis (one year survival of prevalent dialysis patients at St George's (age adjusted to 60 years)

in the 2013 cohort of 92.2% (95% CI 84.7-91.7), which is above the national average. St George's Hospital being one of only five centres which had a survival average above the national 95% confidence interval upper limit.

- In the Sentinel Stroke National Audit (SSNAP) from January 2015 – December 2015, the trust had achieved a level A overall (the highest possible level, in a range of A to E) for the hyper-acute stroke unit and level B for the stroke unit.
- In the most recent national Heart Failure Audit, performance was in line with or slightly better than the England average for three of the four in-hospital care measures and four of the seven discharge measures.
- The national Chronic Obstructive Pulmonary Disease (COPD) audit examining the resources and organisation of pulmonary rehabilitation services in England and Wales 2015, indicated that proportionally fewer patients completed the pulmonary rehabilitation course than the national average, but of those that did complete the course, 84% showed an increase in their COPD assessment test compared to 68% nationally.
- Results from the national adult Community Acquired Pneumonia (CAP) audit, December 2014 – January 2015, indicated slightly worse performance than the national average in respect of the proportion of patients receiving their first dose of antibiotics and a chest X ray within four hours. The trust had started to implement the community acquired pneumonia care bundle prior to the audit and believed full implementation of this would facilitate an improvement in performance.
- In the National Diabetes Audit (NaDIA) 2015, the trust performed in the bottom 25% of trusts in seven of the 18 measures with all the remaining measures in the middle 50% of trusts. We asked the divisional leads about this and they told us there were significant issues with data collection which had been resolved in readiness for future audits. In addition, there was a small clinical nurse specialist resource compared to the size of the patient population. A business case to provide in-reach services to the wards had been produced previously, but had not been successful. The results were published in the middle of 2015 and action, other than those related to data collection, had only just commenced at the time of the inspection. However, a monthly meeting to address areas of concern had just been introduced and the business case was being reviewed with a view to re-submission.

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- An audit programme for 2016/17 had been agreed. The majority of the audits planned for medical services were national audits. However, some audits planned by specialist services and trust wide audits included a review of practice in medical services within their remit.
- The risk of readmission was higher than the England average (September 2014 –August 2015) in elective neurology and on-elective haematology. The risk of readmission indicates how services compare nationally in providing care that is effective, such that patients recover and do not require a return visit to hospital.
- We discussed the possible reasons for a high risk of re-admission with the senior leadership team and they highlighted that patients recorded under the specialty of clinical haematology were much lower than other trusts and the majority of patients with a re-admission have a primary diagnosis of sickle-cell anaemia.
- The average length of stay for all elective medical patients was longer than the England average between September 2014 and August 2015 and the non-elective length of stay was in line with the England average. The trust provided us with Dr Foster data for 2014/2015 and 2015/2016 which indicated that although the length of stay was greater than the national average, it was better than expected given the mix of patients for both periods and that the length of stay had reduced by 0.38 days in 2015/2016 compared to the previous year.
- The 2013/14 MINAP audit (Myocardial Infarction National Audit Project) (latest figures submitted), showed the trust performed better than the England average for all three nSTEMI measures.

Competent staff

- Clinical staff told us they had annual appraisals and ward managers told us annual appraisals were up to date. They said there was a trust wide approach to the appraisal timetable.
- The trust's own appraisal data indicated low appraisal rates for some categories of staff in the medical and cardiovascular division. However, the highest level of appraisals was for medical staff with 82% having had an appraisal in 2015/2016. Appraisal rates for other categories of staff such as nurses, allied health professionals, other clinical staff and administrative staff ranged from 51% to 77% during the same period.
- Junior medical staff said they felt there was good support and supervision from consultants. There were regular weekly teaching sessions and journal clubs.

Some doctors said they found it difficult to attend training when working on Richmond Ward due to the pace of the ward, but in some other specialties, we were told senior doctors covered the junior doctor bleeps in order to enable them to attend training.

- Student nurses told us they were able to achieve the required percentage of their time working with a mentor and they had been offered learning opportunities in other departments in order to broaden their knowledge and they had been supported in identifying skills required along with opportunities to practise the skills. A clinical teacher also provided support for the student nurses and they found this very helpful.
- Practice educators had been appointed to areas where it was identified that additional support was needed for nurses to develop their skills in relation to developments in the service or when skills gaps had been identified.
- This enabled the service to address issues arising from incidents and to provide additional levels of support where there were large numbers of new staff.
- Additional training was provided for staff working in specialist areas, such as tracheostomy study days and training in non-invasive ventilation; and these were ward based.
- Nurses in the renal unit expressed concerns about a reduction in funding for external specialist courses for renal services. They felt it would impact on the ability to recruit and retain staff.

Multidisciplinary working

- There was a multi-disciplinary approach to record keeping with all professions contributing to the ongoing record of care within the patient's medical record.
- We found evidence of the input of dietitians, occupational therapists, physiotherapists, specialist nurses and social workers in patient records.
- We observed a very effective multi-disciplinary handover on Richmond Ward which occurred daily and effective multi-disciplinary board rounds and multi-disciplinary working in all other wards we visited.
- We also observed multi-disciplinary board and ward rounds on other wards we visited.
- Formal multi-disciplinary team (MDT) meetings were held weekly in most areas.
- Staff told us multi-disciplinary working was good. One member of staff said, "We have a fantastic MDT at present; great communication and great team work."

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- Two mental health liaison nurses were based on Richmond Ward and we saw evidence of their input within patient records.
- There was an Older People's Advice and Liaison (OPAL) team which provided assistance with complex discharges and contributed to the flow of patients through the service.

Seven-day services

- Richmond Ward (Acute medical unit) had a consultant on site between 8am – 10pm, whilst for the rest of medical services consultants were available on site between 8am and 6pm.
- Marnham and Allingham wards had weekend working for 12 months, with weekend consultant-led ward rounds. Out of hours, the service was covered by junior doctors and on-call consultants.
- Medical staff told us there was good access to out of hours imaging and diagnostic services. Ultrasound, MRI scanning and angiograms could be carried out seven days a week. Slots were allocated to aid discharge.
- Pharmacy opening times for the main dispensary were between 9am – 5.30pm Monday to Friday and 9am - 4.30pm on Saturdays and Sundays. All areas had access to an on-call pharmacist out of hours, who could be contacted for advice and assistance with medicine supply issues.
- There was a pop up pharmacy on Richmond Ward to enable medicines which patients required to take home, to be dispensed and provided in a timely manner.
- Nursing staff stated they were happy with the pharmacy service received out of hours (evenings and weekends). They commended the support and advice received by the on-call pharmacist and stated they thought medicines for patients to take home arrived quickly after ordering them (there was a satellite pharmacy on the third floor of St James wing which ensured timely access to medicines).
- A ward pharmacy service was provided seven days a week and newly admitted patients were reviewed on a Saturday and Sunday.
- Pharmacists attended the Acute Medical Unit post take ward round seven days a week. The resident pharmacist reviewed patients admitted between the hours of midnight and 4am.

Access to information

- Without exception, staff we spoke with who worked in the areas where the electronic record was being introduced, told us of problems with access. Issues including the computers breaking down, wi-fi issues and software malfunction were all mentioned.
- Staff told us that when there were problems with the information technology, it was not rectified quickly and this impacted on the ability to use the electronic record and the need to use paper based back-up systems.
- They also found the mix of paper and electronic records a challenge.
- Staff reported good access to guidelines and policies on the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us staff gained their consent prior to carrying out procedures such as insertion of a cannula. They told us procedures were explained to them and they were in control of the decision. One patient said, "They respect the fact I can make my own decisions really."
- A relative told us the doctors had wanted to carry out an investigative procedure on their relative, but the patient had refused and the doctors had respected the decision. They said, "Consent is asked for at all times. I have been here with my relative for whatever care they receive."
- We saw written consent had been obtained prior to investigative procedures such as endoscopy.
- However, we also saw an example of a procedure which had been carried out, for which we would have expected consent to have been documented and wasn't. We spoke with a doctor and they said they had obtained consent from the patient and agreed they should have documented it. A consultant told us they were clear with junior staff about consent but there was no formal guidance for staff on specific medical procedures and the type of consent required, to ensure consistency of approach.
- Staff had a theoretical knowledge of the implications of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards for their practice. They told us the medical staff usually took the lead when assessments of capacity were required.
- However, we found documentation of mental capacity assessments and best interest decisions were limited in most cases. For example, we found general statements

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in patient records stating the person did not have the capacity to make decisions and that treatment was given in their best interests. We did not see any evidence of a formal two stage mental capacity assessment in relation to specific decisions or any information about how the best interest decision had been determined or whether alternative options had been considered.

- There appeared to be a lack of recognition that some interventions which had been put into place, may have constituted restraint and consent or mental capacity assessments should have been clearly documented. For example, the use of bed rails to prevent patients falling from bed and the use of mittens to prevent patients removing their nasogastric tubes. We saw six patients on Allingham, Dalby and Rodney Smith wards, where bed rails were used and none had recorded in their medical records, mental capacity assessments or best interest decisions. We also saw two patients on Dalby and Rodney Smith wards wearing mittens and there was no documentation about their capacity to make that specific decision. However, staff told us these decisions had been discussed with medical staff.
- We saw two patients wearing mittens, and in neither case was there a full mental capacity assessment and best interest decision. One patient had minimal documentation about their capacity to make decisions. The second patient was detained under the Mental Health Act and we found clear documentation in relation to this. This patient had a nasogastric tube to provide additional nutrition and a urinary catheter. It was documented that the person did not have capacity to consent to the nasogastric tube and mittens had been applied to prevent the person removing the tube, but documentation related to the decision making was very limited.

Are medical care services caring?

Requires improvement



We rated caring as requires improvement because:

- Patients privacy and dignity were sometimes compromised on some wards due to ill-fitting privacy screens and staff did not have access to additional screening which was required.

- We received some reports from patients about a lack of empathy from staff and poor communication.

However, we also found:

- We observed and received some very positive reports of staff's kindness and caring attitude to patients.
- Patients were given good explanations about their care and treatment and felt able to ask questions. They were aware of the plans for their care.
- Patients felt they were provided with any emotional support they needed.

Compassionate care

- The number of responses to the Friends and Family Test was above the England average at 37.8% as compared to 33.7% nationally.
- The percentage of patients recommending all medical wards was above 90% in April 2016 for medical services.
- We observed staff speaking gently with patients, giving them time and repeating the information patiently when patients were confused or anxious. This included all professions and job roles including porters and a phlebotomist.
- Patients made comments about the kindness of staff such as, "From the minute I walked through the door, the staff have been very kind." "I felt like a nuisance, wasting their time, but they never make you feel like it; they are so sweet and tender. They told me they had a bed for me and not to worry about anything."
- However, we also received some adverse comments from patients about the attitude and interpersonal skills of staff. For example, a patient said they had been told twice by staff that, "This isn't a hotel." Another patient said the night staff had had a poor attitude and a relative told us when they asked the whereabouts of their relative, the staff just pointed in the right direction and hadn't spoken. They commented, "Where has the personal touch gone?" "What happened to being friendly; I understand they are rushed off their feet but a small conversation goes a long way to creating a good impression." Another patient who told us they could not read or write, said they had asked a carer to write a message on their phone for them, but the carer had told them to "Get someone else to do it."
- A lack of compassion and empathy and a poor attitude of individual staff was mentioned in some of the complaints we reviewed and the enquiries we received.

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- Wards had identified dignity champions and we observed staff trying to preserve people's privacy and dignity when providing care. They drew the curtains around beds when providing care, but did not have access to additional screening which was required.

Understanding and involvement of patients and those close to

- Patients felt they had a good understanding of the plans for their care and treatment and they were kept informed of developments and changes to the plan. One person who did not feel they were initially kept informed, said that after their family spoke to staff they had been fully informed.
- Patients said they were able to ask questions and if staff did not know the answers they would find out or find someone with the information to talk with them.
- Patients told us staff explained things fully, in a way they could understand. For example, a patient said the respiratory physiotherapists had explained the exercises they needed to do, and informed them they would check with them again before discharge. Another person told us they had received good information about a low potassium diet.
- Information boards on each of the wards provided patients with details of protected mealtimes, visiting times and staff uniforms,
- Communication with relatives to notify them of changes in patients' condition wasn't consistently good. A relative told us they weren't informed when their close relative had a cardiac arrest and was transferred to the coronary care unit. In addition, they told us of inconsistencies in the information given to relatives over the telephone. We found examples of similar communication issues in the complaints we reviewed in relation to medical services.

Emotional support

- Most of the patients we spoke with did not feel they had needed emotional support but those who did, told us they had received the support they needed. One patient said, "Absolutely, they listen to what you have to say; I can talk to them about what I want to and how I am feeling and they don't mind."
- Patients had access to clinical nurse specialists who provided emotional support and help in managing their long term conditions. An example we were given of this by a patient, was the diabetes nurse specialist.

- Patients in the renal unit told us they received help and support in coming to terms with their condition. A patient who had a failed kidney transplant and had been having dialysis for a long period of time, said it had been difficult to accept, and they had received, "lots of psychological support and information." They told us someone still came round during dialysis to talk to them which they found supportive and reassuring.
- Staff told us that patients sometimes said they wanted to discontinue dialysis and although decisions were respected, they were able to refer them to the advanced kidney team for further support and information.
- We saw assessments within people's care records to identify anxiety and depression when this was appropriate.
- The privacy of a patient who was accompanied by two police officers was compromised due to their placement on Caesar Hawkins Ward, where both the patient, who was placed in a side room, and the police officers, were overlooked by other patients. A patient said, "The thing is, it's in the middle of the ward, so everyone can see them inside there and the fact there are two police officers, doesn't make it any more discrete."
- Other patients on the ward commented on the situation which they found unsettling and anxiety provoking. One patient said, "It is unnerving having a prisoner roam the corridors," and another said, "I do feel safe usually, but I have heard a lot of noise in the corridor over the last few days and there's a policeman walking about." However, the nurse in charge of the ward at the time, felt that patients were not too affected by the situation and that it was well-controlled, despite the patient showing behaviours which others found challenging.

Are medical care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- There were a significant number of patient moves at night, between the hours of 10pm and 6am, which caused disruption and anxiety to some patients.
- Curtains used to screen the beds on at least four of the medical wards did not preserve people's privacy.
- Some patients were unhappy with the use of disposable utensils and plastic beakers.

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- Although a hospital passport had been completed for patients with a learning disability, their care plans were not adapted to take account of their individual needs.
- A translation service for people for whom English was not their first language was available but staff preferentially used family members to interpret for patients.
- The ward environment was not adapted to meet the needs of people with dementia on Dalby Ward.
- We did not find a systematic approach to the management of actions and learning from complaints.

However, we also found:

- There was evidence of service development to meet the needs of the local population and collaborative working with commissioners and external agencies.
- Dementia and delirium care pathways, patient assessments and care plans were in the initial stages of being introduced to improve the assessment and care of patients with dementia and delirium.

Service planning and delivery to meet the needs of local people

- The heart failure unit had been developed to provide bespoke services to better accommodate the needs of a specific group of patients. It was launched in quarter four of 2015/2016 as a result of collaborative working between the local commissioners and the cardiologists.
- The rheumatology department had been working with local GPs to agree and improve the management of patients and ensure appropriate referrals.
- The acute dependency unit on Richmond Ward was developed to meet the needs of acutely unwell patients in the initial stages of admission. It was able to care for high dependency patients and had improved patient flow within the service.
- Outpatient clinics within the Ambulatory Assessment Area (AAA) had been increased in response to rises in local demand over the previous year. In February 2016, changes were made to the cellulitis pathway in collaboration with the emergency department enabling patients to be seen in ambulatory care as opposed to the emergency department.
- An IT-based communication portal between primary and secondary care (the kinesis service) provided a portal for GPs to obtain specialist advice within 24 hours.

Access and flow

- Richmond Ward had a total of 58 beds and was divided into a number of different areas including an acute dependency unit, acute assessment area, acute medical unit and the Richmond annexe.
- The trust had appointed patient flow coordinators based on Richmond Ward to improve patient flow.
- We observed effective multi-disciplinary board rounds on Richmond Ward at which each patient on the ward was discussed with reference to their triage, progress, plans for care and treatment, their destination ward and/or expected date of discharge. The team taking responsibility for their care was also agreed. Information about bed availability on medical and care of the elderly wards was available and the most appropriate destination ward for patients was agreed.
- The Older People's Advice and Liaison (OPAL) team were present at the board rounds and contributed to the discussion about patients they were involved with.
- From our observations and feedback we received from staff, Richmond unit functioned effectively and very few patients stayed for long periods. A patient commented, "This unit has a fast turnover of patients. We get sent to different wards or we go home; one of the two. It's a very efficient service."
- There were a significant number of patient moves at night, between the hours of 10pm and 6am. Trust data indicated that most of the patient moves involved Richmond, Caesar Hawkins, Amyand and Allingham wards. In December 2015, the number of patients being transferred at night was 154 for Richmond, 34 for Caesar Hawkins and 15 for Allingham.
- The disruption and anxiety caused by moves at night was illustrated by a patient who told us they were transferred from Richmond Ward at 1am. They said, "I was just settling down for the night and they suddenly said, sorry we are moving you now, just as I was dozing off."
- The number of medical patients outlying in general surgery was low, although cardiology reported some impact on the ability to undertake elective investigations due to the numbers of non-elective medical patients on the ward.
- Medical services operated a formal buddy ward system with core medical wards having nominated outlying wards to accommodate increased patient demand

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within each specialty. The list of medical outliers was circulated daily to clinical teams including junior doctors who ensured patients were reviewed during routine rounds.

- Staff reported waits for patients requiring residential and nursing home care or intermediate care. They told us there was timely completion of the assessment documentation, but due to a shortage of beds in the community, patients had to wait for discharge.
- The trust were working to improve discharge information and timely communication with GPs.
- Patients attending the dialysis unit told us they were attended to promptly when they arrived and did not have to wait for a dialysis machine.
- The trust had identified an inability to meet activity demand in haematology day unit due to lack of capacity and placed it on their risk register. Controls to mitigate the risk were in place and a steering group had been set up to review referral patterns and explore ways of increasing capacity such as increasing opening hours to increase the chair capacity.
- The AAA service was expanded to seven days per week from July 2015, with the provision of nurse practitioner cover between 10am – 6pm every Saturday and Sunday. This reduced avoidable admissions for patients in line with Ambulatory Emergency Care standards.

Meeting people's individual needs

- Curtains used to screen beds on several of the medical wards did not serve their purpose. On Dalby Ward, we saw curtains did not completely surround the bed spaces and there were too few curtain hooks to enable the curtains to hang properly. The ward manager told us they had repeatedly asked for different curtains, provision of more hooks and for curtains to be changed, but had not been able to improve the situation. On Gordon Smith, Amyand and Belgrave wards, we found the curtains were very short and when patients were sitting on a commode, they would not be adequately screened. One of our inspection team observed a patient on a commode during their visit to Gordon Smith Ward.
- Some patients were unhappy with the use of disposable utensils and plastic beakers. One patient said about the plastic beaker, "It's undignified. Sometimes they don't think about the able people's needs." Their relative went on to comment, "At home (the person) has a normal cup, so why should it be different here."
- Patients and relatives on Buckland Ward identified environmental issues which impacted on their experience of care. Renal dialysis was carried out on Buckland Ward and patients and relatives attended the ward as day patients on a regular basis. Relatives often accompanied the patients in order to transport them to and from the unit. A relative talked about the day room which did not have comfortable chairs for people who were waiting for long periods. It was suggested that shelves for books would have been helpful as they wanted to bring in books for people to read while they were on the ward.
- The relative also identified that they had to walk across the hospital to obtain a hot drink and something to eat as the only facilities available were machines with cold drinks and crisps. The relative said staff often offered them a hot drink when providing them for patients, but recognised this was not part of the service and would have liked the opportunity to buy food and drink for themselves.
- There was access to a service which provided translation for people whose first language was not English, but staff did not always know about the ability to obtain an interpreter and one person who did know about the service said, "We only use an interpreter if we really need it as they often don't understand the patient anyway due to regional variations in language." They said if a person could not speak English they used the family wherever possible and would ask the family to write down some key words to help staff to communicate key issues.
- A learning disability liaison nurse was available to provide advice and support when a person with a learning disability was admitted to the wards.
- A hospital passport was in use and we saw it had been completed for the patients with a learning disability whose records we reviewed. They contained a good level of detail about the person and their support needs and preferences.
- However, standardised pre-printed care plans were in use in medical services and they had not been personalised for the individual patient. For example we saw that although a learning disability passport was used for one person, there was no reference within the care plan to the fact the person had a learning disability and the adjustments which were needed for the person.

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- Staff told us about the arrangements they may put into place for people with a learning disability. They said they would inform the Learning Disabilities liaison team and they "Let us know the type of thing we should do."
- The trust had a dementia team in place to improve the care of people living with dementia within the trust. Dementia and delirium pathways had been developed, along with a proforma for the assessment of delirium and dementia and a care plan. Training for staff had begun and the initiative was being rolled out in a staged process.
- The butterfly scheme was being used to identify patients living with dementia and delirium on the patient boards on the wards, on their wrist bands and on the notes. Several medical wards had display boards to provide information on the scheme for visitors and staff.
- We found variable use and completion of the dementia assessment and care plans for patients whose care we reviewed. In some cases the documentation was well completed whilst in others it had been placed in the patient's record but had not been consistently completed.
- Dalby Ward was one of the wards which cared for people with dementia. The team were very dementia focussed and staff had a good knowledge of dementia. The ward manager was passionate about improving care for people with dementia, but was hampered by environmental issues.
- The ward had not been adapted to better meet the needs of people with dementia and was not modernised, which increased the risk for people with dementia. For example, there were no bedside night lights, portable oxygen and suction had to be used as there were no piped supplies to some beds and there were portable air conditioning units with trailing hoses in the bays. The dayroom was small and cluttered. Without bedside lights, patients with dementia would have more difficulty in orientating themselves to their surroundings and it could lead to increased anxiety.
- The dementia team had been successful in obtaining some funding to enable some changes to be made to the environment and they told us of the changes which were planned. In addition, refurbishment of the ward had also been agreed, but no timescale had been given for either of these schemes.

- Patients told us they were given a choice prior to the meal and we saw pictorial menu guides were available to help those who had difficulties with the written word or understanding verbal communication.

Learning from complaints and concerns

- Staff were aware of the complaints policy and the action to take if a patient or visitor raised a concern or a complaint with them.
- Staff told us they received feedback about complaints at ward meetings and handover. On one ward we were told the ward manager read out the complaints at handover. Staff said they also received individual feedback if the issue involved them personally. One nurse said, "A relative complained and I learnt that I had to improve my communication."
- Complaints were discussed at the divisional governance board and directorate and care group meetings.
- However, we did not find a systematic approach to the management of actions from complaints. The information we were provided with in relation to complaints listed all the complaints received, but the action taken or response to the complaint was only identified in less than 50% of complaints and in some cases the action did not include some of the main issues within the complaint.

Are medical care services well-led?

Requires improvement



We rated well-led as requires improvement because:

- There was a lack of a safety culture and a reactive rather than proactive approach to risk and environmental safety.
- Although most of the safety issues we identified during the inspection were included on the risk register, actions taken to mitigate the risks were insufficient. Timescales of action to fully address the risks were unclear.
- The perception of some junior staff was that visibility of some leaders within the medical and cardiovascular division was limited.
- Plans existed to address the environmental issues within specific clinical specialities. Clinical staff and managers, in consultation with patients and patient representative groups, had developed business plans

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and proposals to develop and redesign specific services including renal services. Financial restraints and decisions at executive level had meant that these proposals were slow to be implemented, resulting in patients continuing to receive care and treatment in environments which were not fit for purpose.

- Not all staff were aware of the trust's quality and safety priorities.

However, we also found:

- A commitment from staff to improvement.
- There were examples of the development of services and the introduction of new practices to take the service forward.
- Engagement of patients and the public in the improvement of services

Vision and strategy for this service

- The medical and cardiovascular division had a business plan with milestones for 2016/2017 and SMART outcomes (specific, measureable, achievable, realistic and time-scale) had been identified. The senior leadership team told us further developments would be driven by the trust strategy.
- The trust had identified a medical lead for dementia and a dementia team was in place to improve the care of people living with dementia. A dementia strategy had been developed to ensure the development of a sound infrastructure, including the provision of staff training, dementia friendly environments, leadership and policies and procedures. The dementia strategy group's membership included representation from the different professional groups within the trust, the Alzheimer's society, and external agencies including Wandsworth carers.

Governance, risk management and quality measurement

- A governance structure was in place with committees at divisional, directorate and care group levels. We reviewed minutes of these groups and found there was discussion of risks, incidents, clinical audits, and complaints. The nursing scorecards which gave information on performance in relation to key quality issues were also discussed.
- Governance half days were held quarterly and all elective activity was cancelled for those sessions.

- Reviews of serious incidents were chaired by someone outside the immediate service affected, who had received training in root cause analysis. They were attended by medical staff, nurses and other professionals involved.
- Risk registers were in place for each of the directorates/ care groups within the medical and cardiovascular division. Actions to control and mitigate the risks were identified and review dates were in place. Many of the environmental issues we identified during the inspection had been identified on the risk register and action put into place to mitigate the risk. However, plans to address the underlying issues did not have clear timescales and services had continued to be provided in environments which were not fit for purpose.
- The maintenance of records for staff who had attended mandatory training was not accurate.
- Issues with the ingress of water during heavy rainfall were identified on the renal unit in 2013, but services continued to be provided in this area. There was a business proposal for the transfer of the renal service to a new area, but this was awaiting funding agreement, at the time of the inspection. Following the inspection, the affected roof had been repaired and the water ingress had stopped. The affected beds were not being used. We were told that the relocation of the renal unit had commenced and expected to be concluded by October 2016.
- There were displays on each ward providing details of the ward's performance in relation to MRSA, Clostridium difficile, pressure ulcers and falls. However, when staff were asked about the trust's quality and safety priorities, most were unable to answer the question and were unaware of any targets related to these when asked.

Leadership of service

- We found nursing leadership was generally good at ward manager and matron level and when concerns had been identified additional support had been put into place.
- Staff said their ward managers were approachable and they were able to raise issues and concerns.
- Ward managers told us they felt listened to and supported, but some were frustrated by a lack of progression of issues, particularly in relation to estates and facilities issues.

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- Some patients told us they did not know who the ward manager and matron were, but others said, whilst they did not know their names, they would recognise them. However, patients on Dalby Ward knew the ward manager and praised their supportive attitude to patients and staff.
- Senior managers and leaders were less visible to staff in medical services. We were told, "Senior management only visit when something serious goes wrong. It would be nice to see them at other times."
- In contrast to clinical staff who worked closely together and communicated well, communication between the estates and facilities department and the clinical areas did not appear to be effective. Staff felt they reported issues and little happened.
- We also found an example where estates and facilities were planning some ward refurbishment on Dalby Ward to address long standing environmental issues. The dementia team had also obtained funding for dementia friendly initiatives which estates and facilities were implementing, but the two schemes were not being taken forward together.

Culture within the service

- Staff showed considerable loyalty to the trust and were committed to improving services for patients. A member of staff said, "People come to work and want to make it better. We are making an effort to do things better."
- They emphasised the positive team working and support across different professional groups. We saw evidence of this during the inspection where the contributions of different members of the team were listened to and respected.
- A student nurse said they enjoyed working in medical services because, "The doctors talk to me and I feel valued as a member of the team."
- Staff felt there was an open and supportive culture within the service. They said issues were discussed within their teams and they were encouraged to contribute their views.
- We asked about equality and diversity and were given different views from staff. A nurse felt there was no promotion opportunities for people from black and ethnic minority groups and said some staff did not apply for promotion as knew they would not be successful. However, other staff said they felt promotion opportunities were available to everyone. One person

said, "Our workforce is very diverse; there is a good mix within the unit and we are all promoted on merit." They said they felt their colour had not affected their progression.

Public engagement

- Patients, carers and voluntary organisations were members of the dementia strategy group and they had contributed to the development of the strategy. Carer experience questionnaires had been introduced to obtain feedback from a wider group of carers.
- The Alzheimer's society had advised on signage, clocks and décor to assist patients with dementia and these had been prioritised for purchase with the charitable funding obtained.
- The dementia team had obtained funding to develop a website for younger adults living with dementia.
- The trust had an active kidney patients association, which offered support to patients and made recommendations to the trust about improving the service.
- The alcohol liaison service had links with local community groups and commissioners.
- Waiting times in the oncology day unit for patients attending for chemotherapy had been reduced as a result of working with patients and involving them in a steering group to review the patient pathway. The size of the unit had been increased to enable issues raised to be addressed.
- Most patients could not recall being asked their views on the quality of care or being asked to complete any surveys. We did not see any suggestion boxes or other ways of gathering patient feedback in use. However, the Friends and Family test was given to patients on discharge and this also included additional questions regarding patient experience and a section for their comments.
- We saw specific initiatives had been put into place to reduce noise at night as a response to patient feedback.

Staff engagement

- Where staff meetings took place, staff said they enabled discussion of issues and sharing of ideas.
- Staff were aware of the recruitment challenges faced by the trust and the action being taken to recruit additional staff. They were understanding of the difficulties and said they had made an effort to welcome new recruits and temporary staff.







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- Junior doctors on Dalby Ward were able to attend regular speciality teaching and governance sessions. We saw evidence of good junior doctor representation at governance meetings.

Innovation, improvement and sustainability

- The heart failure unit was the first designated heart failure unit in the UK.
- Haemato-oncology services achieved JACIE (Joint Accreditation Centre for stem cell transplantation) accreditation in January 2016.
- The medical service was using capnography to monitor patients receiving non-invasive ventilation (NIV) in the acute dependency unit. Capnography is the monitoring of the concentration or partial pressure of carbon dioxide in the respiratory gases and is a new approach to monitoring NIV patients.
- The trust had been successful in a bid to become a home parenteral nutrition centre. It was one of three centres in London to provide the service.
- The bowel screening programme for 55 year olds had been introduced.
- The older people's assessment and liaison service (OPAL) commenced in October 2015 with specialist MDT in-reach provided into the acute medical unit. There were plans to extend the service from July 2016 into the clinical decisions unit and the emergency department with the aim of reducing admissions and re-admissions in the frail elderly and ensuring patients have access to community-based services.
- Renal research was being further strengthened as part of the South West Thames Institute for Research- on ischemia reperfusion injury.

Surgery

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

Information about the service

The surgical specialties at St George's Hospital, Tooting (the hospital) include trauma and orthopaedics, plastics, urology, neurosurgery, cardiac, vascular, ear nose and throat (ENT), colorectal, and maxillofacial. The hospital provides surgical services to local residents from the London Boroughs of Wandsworth and Merton. There are specialist surgical services providing treatment regionally, and in some cases nationally, including neurosurgery, cardiac surgery, bariatric surgery (for patients who are severely overweight) and urology cancer treatments. The hospital is the major trauma centre for South West London and Surrey and receives patients with multiple serious injuries, such as head injuries, internal injuries and multiple fractures by helicopter and ambulance. There were 22,100 surgical procedures at the hospital in the year to August 2015, of which 29% were emergency, 27% were planned day cases, and 45% planned inpatient cases.

There are 31 operating theatres in the hospital. These include four specialist cardiac theatres, four neurosurgery theatres and a hybrid theatre for vascular surgery and interventional radiology procedures. There are two trauma theatres available at all times and a theatre for general emergency surgery. Each of the theatre suites has recovery areas. There is a unit for assessing patients before they come for surgery, and an admissions lounge for patients coming to the hospital on the day of surgery. There are 13 wards with surgical patients. The day surgery unit is self-contained, with five theatres, a recovery area and seats for patient waiting for discharge.

Therapists in dietetics, physiotherapy, occupational therapy and speech and language therapy (SALT) work with surgical patients to optimise recovery.

The surgery, theatre, neurosciences and cancer division (the surgical division) oversees the theatre and anaesthetics, surgical, and neurosciences directorates, which are sub-divided into care groups for each specialty. The major trauma directorate in the division co-ordinates the trauma network for south-west London and Surrey. Cardiothoracic and vascular surgery sits within the medicine and cardiac division.

During our inspection at the hospital in June 2016 we inspected the pre-assessment and admissions area, three theatre suites, the day surgery unit, 11 surgical wards and the discharge lounge. We spoke with about 50 members of staff including ward clerks, domestic staff, healthcare assistants, all grades of nurses, theatre staff, clinical nurse specialists, general managers, junior doctors, surgical and anaesthetic consultants and divisional leaders. We also talked with 13 patients and two relatives and looked at patient records. We held focus groups to hear the views of staff in the week before the inspection.

We reviewed national data about surgical services in England and information provided by the trust, such as policies, audits, risk registers, incident data, and plans for developments.

Surgery

Summary of findings

We rated this service as requires improvement because:

- Some theatres were not fit for purpose. Theatres were sometimes closed due to electrical faults or unsafe temperatures. There were also water leaks following rain in some theatres, wards, pre-assessment unit and the day surgery unit.
- Theatre air handling units (AHU) were at risk of failing intraoperatively due to the age of the plant. This was on the divisional risk register and rated as 'extreme'.
- Two of the theatres in St James' Wing (5 and 6) were closed at the time of our inspection for refurbishment, including electrical repairs and the installation of laminar flow. Sixteen of the 51 theatres needed to be completely refurbished.
- Since the inspection, we have been told by the trust that the refurbishment of theatres 5 and 6 had been completed.
- The system for managing theatre stock was not effective and this resulted in items running out before theatre staff had ordered replacements. Theatre staff spent time looking for items in other parts of the hospital and sometimes surgeons or anaesthetist did not have their preferred equipment. The equipment purchase and replacement programme had been affected by budget cuts.
- Some medical and surgical staff ignored challenges to their infection control practices.
- The processes for reporting and investigating serious incidents (SIs) were slow and did not always identify factors that contributed to incidents.
- The trust had temporarily ceased national reporting of the RTT data. This was because, they could not guarantee the data they were reporting was robust and accurate. The divisions made additional checks to limit the risk of losing track of patients, but some patients were not receiving treatment within the expected time from referral. There were sometimes additional delays when patients had to wait for tests because of demand on ultrasound and MRI scanners.
- Theatres were unable to meet demand. Cancellations of operations were frequent and some of these were not re-booked within 28 days.
- Patients sometimes had to wait for tests because of demand on ultrasound and MRI scanners.

Are surgery services safe?

Inadequate



We rated safe as inadequate because:

- Some theatres were not fit for purpose. Theatres were sometimes closed due to electrical faults or unsafe temperatures. There were also water leaks following rain in some theatres, wards, pre-assessment unit and the day surgery unit.
- Theatre air handling units (AHU) were at risk of failing intraoperatively due to the age of the plant. This was on the divisional risk register and rated as 'extreme'.
- The system for managing theatre stock was not effective and this resulted in items running out before theatre staff had ordered replacements. Theatre staff spent time looking for items in other parts of the hospital and sometimes surgeons or anaesthetist did not have their preferred equipment.
- Some medical and surgical staff ignored challenges to their infection control practices.
- The five steps to safer surgery process was used in all theatres to reduce avoidable harm. However, poor relations among some staff who worked in theatres affected teamwork, which is necessary for their effective implementation.
- There was an inconsistent approach on the wards to requesting advice and support for the deteriorating patient.
- The processes for reporting and investigating serious incidents (SIs) was slow and did not always identify factors that contributed to incidents. This resulted in delays to learning from SIs, and recommendations did not always address the root causes of incidents.
- There was a mixture of paper and electronic patient record systems, and staff sometimes found it difficult to get information about patients in a timely way.
- Compliance with mandatory training was improving, but was still below target in some care groups. The division was unable to provide training in basic and intermediate life support for all staff because of limited places.

However:

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- Nursing, therapy and theatre staff understood the importance of reporting incidents that affected the safety of patients. Medical, surgical, nursing and allied health staff understood the principle of being open to patients when something went wrong.
- The surgical ward staff had increased harm free care by improving pressure area care. Infection protection and control processes had improved in theatres, reducing the number of surgical site infections.
- There had been a successful recruitment campaign for theatre and ward staff. Ward staff rosters were organised well in advance to check that there was a skill mix of staff and to obtain bank or agency staff when there were shortages.
- Staff were trained in safeguarding adults and children and there were policies and processes in place for them to follow.

Incidents and promoting learning

- There had been improvements to the management of incident reports, but there remained weaknesses that affected the timeliness and effectiveness of responses to serious incidents requiring investigation (SIs).
- During our inspection, nursing staff on surgical wards told us of improvements in the management response to incidents, with less focus on blaming an individual when things went wrong. Nursing and therapy staff on the wards told us there was an expectation of openness in their teams, and staff were encouraged to report, reflect and share learning when they were involved in an incident that affected, or might affect, the safety of patients.
- Staff did not always receive individual feedback about changes to practice as a result of their reports, but there had been improvements to the sharing of information within teams since our last inspection. We saw the folders of information about incidents, which managers collated and put in the staff room on surgical wards. These were also discussed at ward meetings. Some wards used the handover meeting each morning for a brief session on sharing learning from incidents. Therapy team discussions about incidents included what action to take to avoid a repetition.
- Theatre staff regularly reported incidents, such as medical equipment unavailable, incomplete sterilisation, inadequate staffing levels and delayed availability of operating theatre. The general manager for theatres reviewed incidents and discussed themes at meetings. Staff said there had been action, such as improved staffing levels, but felt frustration because there was no feedback mechanism from the procurement department when staff reported incidents related to availability of equipment. Because environmental and equipment problems in theatres happened so frequently, it was a challenge for staff to remain vigilant to the risks these posed.
- Some consultants reported incidents, but it was usual practice for consultants to rely on nurses to log incidents. A surgical consultant told us of a delay to a patient's cancer pathway because of the difficulty getting an appointment for a scan. However, he had not reported this as an incident and did not know if anyone else had done so. Surgical speciality and anaesthetic quarterly audit days discussed incidents and serious incidents were reviewed at divisional governance meetings. However, staff felt there was not much shared learning across divisions.
- There were eight SIs relating to surgical procedures reported to the national reporting system in the 12 months to April 2016. These included lack of availability of theatre capacity, unavailability of medical device equipment, and two never events (a retained foreign object post procedure and a wrong site surgery). Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The reporting and investigation of serious incidents requiring investigation (SIs) was not meeting expected standards. NHS organisations were expected to report SIs on the national system within 24 hours, but the trust took longer than this. One unexpected death was not reported for two months, indicating and that the review process for incidents did not work effectively and failed to identify the serious incident.
- The governance manager convened a panel to investigate an SI, but it was difficult to find appropriate senior staff, causing further delays in identifying causes of an incident and taking action to prevent a reoccurrence. The panels asked for statements from staff, interviewed staff and reviewed patient records. We read the investigation reports of three serious incidents. The reports contained a chronology of events, what staff recorded (or did not record) about the patients' care and treatment, and listed findings and

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recommendations. However, we did not find a systematic approach to identifying contributory factors, using a root cause analysis tool. For example, an investigation found poor decision making by a junior doctor at night, but did not refer to the pressures on the doctor, although this was mentioned in the interviews. The division allocated identified issues to named individuals and monitored the implementation of agreed actions. However, it was not always specified how the effectiveness of some actions should be measured, such as reminding junior doctors to take a holistic approach to patients.

- The external commissioners, who maintained an overview of serious incidents at the trust, raised concerns about the serious incident process and the delays in reporting in May 2016. The trust responded to the report recommendations with an action plan. This included a trust wide awareness programme about the recognition and escalation of potential SIs and a review of the escalation process of incidents with moderate harm. Another recommendation was to explore options for external root cause analysis training, and to improve the measurability of actions arising from investigations.
- Staff recognised the importance of reporting medicines related incidents and there were efficient processes in place to analyse these reports and to share learning. The trust rate of reporting of medicine incidents was better than average (14% against 10% nationally). However, a trust pharmacy report found that there was a lower level of reporting in the surgical division, which had the highest proportion of harm incidents.
- The hospital pharmacy team regularly reviewed these incidents to look at trends for individual prescribers, teams and hospital wide. They were also reviewed by the medicines safety committee every quarter. There was feedback to staff through newsletters and emails and taken up with individual staff and their managers if there was an issue of staff competence. Serious incidents, such as an overdose of insulin, led to a change in practice trust wide which an audit found had been implemented.
- An anaesthetist was leading the use of the 'Global Trigger Tool', which is known to be an effective method for measuring the overall level of harm in a health service. The trust had begun using the tool in 2010 and

reviewed 20 sets of notes a month. The reports of the findings identified areas for improvements, but the clinical governance reports we looked at did not refer to these.

- There were regular mortality and morbidity (M&M) meetings in each surgical care group, attended by medical and surgical staff. Junior doctors told us these discussions were a useful learning forum, but there were not always notes from these, and no wider sharing of the information. Furthermore, there was no mechanism for integrating these findings with other information, such as incident and audit reports to contribute to learning.
- Staff were willing, and processes were in place, to be open with patients when things went wrong and to abide by the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and to provide reasonable support to that person.
- The SI investigation reports included a section on the duty of candour and described the contact made with the patient or relatives and the offer to send them the investigation report. The member of staff assigned to liaise with a patient or their family when there was an SI was expected to complete a 'being open record' with details of conversations and the apology, although we were not informed whether the use of this form was monitored. There was a field on the electronic incident reporting system to record compliance with the duty of candour.
- Between 2011 and 2013 the trust provided 180 senior staff, including consultants with training sessions on the duty of candour. There were shorter sessions for all staff, which were continuing at the time of our inspection. The duty of candour was part of the induction training on reporting incidents.

Safety thermometer

- Nursing staff on the wards assessed patients to check they had received 'harm-free care', using the specific measures of the NHS Safety Thermometer. This included patients with new pressure ulcers, catheter associated urinary tract infections (CAUTIs), falls with

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harm to patients over 70 and cases of venous thromboembolism. The results of these were displayed on each of the wards we inspected, and showed that there were very few cases of harm

- Our last inspection in February 2014, found high numbers of pressure ulcers on the wards. This risk was placed on the surgical division risk register, and a prevention programme introduced, including training and education in wound care, regular turning of patients and encouraging patients to mobilise more often. This had been successful, with no grade three pressure ulcers on the surgical directorate wards for the year to May 2016. The risk had been closed on the register.

Cleanliness, infection control and hygiene

- The trust carried out regular audits to monitor adherence to infection prevention and control (IPC) processes. All areas were expected to carry out monthly audits of cleaning and decontamination, hand hygiene and theatre practice, with less frequent additional audits in areas such as catheter care. Actions for improvement were identified and monitored and results reported to the divisional clinical board.
- There was evidence of improved IPC processes in theatres. This included reinforcing national guidance on preventing surgical site infections (SSIs), resulting in a fall in the number of surgical site infections (inpatients and readmissions), from 1.5% in Q1, 2015/16 to 1.4% in Q2, 2015/16.
- An IPC nurse worked with theatres to reinforce best practice and assist with audits.
- The contracted cleaners cleaned between procedures and at night. They deep cleaned all theatres regularly on a roster basis. We saw an example of the IPC audit carried out in December 2015 in Paul Calvert theatres. The audit covered waste disposal, whether the environment was visibly clean and in a good state of repair, and checks on staff knowledge. The audit report identified actions and a follow up check. Actions within the remit of theatre and the IPC team had been implemented, such as training sessions with staff on identifying single use items and updating the IPC notice board. A meeting was arranged with the cleaning company to discuss actions such as theatre hoods to be cleaned weekly. There were monthly audits of cleaning and decontamination, which had found between 96% and 97% compliance in the three months to April 2016.
- Some medical and surgical staff did not comply with trust policies on hand hygiene and ignored challenges from theatre staff and the IPC team. Monthly audits had found a reduction in compliance with hand hygiene in theatres from 95% in February 2016 to less than 90% in March and April 2016. There was 100% compliance in Paul Calvert theatres, but lower in the day surgery unit and in cardiac theatres. The audits attributed non-compliance to consultants and registrars failing to decontaminate their hands before and after patient contact, and staff not being 'bare below elbow' when decontaminating hands. The actions from these findings were for staff to continue to challenge poor practice and to carry on weekly audits until compliance was reached and maintained. At the time of our inspection, theatre staff told us anaesthetists and surgeons ignored challenges and that a decision to 'name and shame' those who failed to comply with trust policies was ineffective in changing behaviour. Hand hygiene audits on the wards also found some medical and surgical staff were not complying with trust policies.
- Audit results demonstrated good adherence to cleaning and hand hygiene standards on most surgical wards. Gray Ward had the lowest compliance rate (83.1%) for the 2015/2016 audit, with consultant and medical staff observed not complying with hand hygiene standards. The report was presented to the relevant surgical care group meeting and a re-audit found improvements.
- The IPC nurses provided training and passed information to infection prevention and control link nurses in theatres and wards. There were monthly infection control rounds with the matron and the IPC nurse in clinical areas.
- We observed some wards without hand-free taps in the sluices, and raised this with the director of nursing at the time of the inspection.
- There were no cases of hospital acquired meticillin-resistant *Staphylococcus aureus* (MRSA) or meticillin sensitive *staphylococcus aureus* (MSSA) and seven cases of *clostridium difficile* in the 12 months to March 2016. The IPC audited compliance with protocols, such as medical review, the isolation of the patient within two hours of medical review, and IPC processes followed. A project to check adherence to national standards on preventing sepsis was beginning on one of the wards at the time of our inspection.
- During our inspection, we saw theatre staff in 'scrub' suits walking around the hospital without an over gown

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on top of their scrubs in breach of the uniform policy. The trust made some ad hoc checks on compliance with the trust uniform policy, and theatre staff were expected to wear 'misty blue' scrubs to differentiate themselves from other groups of staff who wore scrubs, but did not have to meet the same IPC standards.

Environment and equipment

- The trust had not maintained the fabric of the hospital over a number of years and as a result there were frequent problems with the environment in the hospital's older buildings. Two theatres were closed on the first day of our inspection because of an electrical fault. There had been other theatre closures because the temperature fell outside the safe range. Staff also told us of leaks in theatres, wards, the day surgery unit and the pre-assessment unit when it rained, and we saw some of these after very heavy rain during our inspection.
- The majority of extreme and high risks on the surgical division risk register at April 2016 related to the environment or equipment. There was an 'extreme' risk of theatre air handling units failing intraoperatively, which posed an increased infection risk. There was a risk of insufficient sterilised instruments to meet demand because of failings of the sterile services department equipment. There had been incidents of incomplete instrument packs.
- The surgical division had contingency plans in place to mitigate these risks. Staff monitored temperatures in Lanesborough theatres and followed the standard operating procedure if this fell outside the agreed temperature range, which sometimes led to the clinical director closing theatres. The day surgery unit had a sterile services unit, which other theatres used if necessary, and there was an arrangement to outsource instrument sterilisation to a neighbouring trust if necessary. In addition, theatre staff were receiving training in managing and tracking instruments. Senior management in the surgery division told us funds were to be made available for purchasing vital equipment, and staff confirmed that the procurement had been more efficient recently.
- Gray Ward was cluttered because of a lack of storage areas. There was insufficient space around bed spaces on Gray ward. This posed a potential risk in the event of a patient experiencing a medical emergency which may entail a significant number of staff and medical equipment being required to stabilise the patient.
- The system for managing theatre stock was not effective and this resulted in items running out before theatre staff had ordered replacements. Theatre staff spent time looking for items in other parts of the hospital and sometimes surgeons or anaesthetist did not have their preferred equipment. There was no service level agreement with the procurement department. A procurement group had been set up to look at the concerns with the supply of stock, and staff said there had been recent improvements. The general manager for theatres told us they were looking at a possible replacement system for stock management so that staff had more control over supplies. Therapy staff told us the supply of their equipment and stock had improved and housekeepers on the wards kept an overview of stock so that there was less chance of running out.
- We observed a lack of diligence with consumables when we inspected the hybrid theatre. During the procedure, multiple catheters were used and sheaths the wrong size were tried, which resulted in wastage.
- We saw the records of checks of the resuscitation equipment in the areas we visited. In theatres, the difficult airway trolley was also regularly checked.
- Equipment had stickers with a date for when it was last serviced. Trust medical technicians checked some equipment, and contractors serviced and repaired other items. We noticed an item of theatre equipment had a sticker indicating a repair had been requested, but no date by which this would happen
- Staff reported poor relations with the estates management department and said there had been a high turnover of key staff in the department. There was a significant backlog of repairs and routine maintenance. When theatre staff sent orders for repairs to estates, they were not always given a date for completion of the task. Staff told us when estates did give a date, they sometimes did not attend, for example to repair some drawers in the Paul Calvert theatres. Ward managers complained that there was no triage of requests for repairs, so simple repairs were not carried out promptly, causing unnecessary disruption.

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Medicines

- Patients were protected from avoidable harm from medicines because there were processes to obtain, store and manage medicines safely, but some improvements identified in audits had not been implemented.
- There was close working between pharmacists and staff in the surgical division which promoted safe practice. A lead pharmacist for the division attended divisional governance meetings and there was a dedicated pharmacist available daily Monday to Friday on the wards we visited. The pharmacists screened drug charts, reconciled medicines, ordered medicines from pharmacy and advised patients on specific medicines. The latest trust-wide data showed that more than 90% of patients had a medicines reconciliation done within 24 hours. There were enough medicines in stock and ward staff said they could obtain medicines from the pharmacy when needed.
- Wards and theatres submitted audits about compliance with standards for the safe storage of medicines. The findings of the audits for 2015 reflected what we found on our inspection. All wards and theatres participated in the audit, but there was variation in compliance with standards. Wards such as Kent, Gunning and Florence Nightingale met all but one of the standards; Cavell Ward performed the least well. One of the recommendations was to ensure all unattended medicine trolleys were locked and immobilised when unattended and not in use; we found a trolley was not immobilised on Cavell Ward. The audit found there was no locked cupboard for inflammable liquids on Gray and Cavell Wards; we also found Cavell Ward did not have a locked cupboard. There had been a risk assessment which allowed medicine cupboards and fridges to be kept unlocked in theatres when lists were in progress to allow immediate access.
- The audits reported, and we found on our inspection, that Controlled Drugs (CDs) were securely stored in accordance with legal requirements on wards and theatres, and the key was kept separate from other keys. We observed these practices during our inspection. Entries were double-signed in the CD register on wards.
- Both audits and our inspection found that medicines cupboards and fridges were clean and tidy. Staff checked and recorded daily fridge temperatures and these were within the recommended range of 2 to 8°C.

Treatment rooms were clean and tidy, with no unnecessary medicines in the room. Some parts of the hospital had introduced a temperature check of rooms where medicines were stored because of the problems with maintaining a constant temperature.

- The use of electronic prescribing had been implemented in some areas of the trust, but some surgical wards still used paper medicines charts. Pharmacy regularly audited medicine charts and the most recent results found good practice.

Records

- There were regular audits of patient records to check compliance with record keeping standards, which recommended improvements. However, recommendations for improvement were not always implemented.
- The trust audit team worked with clinical staff to develop a health record quality audit tool based on national record keeping standards, which care groups were expected to use every quarter and submit 10 cases to the audit team. Two surgical care groups, plastics and Ear Nose and Throat (ENT) submitted audit results for the five quarters to the end of 2015, but trauma and orthopaedics only submitted two. Cardiac services and neurosciences were exempt from the audit. The surgical division met three of the five standards in the last audit: the notes were bound and entire, the last day's entries were dated, and entries were signed with a legible signature. Notes were not always filed in chronological order. The trust and surgical division did not meet the standard that the responsible consultant for the patient should be identified in the last history sheet in the notes.
- Staff completed a form for recording the surgical patient pathway through from ward and theatre to recovery. The last audit in 2015 found some parts of the form were well completed, but some were incomplete. This was not a regular audit and we were not informed of a follow-up audit to check whether recommendations from the 2015 audit had been implemented.
- We looked at four paper records on surgical wards and saw regular entries from medical, nursing and therapy staff that were legible and signed. We found that the allergy status of patients was routinely recorded on the medicines chart and electronic prescribing system, along with VTE risk assessments in most cases

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- Staff sometimes found it difficult to get the patient information they needed. There was a mixture of paper and more than one electronic record systems in operation, and new staff told us they were not always sure where to look for information about a patient, for example MRSA status. Neurosurgery had electronic records and orthopaedics had paper records, which caused confusion for clinicians working across specialties with trauma patients. The roll out of the electronic patient record system was delayed and there had been problems with its delivery, with staff complaining of inadequate support.
- There had been a recent decision to store records off site. When a patient had a new clinical episode at the hospital, it took 24 hours to get the records. Staff in the pre-assessment unit said there were no notes available for about half the patients who had appointments
- Ward clerks on the trauma and orthopaedic wards showed us the manual log they created to back up the patient record tracking system when they sent patient records to another part of the hospital. Management met regularly with ward clerks to discuss any issues with records.

Safeguarding

- Staff we spoke with understood their responsibilities in safeguarding vulnerable adults and children and knew how to get the trust policy and further information from the intranet or to contact someone with level three training. The risk of staff not completing safeguarding training had been identified an action plan put in place to increase compliance with level three training.
- There was variation in compliance with safeguarding training between care groups in the surgical division, with 92% for anaesthetics and theatres, 88% for ENT & audiology, 73% for neurosciences, 63% for general surgery and 42% for oral and maxillofacial (max fax).

Mandatory training

- We were told that the data the trust on staff compliance with mandatory training was not accurate.
- Compliance with mandatory training varied between care groups in the surgical division. There was between 85% to over 90% compliance in anaesthetics and theatres, 85% in ENT and audiology and to as low as 55% in oral and maxillofacial (max fax) surgery. General surgery was 68% and neurosciences 75%.

- There were limited places for basic life support training, and many staff we spoke with said they had not had this mandatory training. This was not on the risk register and we were not informed whether this lack of training was viewed as a risk, and if so what mitigation plans there were.

Assessing and responding to patient risk

- The surgical division had made progress in reducing risks to patients by focused effort to improve compliance with good practice.
- The project to reduce pressure ulcers acquired in hospital improved consistency in assessing risk and acting appropriately on these assessments. We also saw evidence of falls risks assessments. The next focused project, which was beginning at the time of our inspection, was to improve practice in the detection and response to patient deterioration. The Global trigger tool reviews consistently found cases of deterioration not acted on, and audits in the surgical division found performance in the use of the National Early Warning Score (NEWS) worsening in the six months to January 2016. The appropriate response to triggers was only 35% in the January and the average score for regularity of observations was only 54%. There was variation in performance on the surgical wards, with three wards audited scoring 100%, while 14 wards scored less than 60%. Some observations of vital signs were omitted for periods of between 8 and 12 hours, predominantly overnight.
- The correct scoring of NEWS charts was 77%, nearly meeting the trust target of 80%, and the level of completion of observations (88%) exceeded the trust target. The plan of action was to reinforce the importance of the appropriate use of, and response to, through emails, discussion and ward based training. The head of nursing sent letters to each member of nursing staff on surgical wards reminding them of good practice.
- Nurses were expected to use the SBAR tool to communicate information to medical staff, but staff told us, and we saw records, of incidents when it was difficult to get an appropriate review of patients who were deteriorating in the evenings and overnight because junior doctors were very busy. There was no critical care outreach team to review deteriorating patients at short notice, and no consistency across the wards in getting a review. Cardiac and neurosciences ward staff told us they had access to advice and support from specialist

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ICUs near the wards. We understood there was a general Intensive Care Unit (ICU) 'outreach' doctor (registrar level) available to review ward patients who were causing concern. However, a ward matron said critical care staff rarely agreed to take patients when they were first called, and waited until there was further deterioration. ICU staff told us they only accepted patients who had a NEWS score of six or more, but we were not clear that ward staff knew this. Other ward staff said they called the 'crash' team for advice, without waiting for serious deterioration.

- The trust had reinforced the importance of following the five steps to safer surgery (the 5 steps) to reduce avoidable harm during procedures. The 5 steps are pre-list briefing, the three stages of the World Health Organisation (WHO) Surgical Safety Checklist (sign-in, time-out, sign-out) and post-list debriefing. Audits showed there had been improvements in recording adherence since our last inspection, notably in the cardiothoracic theatres, which previously had low compliance. The results for the January to March 2016 audit were 96% compliance with the three steps of the WHO checklist and 92% compliance with the briefing and debriefing. Cardiac surgery scored 94% and 91% compliance, while neurosurgery had the lowest compliance rates at 92% and 69%. The audit reports listed actions and recommendations, including circulating the report to all relevant clinical directors and care group leads to agree actions to improve compliance. The audits included observations about interaction between staff and noted, for example, challenges from a scrub nurse, good interaction between staff, and the surgeon taking the lead at time out. We did not see the audit tool used to collect the data, but the inconsistency in the qualitative data recorded indicated that the audit did not use a reliable, verified observational tool to capture interaction between staff.
- The National Safety Standards for Invasive Procedures (NatSSIPs) from NHS England emphasises the importance of teamwork in the effective implementation of the 5 Steps. We were given examples of poor working relations and a lack of respect for colleagues between individuals working in theatres. This included medical and surgical consultants ignoring challenges about poor IPC practice and blaming theatre staff when the instrument or equipment they wanted was not available. Furthermore, theatre staff often took

the lead in doing checks as well as auditing adherence to them. Paul Calvert theatre staff told us the checks in theatre were '99% nurse led'. They explained that time out and debrief were often combined and that surgeons sometimes left as soon as they had completed the procedure. There was an incident report of surgeons ignoring issues raised by anaesthetists and refusing to record this at debrief. We did not see evidence that information gathered at the debrief about any issues arising during the list was collated and used for learning.

Nursing, theatre and therapy staffing

- Staffing levels had improved since our last inspection in February 2014, with notable success in the recruitment of theatre staff.
- The surgical division had worked with the human resources department to increase recruitment, including nurses from overseas and to streamline the recruitment process. The trust had trained theatre nursing staff to enable them to work with anaesthetists because there was a shortage of operating department practitioners.
- Senior nursing staff completed a safe staffing tool to assess if staffing levels on surgical wards were adequate. This had demonstrated improved staffing in many areas, but Cavell and Gray wards remained short staffed. Nurses in charge of wards took action to maintain appropriate numbers and skills of ward staff. They completed rosters eight weeks in advance and requested bank staff one month in advance to fill gaps. There was a national cap on the hours of agency staff use and senior managers authorised any agency use. This meant charge nurses and matrons were not able to select the agency nurses they knew who were familiar with the surgical wards. The rostering of staff took account of the deployment of agency staff so that they were working with permanent staff. However, nurses told us there were times on the night shift that there was only one permanent member of staff, working with two agency staff who were not able to administer medicines.
- When we inspected theatres in the evening, we observed theatre teams were very tired. They were due to finish a 12 hour shift at 8 pm, but a trauma case was overrunning and was unlikely to finish until 10 pm. Furthermore, theatre information showed that some lists overran regularly in order to complete all planned operations. Theatre staff told us surgeons made them feel responsible for the cancellation in order to

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persuade them to work late. Consultants worked long hours, and there were no arrangements when they had worked at night on call to reduce their hours the following day. When people are tired, there is a risk they may make more errors, but there had been no discussion about the risk of long working hours.

- The therapy team reviewed staffing found appropriate levels of support for Trauma & Orthopaedics patients, but therapy staffing in surgery generally did not meet recommended levels. The review found that an additional therapist was needed on both Gray and Vernon wards, and that staffing in vascular service did not meet local or national expectations. Physiotherapists were unable to effectively treat outlier patients.

Medical, surgical, physician assistant and advanced nurse practitioner staffing

- The trust had a lower proportion of junior doctors than the England average. The surgery division had created additional non-medical posts of surgical advanced nurse practitioners (ANPs) to mitigate the impact of the reduction of junior doctor numbers. Junior doctors spoke positively about the introduction of ANPs in the Health Education England survey. There were also physician assistants (PAs) attached to consultant teams. Nevertheless, nursing staff told us of difficulty getting reviews of patients and prescriptions and junior doctors spoke of pressures on them out of hours, and during the day when consultant and specialist registrars were in clinic or in theatre.
- There was recent agreement to have an additional orthopaedic consultant out of hours to provide cover when a consultant was in theatre. There was pressure on the surgeons, who provided cover for the emergency theatre in addition to reviewing and operating on patients having planned surgery.

Major incident awareness and training

- The surgical division had demonstrated that there were effective processes in place for unexpected interruptions of theatre lists. There was a process for cancelling elective work to prioritise emergency surgery at these times.
- Fire training had improved since our last inspection.

Requires improvement



We rated effective as requires improvement because:

- IT systems were not fit for purpose.
- We did not find a multidisciplinary approach to enhancing good practice in theatres, with some surgeons in particular, remote from initiatives to improve standards.
- Some surgeons did not make effective use of interventional radiologists, prolonging the procedure unnecessarily.
- There had been improvements in the appraisal process for nursing staff, but there were limited opportunities for training and development.

However:

- The bowel cancer results of 2015 showed positive results.
- The relative risk of readmission to the hospital following an operation in the year to July 2015 was better than the England average for emergency surgery, but worse for elective (planned) surgery.
- The national hip fracture audit for 2015 showed that the hospital performed better than the England for average length of stay in the hospital, surgery on the day of or after day of admission, patients developing pressure ulcers, bone health medication assessment and falls assessment.
- Surgical services participated in national audits and acted on the results to improve performance. National data demonstrated that the hospital adhered to good practice standards and that outcomes were within expectations. There was a trust-wide audit programme to monitor and improve standards of care, including infection protection and control, five steps to safer surgery, records and medicines.
- The pain team worked with wards so that patients received adequate pain relief when they needed it, but there was sometimes difficulty in getting analgesia prescribed out of hours.
- The surgery division had identified the need to improve pre-operative hydration and had taken action to address this.

Are surgery services effective?

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- Patients were given the information they needed to make informed consent and there was improved understanding of how to make decisions for people who might lack capacity.

Evidenced-based care and treatment

- Surgical, anaesthetic, therapy and nursing staff used evidence-based guidance and audited their service provision to check they were meeting expected standards.
- There were clinical governance leads for each care group in the surgical division, who linked with the trust clinical governance team to review new guidance from the National Institute for Health and Care Excellence (NICE) and professional associations. Care group meetings discussed relevant new guidance.
- St George's University of London Medical School shared the site and some consultant staff with the hospital. These links and participation in national and international research, gave access to the latest evidence in some areas of surgical practice.
- The trust was one of only 13 NHS organisations in the UK to receive Anaesthesia Clinical Services Accreditation (ASCA). The anaesthetic care group achieved this by demonstrating 100% compliance with the ASCA standards in five domains, such as clinical governance and patient experience.
- Surgical specialties submitted data to national audits and acted on the results when reports indicated they were not meeting expected standards. There was a rolling programme of internal audits, to check adherence to standards of infection control, record keeping, responding to the deteriorating patients and so on. The results of audits were reviewed and recommendations for improvements identified, which were monitored. When there was no improvement, a more formal process was used to identify how to reach the expected standards.

Nutrition and hydration

- The surgical division had taken action to improve adherence to recommended standards for patients eating and drinking before an operation. An audit found that patients were often 'nil by mouth' for food and drink for much longer than necessary. Action included pre-assessment staff explaining the fluid rule to patients. Staff ward and admissions lounge were expected to check with patients coming for surgery when the last ate and drank and to give them sips of

water until two hours before their operation. Theatres were asked to let the admissions lounge know the theatre list order so that patients lower down the list could be able to have a drink. A second audit was planned to check whether there were improvements. Patients at higher risks of dehydration, such as older people and people with diabetes, were given intravenous fluids on the ward before surgery.

- We saw that staff on the admissions ward had offered water to drink to a patient whose operation was delayed. Some patients on wards confirmed they were able to have drinks of water until shortly before surgery. However, others told us during our inspection that they went for long periods without a drink. For example, a patient who was nil by mouth from 10pm but did not have surgery until 12 noon the following day said "I never had a sip of water until after the surgery." A patient admitted to the ward on a Sunday had her operation cancelled twice and was told she would now have it the following Friday. She had not had anything to eat, but had been drinking water.
- We observed patients being offered drinks on the wards following surgery, and patients confirmed they had enough to drink. There were mealtime 'champions' on each ward with the role of making sure patients were supported to eat their meals. There was a board displaying patients' preferences and needs, including special diets. Patients had mixed views about the standard of food, with one patient said they had run out of bread at breakfast, and there was no food between meals. Another patient commented, "It's like a hotel."
- The trust had published a three-year Food and Drink Strategy in 2016 to promote good standards in nutrition and hydration. The dietetic department provided advice and support to patients when this was required.

Pain relief

- The hospital acute pain team provided advice to wards on managing patients' pain.
- Ward staff recorded patients' pain scores and regularly asked them whether their pain was being effectively managed.

Outcomes

- The relative risk of readmission to the hospital following an operation in the year to July 2015 was less (better) than the England average for emergency surgery, but greater (worse) for elective (planned) surgery.

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- Patient Reported Outcome Measures (PROMs) are nationally reported patient responses to questions about whether they felt things had 'improved', 'worsened' or 'stayed the same' following a surgical procedure. In the year to March 2015, the trust performed similar to the England average for groin hernia surgery, but worse than the England average for patients reporting improvements following varicose vein surgery. The trust was worse than the England average for those who reported an improvement following knee replacement on two of the three measures.
- The national hip fracture audit for 2015 showed that the average length of stay in the hospital was shorter (better) than the England average (9.2 versus 15.7 days), but overall length of stay (including rehabilitation) was slightly longer (worse) than England average (21.2 versus 20.3 days). The audit also showed that patients admitted to orthopaedic care within 4 hours were less (worse) than the England average (35.1% versus 46.1%). The hospital took action to address areas of weakness identified in the national audit reports, improving its performance between 2014 and 2015 and making further improvement since 2015, demonstrated by internal data collected, but not yet published nationally. The hospital was unable to meet standards for timely surgery in 2016 because of high demands for theatres. However, it performed better than the national averages for falls assessment, pressure ulcers, bone health assessment and acute length of stay. Following the appointment of a second orthogeriatrician, all older patients were receiving appropriate medical review.
- The bowel cancer results of 2015 showed the percentage of bowel cancer patients receiving laparoscopic ('keyhole') surgery, was much better than the national average. This was attempted in 55% of patients compared to only 5% nationally and as a result, patients recovered from surgery more quickly and had lower lengths of stay in hospital. The audit also showed that more patients (better) were seen by a clinical nurse specialist than the England average (99% versus 93%).
- In the lung cancer audit of 2015, the hospital met the standard for pathological diagnosis (85%), which was greater (better) than the England average of 69%.
- The standard for non-small-cell lung cancer, not otherwise specified rate was also met (11.7%), which

was less (better), than the England average (12.4). However, the hospital did not meet the standards for patients discussed at MDT and patients seen by a nurse specialist.

- The major trauma centre (MTC) submitted data to the trauma audit and research network (TARN). It is assessed by peer review for the national quality indicators for trauma (TQUINS). The review in March 2015 found the hospital performed well compared to other MTCs on many standards. The trauma service took action to address the only serious concern identified; the low percentage of open fractures treated within 72 hours. The hospital received a 2016 annual TARN award for using TARN data to review gaps in service provision and to develop a data collection tool which improved compliance with the standard.

Competent staff

- There was a week's induction for newly appointed permanent staff and for doctors in training. The junior doctors we spoke with were positive about the level of support they received during their rotation in surgical specialties.
- Newly qualified nursing staff were supported by way of structured preceptorship programme. The six month programme offered newly qualified staff a named preceptor, bespoke study days, competency assessment framework and progress meetings. At the time of the inspection, six newly qualified nursing staff were being supported via the preceptorship programme. During 2015/2016, the trust had trained thirty staff to be preceptors for newly qualified staff within the main theatres.
- Agency staff received introductory information and completed a check list of things they had been shown.
- Physician assistants (PAs) were valued for their contribution to the smooth management of patients on the wards. Surgical advanced nurse practitioners provided out of hour cover. However, nursing staff told us they referred to junior doctors if they were concerned about a patient to arrange more senior medical or surgical review. The PAs we spoke with felt they did not have opportunities for development or learning and did not feel part of the consultant team. We did not speak to PAs from all specialities so did not find out if this was a common concern.
- Appraisal rates for theatre, support, therapy and nursing staff had improved and was about 80% at the time of

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our inspection. The staff we spoke with said they found appraisal meeting with managers useful in their development, but commented on the lack of training opportunities because of budget cuts. A practice facilitator supported the line managers in identifying training needs and delivering in-house training.

- Each ward cared primarily for one group of surgical patients and developed experience and skills in their care. There were sometimes patients from a different speciality in addition to medical 'outliers', for whom no bed was available on a medical ward. Staff complained that it was sometimes difficult to get medical staff to review these patients.
- The vascular surgical service was badly affected by internal disputes and an external review had found the service was not operating effectively. At the time of our inspection, there were concerns about the shortage of experienced vascular surgeons and the ability of the team to provide the level of service required, in particular in complex or trauma cases. The trust had taken remedial action to address the concerns identified within the external review. Supportive measures had also been introduced shortly prior to the inspection, including the appointment of two external consultants whose remit included a review of working arrangements and of providing professional peer support to the team.
- The Major Trauma Directorate work plan included the roll out of a damage control surgery course to all relevant consultants and trainees. The course was accredited for continuing professional development.

Multi-disciplinary working

- There was close working between some staff groups to enhance the care of patients. However, we did not find a multi-disciplinary team approach to patient care in some specialties.
- Therapy staff worked closely with ward staff in enhancing the recovery of patients and in arranging discharge. We observed ward pharmacist were frequently present on the wards and some were prescribed medicines. Ward staff valued the physician's assistants in taking on tasks such as preparing patients for discharge. Clinical nurse specialists (CNS) were key to enhancing the patient pathway in some specialties.

- There were daily trauma meetings on weekdays with good attendance from consultants and medical staff from different surgical specialties. However, neurosurgery and radiology were not always present and nursing and therapy staff did not attend.
- Staff told us, and we saw from incident reports, that junior doctors and registrars working in orthopaedics sometimes found it difficult to discuss complex trauma cases with neurosurgery medical staff. We were told of delayed access to MRI scans (only neurology registrars were able to request these) and of incidents when there were delayed review of trauma patients by neurosurgery teams.
- We did not find a multidisciplinary approach to enhancing good practice in theatres, with some surgeons in particular, remote from initiatives to improve standards.
- When we observed a procedure in the hybrid theatre, we found the surgeons did not make effective use of interventional radiologists, prolonging the procedure unnecessarily.
- We observed a multidisciplinary ward round on one of the trauma and orthopaedic wards, which included a pharmacist, junior doctor, therapist and physician's assistant. There was a detailed review of patients, with the consultant checking on pain and recovery with postoperative patients. Staff told us however, that there was wide variation in the length and thoroughness of the ward rounds, which meant that there was inequity of care for patients.
- Nurses did not always take part in ward rounds, and we did not observe consultants discussing patients with nurses. A patient on one ward commented "there's not a lot of interaction between the doctors and the nurses".
- There was a consultant of the week in trauma and orthopaedics and in some other specialties, which promoted continuity of care. The consultant carried out a thorough handover to the next consultant.

Seven-day service

- The pharmacy department provided a seven-day-a-week service and a 24 hour service provided by a resident pharmacist shift system. There was 24 hours a day, seven days a week access to acute pain management.

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- Computerised Tomography (CT) scans, Magnetic Resonance Imaging (MRI) and Interventional Radiology were available during the week and from on call teams out of hours.
- Consultants or registrars carried out ward rounds every day of the week.
- There was physiotherapy cover at the weekend for trauma and orthopaedic patients.
The trust had a therapy service with extended hours during the week and was provided on Saturdays. An acute speech and language therapy team ran a weekend service to cover the medical and surgical wards, but there was no head & neck or maxillofacial weekend service.

Access to information

- There were three separate patient tracking systems, which did not provide accurate information about the pathway for patients receiving planned surgery. However, the theatre tracking system was providing accurate information about patients once they had been booked for surgery.
- Staff showed us how they found policies on the intranet. However, we saw that some policies were out of date. The trust had a programme to update policies, but this had been hindered because the software for storing them was not adequate.
- Staff had little faith in the IT systems or IT support. For example, a consultant told us of a failure of a system to upload audit data for a national audit. Consultant staff were not able to run a planned video conference with colleagues from another trust because of a fault. The trust audit committee was not able to review whether actions identified in audits had been implemented because they were unable to display the electronic tracking system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us staff explained treatment and care and sought their consent before proceeding. They said they had been given information about the benefits and risks of their surgery before they signed the consent form. Interpreters were booked to assist with taking consent if patients needed this.
- There had been improvements in the training for staff in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) since our last inspection, and staff

told us of how this was used if there were indications that a patient might lack capacity to make a decision about treatment. However, we saw a number of patients with bed rails up on the trauma ward and on the neurology ward. We saw there had been a risk assessment about the use of the rails, but there was no consideration that this was restraint and a DOLS assessment was indicated.

- There was no monitoring of the use of MCA and DOLS at the time of our inspection so we did not have information about how often these were used.

Are surgery services caring?

Good



We rated caring as good because:

- Staff were kind and attentive to patients.
- The hospital encouraged patients to comment on their time in hospital and took action on the feedback.
- Patients said they received the information they needed to understand their treatment.

Compassionate care

- Patients and their relatives who spoke with us praised the kindness of staff on the wards, in the day surgery unit and in the admissions lounge.
- The trust scored about the same as the England average in questions relating to the care they received in the NHS in-patient survey of 2015. Two patients who had been inpatients before said things had improved since their previous visit.
- The four patients we spoke with on Cavell Ward said the staff were kind and always introduced themselves. Comments included, “nothing is too much trouble for them”, and “they always put you first”. A daughter of a patient who did not speak much English said ward staff communicated well and understood her needs. They all said staff responded very quickly to call bells during the day but it sometimes took a bit longer at night. A patient on Gunning Ward said “I have had nothing but kind, caring, thoughtful people, from those who clean the floor to the surgeons... They make you feel like a person, not a bed number.” A patient admitted overnight to Vernon ward following tests praised the

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attentiveness of the staff. We observed staff being responsive to patients and treating them with courtesy. For example, we observed a ward clerk talking to a patient's relative in a calm and caring manner.

- The patients we spoke with on the day surgery unit also praised the staff. Comments included, "they are very helpful and considerate", and "the staff – consultants too – are very caring". Staff always introduced themselves.
- The surgical wards, with the exception of Cavell ward, scored over 90% in the friends and family test (FFT), which asks whether patients would recommend the trust to those close to them. There were some areas, including the day surgery unit where 100% of patients said they would recommend the service to friends and family. Staff encouraged patients to complete questionnaires and the response rate was higher than the England average (52% compared to 35% nationally). Patients provided feedback on additional questions and were asked to comment on their care, and staff acted on these. We saw the results displayed in the areas we inspected. For example, on the FFT board on Holdsworth Ward, there was a comment on noise, and the action staff were taking to reduce the noise at night. We saw a day surgery unit report from November 2015, with the results of the questionnaires and the discussion at a staff meeting with actions identified for any area with less than 90% positive response rate. For example, 86.6% said the discharge nurse gave adequate information including information about medication, so action was allocated to the unit manager to check with some patients about the explanations given.
- The trust used the friends and family test (FFT) dynamically so that patient feedback was gathered and acted on.
- Frontline staff at the trust used an electronic tablet to collect patient feedback, with a high response rate (52% compared to an England average of 35%). We saw evidence of action on the wards we visited and there was an item on the risk register about poor patient FFT feedback on the trauma and orthopaedics outpatients clinics.

Understanding and involvement of patients and those close to them

- All patients we spoke with said they received information about their treatment when they attended

a clinic, for surgery, and following the operation.

Patients said they had the information they needed to make decisions about treatment, including any alternatives to surgery.

- Consultant, nursing and therapy staff on wards spent time with patients explaining treatment and answering questions. A patient on the trauma and orthopaedic ward told us the consultant explained everything on their ward round: "you can ask anything, you have their undivided attention." Senior nurses went round the wards to check if patients were comfortable and to answer questions.
- The proportion of patients who indicated staff answered questions about the operation or procedure was similar to England average in the NHS inpatient survey 2015. In the cancer patient experience survey of 2014, the trust scored in the top 20% of trusts in England for patients who said staff gave a complete explanation of what would be done.
- Several patients on the day surgery unit mentioned that they were not kept informed about dates for surgery and said when they telephoned, no-one answered. One patient said she had been waiting six months and it was difficult to get information. One patient and relative on the day surgery unit also commented on the lack of information about waiting times.
- We observed a procedure in theatre, with the patient's permission. The anaesthetist and operation department practitioner explained what they were doing and checked the patient's understanding of the procedure before anaesthesia.
- The hospital is large and some patients at the day surgery unit said they found it difficult to find. However, there were clear, colour coded signs in all parts of the hospital and we observed staff stopping to offer people directions if they looked lost.

Emotional support

- Patients told us they felt safe and would tell a member of staff if they were worried or anxious. Clinical nurse specialists (CNS) were an important source of information and emotional support for some groups of surgical patients, particularly cancer patients. A patient who had come for invasive tests praised the kindness of the CNS. There was a psychology service available to trauma and some other groups of patients. There was a chaplaincy service that provided spiritual support for patients from a variety of faiths.

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Are surgery services responsive?

Requires improvement



We rated responsive as requires improvement because:

- The trust had to temporarily cease national reporting of the RTT data. This was because, they could not guarantee the data they were reporting was robust and accurate.
- Theatres were unable to meet demand. Cancellation of operations were frequent and some of these were not rebooked within 28 days.
- The arrangements for obtaining theatre instruments and other equipment were inefficient and affected the smooth running of operations. The equipment purchase and replacement programme had been affected by financial restrictions.
- There were not enough cystoscopes (to examine the inside of the bladder) to supply day surgery, main theatres and endoscopy.
- Bed occupancy levels in surgical wards were higher than the England average, with a steady increase over 2015.
- Some patients were not receiving treatment within the expected time from referral.
- Patients sometimes had to wait for tests because of demand on ultrasound and MRI scanners.
- Interpreters were sometimes used when patients were consenting to treatment and did not understand English, but at other times staff relied on relatives to interpret.

However:

- The pre-assessment service provided streamlined appointments for surgical patients to limit the number of appointments patients needed.
- The new surgical assessment unit was due to open in the summer of 2016 (the trust have since confirmed that the SAU officially opened in August 2016). It was temporarily operating a 'virtual' surgical assessment unit from two bays on a surgical ward, which was already improving patient flow.
- Staff had training in dementia care and there were specialist teams to advise staff on caring for patients living with dementia or learning disabilities.

- Nursing, therapy, physician assistant and pharmacy staff worked with discharge staff to support patients to leave hospital safely.

Service planning and delivery

- The trust was unable to meet the demand for surgery effectively because of insufficient theatre and bed capacity and delays in patient pathways.
- There were not enough cystoscopes (to examine the inside of the bladder) to supply day surgery, main theatres and endoscopy. Another item on the risk register was the failure of MRI compatible monitoring for patients having a MRI scan under general anaesthetic.
- The day surgery unit did not have enough storage space.
- Theatres 5 and 6 were closed for refurbishment at the time of our inspection. Since the inspection, we have been told by the trust that the refurbishment of these two theatres has been completed.
- We saw renovations in some parts of the hospital since our last inspection. The recovery area of St James' theatres was enlarged and refurbished. The discharge lounge now had beds and reclining chairs and was more suitable for orthopaedic patients, but there was no sink for staff to wash their hands. There was work beginning in the day surgery to repair the damage caused by leaks.
- Cavell Ward, which was in a poor state of repair in our last inspection, was being renovated, and the matron had regular walk-arounds with the estates team to check that this was going according to plan.
- The trust was a major trauma centre and major trauma network host. It managed and audited the network, working closely with commissioners and neighbouring hospitals.
- Surgeons from the trust and other trusts performed joint replacement surgery at the SW London Elective Orthopaedic Centre (SWLEOC), based at a neighbouring hospital. The trust worked with local commissioners in building relations with GP services.
- The surgical division had plans to introduce a surgical assessment centre (SAU), and was at the time of the inspection, operating a 'virtual' SAU in two bays of a surgical ward. These plans were advanced and the SAU was to open imminently. Since the inspection, the trust have reported that the SAU opened in August 2016.

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Meeting people's individual needs

- Ward staff followed good practice in dementia care by using a butterfly sticker on ward boards and in patient notes to identify patients who required extra support from healthcare staff. An additional member of staff was allocated if there was a risk to the patient. We observed a nurse on one of the wards talking to a patient with dementia with kindness and patience to provide reassurance. There were dementia champions on wards who encouraged staff to follow good practice and they had links with the dementia team.
- The trust had a dementia strategy, which included the development of a more dementia friendly environment. However, the current work to refurbish Cavell Ward did not appear to encompass this objective. Many wards were not dementia friendly because they were cluttered and difficult to navigate.
- The trust had developed dementia and delirium pathways to promote the prompt identification of, and appropriate care of, patients with dementia or delirium. A dementia and delirium team had developed documentation and provided training for staff.
- Nurses told us patients with a learning disability had a hospital 'passport', which ward staff referred to so they understood the person's preferences, dislikes and communication needs. Staff allocated a single room to patients with a learning disability if they wanted this and their carer could attend to support them. A learning disability liaison nurse provided further support to plan for a patient's surgery.
- A relative told us they had interpreted for their mother except during the consent procedure, when an interpreter was booked for the surgeon. Staff confirmed it was usual to use relatives to interpret, when relevant.
- There were choices of meals for patients from a variety of religious and cultural backgrounds.
- The ward which admitted overweight patients for bariatric surgery had suitable beds and other equipment. There was a bathroom adapted for their use, which was changed from 'male' to 'female' as required.
- Data submitted by the trust indicated there were incomplete referral to treatment time (RTT) pathways for ENT, general surgery, trauma & orthopaedics and urology. These patients were not receiving treatment within expected timescales. ENT patients (42%) had the lowest RTT completion.
- It was difficult for administrative staff to track patients effectively because of the poor patient tracking systems. The trust had appointed an RTT lead and the surgical, medical and children's and women's divisions had appointed additional staff, to check patient pathways and reduce this risk of 'losing' patients. Once patients were allocated for surgery, the tracking system operated effectively.
- However, following the inspection, the trust wrote to NHS Improvement and NHS England, to confirm their intention to temporarily cease national reporting of the RTT data. This was because, the trust could not guarantee the data they were reporting was robust and accurate. The trust would continue to report data at a local level and to regulators.
- The trust had a higher rate of cancelled planned operations than the England average (approximately 1.5% versus 1%); with about 150 cancellations a quarter over the last 18 months. Theatre closures as a result of environmental problems exacerbated capacity problems. Two theatres were closed at the time of our inspection because of the refurbishment programme.
- The percentage of patients whose operations were cancelled and not treated within 28 days reached over 20% in the quarter to March 2016, much worse than the England average and higher than the trust figures for the previous year. There had been a marginal improvement in quarter 1 of 2016/2017; the number of patients whose operations had been cancelled for non-medical reasons and not treated within 28 days fell to 17%. This was still significantly higher (worse) than the England average of 8.3% for quarter 1 of 2016/2017. We heard of many examples of cancelled operations during our inspection from staff and patients. Some patients experienced multiple cancellations because emergency patients were prioritised.
- There were two trauma theatres, with appropriate staffing and an emergency theatre for other patients (confidential enquiry into patient outcome and death (CEPOD) theatre). These were covered by a rota of consultant surgeons. Theatre utilisation was high, with

Access and flow

- Some patients did not receive treatment within the expected timescales and other patients had their operations cancelled, sometimes more than once.

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some theatres running at over 100% capacity because of overruns. The average theatre utilisation overall (excluding day surgery) was between 91% and 96% in the three months to February 2016.

- The divisional risk register noted that the allocated theatre for emergency general surgery (CEPOD theatre), was not always accessible, in particular when used for emergency renal transplants, which happened about twice a month. There was no dedicated theatre for renal transplants. The hospital was not able to manage all lower limb fractures within the specified time-frames because of delays in getting patients to theatre.
- The trust was currently unable to meet demand for cardiac surgery. Commissioners highlighted that 69 patients were waiting over 18 weeks for cardiac surgery and the problems with capacity were unlikely to be resolved within current capacity.
- Surgical patients were given appointments for pre-assessment at the same time as their clinic appointments whenever possible so they only had one visit to the hospital. However, waits in pre-assessment were longer than necessary because there was only one room for patients to have blood tests. Patients who needed an echocardiogram, (ECHO), for assessing the heart, had to wait a long time because of the demands on the service.
- Some colorectal patients were able to have an endoscopy or CT prior to seeing a consultant, followed by a telephone consultation or follow up clinic appointment. This reduced cancer wait times and prevented delays in diagnostics.
- Bed management staff worked closely with senior ward staff so that patients were allocated to the most appropriate ward when they were admitted and on return from theatre. There were some trauma patient's cared for in other surgical wards, but those with the most serious injuries were allocated to the trauma ward. The SAU enabled more flexibility in reviewing patients and making decisions about whether they should be admitted.
- Lengths of stay for most surgical patients were similar to the England average for elective and emergency patients.
- Discharge arrangements for patients were planned from the day of admission and sometimes before admission. Ward staff had daily meetings with therapists and discharge staff to discuss readiness for discharge and what arrangements were needed to facilitate discharge.

The pharmacy service worked with ward staff to have medicines ready to take out (TTO). The trust had set a target for the number of patients to be discharged before 11am to free beds for other patients. However, the discharge lounge staff described an influx of patients at 11am, which was difficult for them to manage.

- Nursing staff told us about delays and cancellations with the contracted hospital transport service. There were particular delays in repatriating trauma patients to their local hospital because of difficulties getting transport.

Learning from complaints and concerns

- The surgical division's response to complaints had improved in the last year. There were regular meetings to review complaints and to monitor the timeliness of the response. This had resulted in an increase of complaints responded to within the expected timescales to two thirds.
- We saw an example of a ward matron's investigation of a complaint, her contact with the complainant, the action to prevent a re-occurrence and the monitoring of that action. However, consultants sometimes focused on responding to the complaints rather than implementing and monitoring identified action effectively.
- Complaints were categorised as 'informal' if the complainant did not want a formal response, so there were sometimes missed opportunities to learn from trends in such circumstances.

Are surgery services well-led?

Requires improvement



We rated well-led as requires improvement because:

- The leadership team had not addressed the long-standing problems with the environment of theatres. However, there was some evidence of a safety culture; for example, shutting some theatres to keep people safe.
- There was low morale among theatre staff and consultant surgeons. Some consultant surgeons were not working with a multidisciplinary approach and were not engaged in the divisional objectives.

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- Black and minority ethnic staff felt that they were not given the opportunities that less experienced white staff had.

However:

- The leadership of the surgery, theatres, neurosciences and cancer division (the surgery division) understood the challenges facing the directorates and care groups in the division.
- The division was improving the governance structures, so that care groups were more accountable. The divisional strategy had achievable objectives to address some of the long-standing problems and to bring about service improvements.
- Ward staff in the division were committed to the trust values and were committed to improving fundamental standards of care. Anaesthetists were engaging divisional staff of all professions and grades in tackling the cultural problems that affected team work and staff engagement.

Vision and strategy for this service

- The surgical division was striving to address urgent problems, while maintaining fundamental standards and engaging staff in developing and improving services. There were pressures on some specialties to meet increased demand without always having increased resources.
- The divisional strategy for 2016 to 2019 reflected trust and divisional priorities. The directorates within the division (theatres and anaesthetics, surgical, neuroscience, trauma, and cancer) contributed to the strategic objectives. Directorate management teams, with support from care group leads and general managers, were responsible for their implementation.
- The strategy included the work needed to address long-standing problems, while including aspirational objectives to develop clinical services, address low staff morale and enhance the research profile of the division. The strategy explicitly reflected the trust values to be excellent, kind, responsible and respectful.

Governance, risk management and quality measurement

- The new trust executive and board leadership had identified weaknesses in the governance and risk management processes; in particular the accountability of care groups for the safety and quality of their services.

The surgical division was taking steps to improve accountability but progress was slow because of problems with IT and the weak engagement of some consultants in the process.

- The divisional governance board met monthly and was well attended by senior management, nursing and consultant staff. The meetings reviewed risks, serious incidents and audit information and allocated action to named individuals. These were reviewed at the next meeting. Directorate reports were submitted to the meeting. Actions were cascaded to care groups, but the objective to hold care groups to account for quality was part of the divisional strategy rather than embedded in practice. The divisional management board met monthly to review staffing, finance and other management information.
- The divisional director of nursing and governance worked with the governance manager to maintain an overview of risks. They regularly updated the risk register, with risks identified from national and local audits, published reports identifying nationwide poor practice, staff reports and incidents. They adjusted the rating of the risks according to the effectiveness of controls and some were removed from the register, such as the risk of pressure ulcers, when action was effective. When controls were not effective, this was identified and additional steps were taken.
- The items on divisional risk register were divided into directorates, as well as an overall divisional section. Each directorate risk was allocated to an owner; the majority to general or service managers or to heads of nursing. The risk of failing to meet the referral to treatment access standard for cancer was on the cancer risk register and owned by managers.
- Managers took action to produce an accurate picture of patients affected by delays and to reduce the number of delays. A lead cancer clinician for each of the specialties affected was expected to assess patients who had treatment delays for clinical or psychological harm, but this action had not been implemented. When this gap was identified, a formal monthly clinical harm review board was established to oversee the process.
- The trust was in the process of moving the risk register to the incident reporting system. However, this system did not allow the division control of their register, which was held centrally. At the time of our inspection, there were unresolved problems with the system, including

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difficulties in allocating actions to an individual. The divisional governance manager had no administrative support, but the new system increased the amount of administration. The system will enable risks to be delegated to care group level.

- The surgery division used a dashboard to record key performance indicators, but further work was needed to produce a dashboard which collated data efficiently and to generate dashboards for each directorate and care group. The multiple patient record systems were a barrier to the collection of management information and at the time of our inspection, it was not clear that the roll out of the electronic patient record system would address this problem. The intention, linked to divisional strategic objectives, was to develop and report on key performance indicators, which would be presented in care group quality league tables.
- The theatre management system collected data that was reliable and provided management information about theatre utilisation. The general manager was developing the information stream of the theatre transformation programme and showed us some initial data that reported on actual against planned sessions, cancellations, late starts, turnaround times between operations and overruns by specialty and by consultant. The intention was to use the reports to improve the flow of patients and to reduce cancellations.

Leadership of service

- The leadership of the surgery division, (the clinical chair, director of operations, and director of nursing and governance), understood the challenges staff faced. The issues they raised with us were similar to those raised by front line staff.
- Nursing leadership on the surgical division wards was dynamic and responsive. For example, action was taken to tackle the management and staffing on one of the wards because of poor patient feedback. Many nurses and healthcare assistants said they could approach their ward manager or matron if they had a concern. They said the head of nursing was very visible and came to help out when a ward was very busy. Nurses also told us of how they were encouraged to take on responsibility and were appreciated when they did so.
- The trust work had not met the national expectation of producing a report on the work race equality standards. We heard concerns from black and minority ethnic (BME) staff that they were not given the opportunities

that less experienced white staff had. The NHS staff survey results also indicated that BME staff felt there was discrimination in the trust. There was strong commitment to promoting good practice within the anaesthetics care group and individual anaesthetists were motivated to seek opportunities for professional development. The care group promoted quality improvement methodology to drive service improvements and there were two Health Education England quality improvement fellows working with them.

- The consultant care group lead for urology was engaging different groups of staff across and beyond the directorates to discuss improvements to services for patients. An example was the 'kit group' which started in January 2015 and included procurement, in order to plan how to obtain the equipment they needed in urology. The initiative was supported by the director of operations, who was encouraging other specialties to follow the example. The care group lead also met the head of nursing to discuss developments in the clinical nurse specialist role, with the aim of enhancing the patient pathway.

Culture within the service

- Staff morale was affected by the perceived poor performance of the trust's previous executive team and its failure to address longstanding problems such as the poor environment. Theatres in particular, was affected by the trust's past neglect of the hospital fabric, which required constant vigilance because of the risks these might pose to the safety of patients and staff.
- There were tensions between theatre staff and surgical teams, exacerbated by the problems with stock management and the difficulty in meeting demand for surgery, which resulted in some lists running over the allocated time.
- The tight control of budgets over the last two years limited staff initiative because every expense required approval. Managers and senior nursing staff spent time approving sometimes small amounts of expenditure instead of supporting clinical staff to improve service provision.
- Morale among consultant surgeons was affected by the loss of consultant surgeons following action to address conflict between clinical staff groups in two surgical specialties.

Surgery

- The constant IT problems affected consultants practice, for example in allocating a consultant to each patient so that they had a 'responsible' consultant in line with expected standards. The trust audit committee expressed concern that there was a lack of ownership by consultants in the trust in addressing this difficulty. We found some consultants focusing on their specialty without engaging in anticipating and solving problems or taking an active role in the divisional strategy.
- We heard about an open culture with patients and relatives on the wards. A junior nurse said she immediately told a patient when she had made a medication error, which did not cause harm, and was clear that this was the expectation on surgical wards. A therapist described the apology to the family of a patient who fell.
- The policy for theatres was that three nursing staff signatures were required before administering CDs, which was unusual, as normally only two signatures are required. However, recent audits had found only two signatures, therefore staff were not following their own policy.

Public engagement

- A day surgery unit report from November 2015 on the results of the questionnaires and the discussion at a staff meeting, identified actions on any question with less than 90% positive response rate. For example, 86.6% said the discharge nurse gave adequate information including information about medication, so the unit manager checked with a selection of patients about the explanations staff gave them.

Staff engagement

- The trust and the division had identified low poor staff engagement as a risk following the results of the 2015 NHS staff survey. The trust performed worse than the England average on a number of questions, such as recognition and value of staff by managers and the organisation and effectiveness of team work. An objective in the divisional strategy was to engage staff by involving them in service developments, and encouraging staff to put 'learning into action'. Senior nurses were disseminating compliments from patients to wards and displaying them on the patient experience boards.
- We found ward staff engaged in most areas we visited, with staff commenting on the good team work and







support from their ward managers. Healthcare assistants from Gunning Ward said they felt they were respected and that everyone helped each other to provide patient centred care. However, some staff from cardiac wards did not feel there was mutual respect for all members of the team.

- There were weekly 'Grand Round' meetings open to anyone in the trust, which discussed a different topic each week.
- 'Schwartz rounds' were held for any staff to attend to discuss the emotional impact of their work with patients.

Innovation, improvement and sustainability

- The clinical lead and the general manager for the theatre care group led the refocus on the theatres transformation programme by engaging staff in five work streams using quality improvement methodology to implement and measure progress. The streams included improved use of information, list planning and equipment management. The general manager of theatres produced a paper outlining the options for the refurbishment of theatres.
- There was a strategic objective to improve emergency patient flow through the effective use of a SAU. The plan was well considered, with a project lead developing and testing all aspects of the running of the unit, including admission criteria, staffing, involving medical, consultant and therapy staff in reviewing patients, and equipment. The project lead had monitored the 'virtual' SAU, run from two bays on a surgical ward, to make sure any issues were addressed before the unit opened in the summer 2016. The unit had already demonstrated success in improving patient pathways for emergency patients.
- The divisional strategy included a trust wide objective of improving the governance of major trauma services through improved ward rounds and daily multi-disciplinary meetings and improved attendance at network meetings. Work was underway with commissioners to develop rehabilitation pathways.
- There was a business case to expand robotic surgery for ENT, gynaecology and colorectal patients. Neurosciences was also making the business case to develop cognitive rehabilitation.

Critical care

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

Information about the service

There are 57 critical care beds available within the hospital. Level three care (advanced respiratory support alone or basic respiratory support with support of two other organ systems) is provided on General Intensive Care Unit (GICU) (18 beds), Cardiothoracic Intensive Care Unit (CTICU) (15 beds), Neuro Intensive Care Unit (NICU) (14 beds) and CTICU A (three beds). Level two care (more detailed observation and higher levels of care such as those receiving basic respiratory support or with single organ failure) is provided on Holdsworth HDU (3 beds) and on McKissock Ward (four beds).

Patients were admitted to the units after becoming medically unwell in the community or on the hospital wards, or following surgery. Critical care outreach support was provided by an on call registrar who reviewed patients for potential escalation to critical care.

We visited each of the units during our announced inspection. During our inspection, we spoke with 37 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the critical care leadership team, 13 patients and 7 relatives. We reviewed information provided by the trust, checked 14 patient records and more than 30 pieces of equipment.

Summary of findings

We rated this service as good because:

- We saw good evidence of learning from incidents and varied methods of disseminating learning points, including the 'Big 4' and work based social media. Learning from serious incidents was shared across the units.
- The leadership team demonstrated appropriate responses to issues identified, such as gaps in the critical care service specification standards (D16) 2015, a review of the current outreach provision and increased in-house training opportunities for staff.
- Suitable processes and development opportunities were in place to ensure nursing staff working on the units were competent. We also saw training and learning opportunities for doctors on CTICU and GICU and feedback from these staff members was positive.
- We saw staff following evidence-based practice via specific clinical guidelines across the ICUs.
- The ICUs had a comprehensive audit programme in place to ensure audits were completed at appropriate intervals to monitor quality and safety. We also saw evidence of suitable responses to address audit findings, for example with regards to reducing pressure ulcers.

Critical care

- There were minimal non-clinical transfers out of the ICUs and few patients were discharged from ICU out of hours. Performance in this area was better than the national average for GICU and CTICU.
- Patient and relative feedback was very positive about the care provided across the ICUs and staff were frequently described as considerate and respectful. Relatives told us they felt suitably involved in patient care and hospital feedback forms showed most relatives were as involved as they wanted to be in decisions about their loved one's care.
- We saw some specific examples where staff anticipated and met specific patient needs, such as nursing a patient in accordance to their religious beliefs on GICU and supporting a patient through a marriage ceremony on CTICU.
- ICNARC data demonstrated that patient outcomes, including mortality and readmission rates, were as expected. Good outcomes were also achieved for patients who had their chests opened on the unit in emergencies.

However;

- We were concerned about a potential culture of under reporting incidents. This was due to low incident numbers, staff feedback and minutes from the morbidity and mortality meetings that indicated incident reports were not always completed when they should have been. This had not been identified as an issue by the leadership team.
- The risk register did not fully document all risks identified across the units and mitigating actions were not always sufficient to address risks.
- The leadership team did not identify oversight of the satellite areas as an area for concern, despite us identifying some safety concerns in these areas such as poor completion of resuscitation trolley checks on CTICU.
- Arrangements for doctors' inductions on NICU were not robust and were not addressed when concerns were raised by staff. Feedback about teaching opportunities for doctors working on NICU was not positive.

- Processes for managing patient risk on the hospital wards and providing critical care support were not optimised. Patients had to become sufficiently unwell to trigger a National Early Warning Score of six or more before a referral to the critical care team would be triggered.

Critical care

Are critical care services safe?

Requires improvement



We rated safe as requires improvement because:

- We were concerned about a potential culture of under reporting incidents. This was due to low incident numbers, staff feedback and minutes from the morbidity and mortality meetings that indicated incident reports were not always completed when they should have been.
- Staff mandatory training completion did not meet the 95% hospital target in most topics. Completion of training for intermediate life support and infection prevention and control were particularly low.
- Resuscitation trolley checks and fridge temperature checks were not always consistently completed. We saw medicine fridges and fridges in patient kitchens which were above the optimal temperature range, however there was no evidence of action taken to address the problem until we raised our concerns with staff.
- The environment in GICU was not optimal due to small bed spaces increasing the risk of cross infection between patients. Use of personal protective equipment and infection prevention and control procedures across the units was not always appropriate.
- Processes for managing patient risk on the hospital wards and providing critical care support were not optimised. Patients had to become sufficiently unwell to trigger a National Early Warning Score of six or more before a referral to the critical care team would be triggered.

However:

- Results from the NHS Safety Thermometer demonstrated a good safety performance across the units and infection rates were within the expected range.
- We saw good evidence of learning from incidents and varied methods of disseminating learning points, including the 'Big 4' and work based social media. Learning from serious incidents was shared across the units.

- Appropriate numbers of nursing staff and doctors worked in all three units, including suitable overnight cover and arrangements for when Holdsworth HDU was open.
- Records were well documented with fully completed care plans and legible entries that had been signed by the relevant staff member.

Incidents

- Incidents were reported via online forms that could be accessed by all staff and completed on any trust computer. Some staff told us the computer system "sporadically shuts down" which sometimes led to delays in incident reporting.
- Between April 2015 and March 2016, GICU reported 218 incidents (average of 18 per month), NICU reported 166 (average of 14 per month) and CTICU reported 153 (average of 13 per month). We were concerned the incident reporting culture across the ICUs was not proactive as we expected more incidents reported in a twelve-month period (other smaller sized units reported approximately 25-45 incidents each month). However all staff we spoke with were able to provide suitable examples of the types of situations which should be reported as incidents, including near misses.
- We reviewed documentation from morbidity and mortality meetings and, other than on GICU, it was unclear if incident reports were completed where issues were identified. None of the minutes we reviewed for GICU showed incident reports had been completed, despite indications that they should have been. For example, a patient required admission to GICU however no beds were available and this led to a delay in treatment. Although the team thought that this would not have changed the patient's outcome, it should have triggered an incident report.
- A small number of staff members raised concerns that not all incidents were reported appropriately. For example, they described a situation where a patient unexpectedly died after being found in cardiac arrest in an unsupervised side room. They told us this was not reported as an incident until eight days later following debate in the morbidity and mortality meeting and the incident report we reviewed supported this. Documentation from the trust identified that incidents should be reported within 48 hours of occurrence.

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- There were three serious incidents which were reported to the STEIS, including two never events on GICU Between May 2015 to April 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although each Never Event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a Never Event.
- We saw evidence that appropriate investigations and actions were completed in response to serious incidents. Root cause analysis was completed and appropriate action plans were put in place to address the issues identified.
- Learning from both never events was included as a training topic on the GICU mandatory training days to ensure all unit staff received the training. Following dissemination of learning points, we saw evidence that audits were completed to determine compliance with the learning points identified.
- We saw evidence that learning from the never events was also disseminated to staff working CTICU and NICU via emails, presentations and on their work social media network.
- Staff were able to describe some action points from incidents which had been reported, for example a high number of pressure ulcers from ventilator tubes had led to different tube ties being ordered.
- The 'Big 4' were reminders or learning points that were repeated to staff during every handover over the course of a month and were shared on their work social media network. Staff told us learning from incidents was often communicated during their 'Big 4' and said that the repetition of learning was helpful.
- Weekly morbidity and mortality (M&M) meetings were held on GICU and staff were encouraged to attend if possible. A summary of outreach referrals were also reviewed at this meeting, to identify issues with specific cases or hospital processes relating to this service.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or

other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Doctors and nurses we spoke with had variable knowledge regarding duty of candour; however senior staff were clear about the requirements of this.

Safety Thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (UTIs), falls with harm to patients over 70 and venous thromboembolism (VTE) incidence. Safety thermometer data detailed below covered the period June 2015 to May 2016.
- Safety thermometer data showed there had been 10 unit-acquired pressure ulcers on GICU, five on CTICU and six on NICU in the reporting period. The 'Waterlow Pressure Ulcer Prevention Score' was used across critical care to identify patients' risk of developing a pressure ulcer. A staff nurse was identified as the tissue viability link nurse on each unit.
- Catheter care bundles were used on the critical care units and there had been one instance of catheter UTIs on CTICU and two on NICU during the data period specified. There were no instances of catheter UTIs on GICU.
- There were no falls with harm to patients on GICU or CTICU during the reporting period, however one patient sustained harm from a fall on NICU.
- VTE assessments were recorded on daily care charts and completed at regular intervals. There were no new VTEs on GICU or NICU; however there was one new VTE on CTICU during the reporting period.

Mandatory training

- Staff completed most mandatory training in face-to-face classroom sessions, although some topics were completed as computer-based e-learning modules. Allocated days were identified for staff to receive their mandatory training. We saw evidence that staff were divided into teams and training was completed with a training day allocated to each team on GICU to ensure all staff were able to attend the training. Senior staff told us that new staff or those who were unable to attend the team training days would be booked onto trust-wide mandatory training days at the earliest opportunity.

Critical care

- Senior staff told us a trust-wide training compliance target of 95% was set for mandatory topics, however we noted this target was not met for almost all mandatory subjects across the units.
- Intermediate life support training was mandatory for clinical staff working in critical care. Training had been completed by 64.9% of staff on CTICU, 78.2% on NICU and 81.8% on GICU.
- Patient moving and handling training had been completed by 94.8% of staff on CTICU, 94.3% on NICU and 91.9% on GICU.
- Information governance training was mandatory for all staff within the trust and had been completed by 88.9% of staff on CTICU, 90.9% on NICU and 85.8% on GICU.
- Training in fire safety had been completed by 97.4% of staff on CTICU, 96.6% on NICU and 85.8% on GICU.
- Health, safety and welfare training had been completed by 94.9% of staff on CTICU, 89.8% on NICU and 92.9% on GICU.
- Cleaning audits were completed on a monthly basis by senior housekeeping and critical care staff. The result on GICU from June 2016 showed 98.9% compliance with cleaning standards. No action plan to address the shortfall was displayed, although housekeeping staff told us they had addressed the issues identified immediately.
- Green 'I am clean' stickers were used to identify equipment which had been cleaned by staff and was ready to be reused, such as commodes or drip stands. We saw stickers were marked with the date the item had been cleaned and observed staff replacing the stickers once they returned the clean equipment.
- We saw dried blood on the arterial blood gas machine on CTICU and a syringe filled with blood left on top of the sharps bin next to the machine. We raised this with the nurse in charge who addressed our concerns immediately.
- We inspected four commodes throughout the units and saw that they were clean, including under the seats and on the commode legs.

Safeguarding

- Safeguarding adults training was completed as part of the trust mandatory training. All staff were required to attend this training and it had been completed by 92.3% of clinical staff on CTICU, 88.6% on NICU and 92.1% on GICU. None of the units met the 95% trust-wide training target for safeguarding adults.
- All clinical staff were also required to complete paediatric safeguarding level 2 training and this had been completed by 94.8% of staff on CTICU, 86.2% on NICU and 91.9% on GICU. None of the units met the 95% trust-wide training target for safeguarding children.
- Staff knowledge about safeguarding principles was generally good, with the majority able to identify circumstances where safeguarding concerns should be raised and who to contact in this instance. However, some staff demonstrated poor safeguarding knowledge. For example, one nurse on NICU described being the patients' advocate during ward rounds as a key safeguarding principle.
- Infection prevention and control mandatory training had been completed by 86.1% of staff on CTICU, 85.1% on NICU and 82.9% on GICU. None of the wards met the 95% mandatory training target for this topic.
- Throughout the units, signs were used on the entrance to patient side rooms to identify patients being barrier nursed. This meant staff and visitors were aware of the need to wear suitable personal protective equipment (PPE) prior to entering the patient area.
- Hospital audits between October 2015 and March 2016 showed 100% of staff on all three units wore PPE at appropriate times. The results of this did not reflect our inspection findings as we observed some staff members did not comply with the infection control policy. For example, the infection control policy on GICU advised that staff should wear gloves and an apron for contact with patients and we observed some occasions where staff did not adhere to this.
- The GICU infection control policy advised staff should be bare below the elbows once past the desk at the end of

Cleanliness, infection control and hygiene

- We reviewed patients areas on the ICUs as well as the sluices and treatment room. All areas were visibly clean.

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each bed space and we observed that most staff were compliant with this policy. However, we observed some occasions when staff wearing rings proceeded past this boundary without removing their jewellery first.

- Between July 2015 and March 2016, there were two occurrences of *Colostrum difficile* (C. difficile) on GICU and one on NICU. Root cause analysis was completed in all instances and results showed no issue with the prescription of antibiotics or cross contamination.
- ICNARC data for April to December 2015 showed there were six unit-acquired blood infections on GICU, seven on NICU and nine on CTICU. This was slightly better performance on GICU and NICU when compared to other similar units nationally and slightly worse performance on CTICU.
- ICNARC data showed there were no cases of unit-acquired infections such as methicillin-resistant *Staphylococcus aureus* (MRSA) between April and December 2015. Patients were swabbed for MRSA on admission and at weekly intervals. Specific swabs were taken from wounds or drain sites if indicated.
- Hospital audit data from October 2015 to March 2016 showed 93.1% on staff on GICU, 94.8% on CTICU and 96.2% on NICU completed appropriate hand hygiene when working with patients. During our inspection, we observed that almost all staff completed hand hygiene in line with the '5 moments of hand hygiene', however we did observe some occasions where no hand hygiene was performed. For example, we observed a non-clinical member of staff on NICU move between two patient bed spaces to open the windows behind patient beds. No hand hygiene was completed prior to moving between the bed spaces or when leaving the bed spaces.
- Disposable curtains were used to separate patient bed spaces, other than on Holdsworth HDU where fabric curtains were in place. Staff told us curtains were changed routinely every six months, unless they became soiled or a barrier nursed patient was cared for within the bed space, when they would be changed immediately.

Environment and equipment

- There was a buzzer entry system at the entrance to the ICUs which was used by staff and visitors without an access card. This meant staff could control who accessed critical care when the door was secured. We

observed visitors to the unit being granted entry without a member of staff checking who they were or greeting them when they entered. This meant visitors could potentially gain access to the units inappropriately.

- Emergency buzzers located in the HDU area of McKissock Ward were linked to the buzzer system of the ward, rather than the NICU. This meant staff on NICU were not alerted when an emergency involving a HDU patient occurred. Staff provided an example where an HDU patient went into cardiac arrest and the NICU team were only aware once the 'crash call' had been sent to their bleeps.
- The ICUs were built several years ago and did not comply with current HBN0402 recommendations. The bed spaces in GICU were particularly small and we observed difficulties in containing some patient equipment in the designated area because of this (for example, a patient receiving high frequency oscillatory ventilation (HFOV) had some items of equipment up against the curtain adjoining the adjacent bed space). This could increase the risk of cross contamination between patients.
- Resuscitation trolleys were found at appropriate locations throughout the ICUs. We saw that the contents of the trolleys were checked twice per day with no gaps on the checking document in CTICU or NICU. We observed there were several checks missed in three weeks on CTICU A and four checks missed in a month on GICU.
- Each ICU had access to a 'difficult airway' intubation trolley, which contained equipment to help staff intubate patients with challenging anatomy. The contents of the trolleys met recommendations from the Difficult Airway Society 2013. An emergency chest opening trolley was also available on CTICU.
- Barcodes were used to track and trace items of equipment and maintain an accurate equipment library. Some items of equipment had electronic tagging which meant their location could be remotely identified and monitored. The equipment technician on GICU had created a naming system for certain items of equipment (for example all ventilators of a certain brand were called names beginning with 'E') to help staff identify

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which items of equipment were not adequately functioning. This system was rolled out in other areas of the hospital to assist with their equipment management.

- Equipment we checked, including bed side computers and patient hoists, was in good working order and was labelled with stickers indicating the last service date. Almost all equipment was within their service period, however we noted two oxygen yokes which were beyond their reconditioning date on CTICU; one was due for reconditioning in January 2014 and the other was due in January 2016.
- We saw evidence of safety testing for equipment within the critical care unit, including ventilators and computers.
- We observed spare consumables and other equipment were appropriately stored in labelled units or in cardboard boxes stacked on top of pallets. Units had pictorial contents lists on the side to assist staff in finding the correct items efficiently. Consumables we checked, including fluids, were in date.
- We noted that kitchen fridges on CTICU and CTICU A, which were used to store supplement drinks, were above their desired temperatures, with the fridge on CTICU A at 14 degrees Celsius. There was no documentation to suggest that action had been taken to address the issue.
- Sharps bins were located within each patient bed space, on resuscitation trolleys and in medicines preparation areas. All sharps bins we reviewed were labelled and locked appropriately, however some were filled above the maximum fill line, for example we observed two overfilled on CTICU and one overfilled on GICU.

Medicines

- Information provided by the hospital indicated that there were 2.0 whole time equivalent (WTE) ICU pharmacists in post to cover the three ICUs plus 1.0 WTE vacancy. Recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units identified there should be 4.0 WTE pharmacists for the number of critical care beds provided; this staffing was less than this.
- Pharmacists attended daily wards rounds from Monday to Friday on GICU and CTICU, however there was no

pharmacy representation on the NICU ward round. This was not consistent with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.

- Pharmacy technical staff visited each ICU twice each week to replenish stock and assist in the storage of medicines. The availability of this type of support staff adhered to recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- Medicines were stored in locked units across the ICUs. Patient's own medicines were stored in individual keypad lockers at the head of each bed space in CTICU.
- Some medicines were stored in designated and lockable medicine fridges. Staff checked the temperature of the fridges on a daily basis and we saw no gaps on the checking document on GICU or CTICU. On CTICU A, we noted five gaps in fridge temperature checks in three weeks and no documented action when the fridge was above the optimal temperature range. During our inspection we observed that the temperature of the medicines fridge on NICU was 10 degrees Celsius, which was above the target range. This had not been identified by staff however, we raised this with a staff nurse who contacted pharmacy to address the issue.
- Controlled drugs (CDs) were stored in lockable, wall-mounted cupboards. On each unit, the keys for these cupboards were held by the nurse in charge unless being used by ward staff. On CTICU, a brightly coloured band identified the keys for the CD cupboard for ease of identification. Staff working on CTICU A had to use CDs stored in the CTICU main unit as no CD cupboard was available in the satellite area.
- Stock books containing details of the CD cupboards were stored within the cupboard and identified the expected stock of each medicine. Two members of staff checked the CD stock levels collaboratively on daily basis. During our inspection, the CD stock levels documented in the stock books were accurate on each unit.
- Electronic prescribing was in use on CTICU and this system fed directly into the prescribing system in use on

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the surgical wards. Paper-based prescription charts were used on GICU and NICU. The introduction of e-prescribing and medicines administration on GICU was planned to start in September 2016.

- We observed staff on each unit preparing and administering intravenous and oral medicines. They followed correct procedures, including checking expiry dates, patient identification and allergies.
- An audit of sedation boluses completed in December 2015 showed that 4% of boluses were documented on the patient's medical chart across the units. This meant patients were receiving medicines without this being recorded on the necessary paperwork. Appropriate actions to address this issue were identified and staff we spoke with were aware of the need to record boluses on the patient chart. We observed staff record boluses when administering them to their patients.
- Oxygen cylinders throughout the ICUs were appropriately stored in designated racks and were in date.
- A risk assessment relating to the prescription and administration of oxygen on the critical care units was completed. The assessment determined that a formal prescription of oxygen was not needed in critical care due to the complexity of oxygen therapy in critical care settings and the close monitoring of patient oxygen levels.
- An antibiotic stewardship audit completed on NICU in April 2016 showed 100% compliance with trust policy, including indications documented and review dates. During our inspection, we observed antibiotic review dates documented on prescription charts across all three ICUs.

Records

- Paper based medical notes were used to record medical interventions and involvement from the multidisciplinary team on CTICU, GICU and NICU. These notes were kept at the end of each patient bed for easy access. Notes we reviewed were legible, signed, fully completed and it was clear who had written the notes, including their designation.
- Nursing documentation was recorded on separate care plans which were stored in ring-binders at the patients' bed space. Patient observations and assessments were

recorded on the daily record sheet. Nursing documents were clear and concise, with care plans fully completed. Most entries had been signed, however it was not always clear who had completed the entry.

- We found four discs containing patient investigation images from other hospitals inappropriately stored in a desk drawer at the nursing station on CTICU, dated January and August 2015. Patient names and dates of birth were documented on the front of each disc. We raised the inappropriate storage of these discs with the nurse in charge who identified that the images should have been downloaded to the hospital computer system and the discs destroyed. The nurse in charge immediately arranged for this to happen.
- An 'end of life and terminal decline chart' was created by staff on GICU to guide the care and interventions given to patients approaching end of life. On CTICU, a 'Limitation of treatment' communication sheet and a 'withdrawal of treatment' communication sheet were in use. There were no equivalent charts used on NICU, however staff told us they used the trust's end of life care forms to guide patient management.

Assessing and responding to patient risk

- Staff described risk assessing the placement of patients in relation to the locations of HDU areas. For example, only low risk patients would be accommodated on Holdsworth HDU due to its fifth floor location. For example, post-operative patients going straight to Holdsworth HDU were monitored for at least 30 minutes in recovery after their procedure to ensure they were breathing independently without any difficulties.
- Staff on GICU and CTICU used the 'Richmond agitation-sedation scale' (RASS) hourly to score the level of sedation for each patient receiving sedative medicines. Staff told us they tried to help patients settle, for example by using earplugs or an eye mask, rather than increasing sedation as this increased the risk of delirium. No formal measure of sedation was used on NICU as RASS was not suitable for this patient cohort, however the practice development nurse told us work was underway to identify a sedation score suitable for neuro patients.
- The Confusion Assessment Method for ICU (CAM-ICU) delirium scoring system was used to identify patients experiencing delirium on CTICU and GICU. We observed

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that this assessment was completed daily. Staff told us patients who experienced delirium would be moved to a side room if possible to reduce their exposure to excessive stimulation. CAM-ICU was not used on NICU as it was not validated for neuro patients, however the practice development nurse told us work was underway to identify a delirium score suitable for neuro patients.

- Designated critical care follow up nurses reviewed all patients discharged from the ICUs to the hospital wards. Data provided by the hospital indicated that the nurses followed up 224 patients on the hospital wards following their discharge from critical care between March and May 2016.
- There was no critical care outreach team available in the hospital to support ward staff in caring for deteriorating patients. However, staff told us that an outreach registrar doctor was available to review ward patients who were causing concern at any time. The registrar could advise on ward level care or decide to admit the patient to critical care following their assessment. All patients referred to the outreach registrar were discussed with the ICU consultant at the earliest opportunity, to determine whether they were suitable for critical care admission or not.
- The National Early Warning Score (NEWS) was used throughout the hospital wards to enable early identification of deteriorating patients, as indicated by their observations. This was in line with guidance from the Royal College of Physicians and compliant with the NICE 50 guideline. Hospital documentation identified that a referral to critical care should be made when the NEWS reached a score of six or above.
- Staff on the hospital wards told us they would refer patients to critical care when they became sufficiently unwell (for example triggering a critical care referral from their NEWS), however they were not clear if they could formally access advice or support from critical care staff until a formal referral had been made.
- Between 8am to 6pm Monday to Friday, the hospital identified that 90% of referrals to the outreach registrar should be seen within 15 minutes and 90% of referrals should be seen within 30 minutes at all other times. Staff told us this performance was not formally audited.
- The critical care follow up nurses told us they were often approached by staff when on the wards to provide

advice to staff caring for deteriorating patients, without a formal process being followed. They also assisted in transferring patients from the wards to the ICUs when required.

Nursing staffing

- There were 331.8 whole time equivalent (WTE) posts for qualified nursing staff to work across critical care and there were 28.21 WTE vacancies (8.5%). There were 9.32 WTE health care assistants who supported the nursing staff in critical care.
- Staff told us of difficulties with recruiting band six critical care nurses and described employing additional band five staff who were then trained and developed to become band six nurses.
- An acuity tool was used to determine safe staffing levels across critical care. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units states that all ventilated patients (level three [L3]) are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care, and for level two (L2) patients a ratio of 1:2. We reviewed staffing rotas, patient allocation records and observed staffing during our inspection that showed GICU, NICU, CTICU and the satellite critical care areas complied with the required staffing levels.
- The critical care matrons and nursing leadership team took turns holding a designated leadership bleep. The person holding this bleep was responsible for coordinating beds and staffing across the critical care units.
- Best practice guidance suggests no more than 20% agency staff usage per shift. Nursing staff rotas we reviewed and our observation of nursing staff on duty during our inspection demonstrated compliance with this standard. Information provided by the hospital relating to March 2016 showed 5.8% of staffing on GICU was by bank and agency staff. The use of bank and agency staff was higher on NICU and CTICU (13.3% and 13% respectively) but remained below the 20% maximum recommendation. This reflected data from December 2015 to February 2016.
- Bank and agency staff received local unit inductions on their first shift and were required to complete medicine administration competencies prior to giving medicines to patients. Agency staff we spoke with spoke positively

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about their induction process and told it was “more thorough” than in hospitals in which they had worked. We saw evidence of completed agency staff induction checklists across the ICUs.

Medical staffing

- A total of 30 critical care consultants were in post across the critical care units. In line with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units, 100% of consultants were Faculty of Intensive Care Medicine accredited or had suitable equivalent qualifications.
- Two consultants were responsible for GICU Monday to Friday, with one on call overnight. One consultant was responsible for the unit over weekends. Consultants were not responsible for any other duties during their allocated week on GICU and the rotas we reviewed demonstrated full compliance with the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. The same consultant provision was available on CTICU.
- Consultants across the ICUs were supported by a varying number of registrars, specialist trainee doctors and foundation year doctors. There were usually a minimum of four doctors supporting the duty consultant during daytime shifts on GICU and three on CTICU.
- Overnight, GICU was the responsibility of an experienced registrar, with support from a more junior specialist trainee and the on call consultant.
- On NICU, one consultant worked during the dayshifts from Monday to Monday, with overnight cover provided by a different consultant for three nights and then another consultant for the next three nights. The consultants had no other responsibilities while on duty. They were supported by four trainees during daytime shifts and two trainees overnight (a combination of registrars, specialist trainees and foundation year doctors). Rotas we reviewed demonstrated full compliance with the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- On GICU, consultants completed a ‘sweep’ ward round at 8am where a quick review of patients was completed

and any issues requiring immediate attention were addressed. A more thorough, office based ward round was held from 10.30am to 12.30pm. A further consultant ward round was held at 6pm.

- Neuro-surgical registrars completed wards rounds three times per day on NICU and a consultant ward round was also held each morning.
- When Holdsworth HDU was open, a specialist trainee doctor was allocated to remain on the unit in line with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. The second on call consultant from GICU assumed responsibility for this unit when it was open.

Major incident awareness and training

- An escalation plan relating to capacity pressures was in place with clear actions and escalations identified for each stage of management. This plan was actioned on a daily basis by the ICU bleep holder (responsible for overseeing capacity across critical care) as required and escalated up to senior trust management level, as indicated.
- Staff received training on major incidents as part of their trust induction. No other training was identified as being in place by staff we spoke with, however staff were aware that the trust major incident protocol was available on the intranet.

Are critical care services effective?

Good



We rated effective as good for because:

- The ICUs had a comprehensive audit programme in place to ensure audits were completed at appropriate intervals to monitor quality and safety. We also saw evidence of suitable responses to address audit findings, for example with regards to reducing pressure ulcers.
- Staff followed evidence-based practice via specific clinical guidelines across the ICUs, for example the Blood Glucose Management in Adult Critical Care guideline.

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- ICNARC data demonstrated that patient outcomes, including mortality and readmission rates, were as expected. Good outcomes were also achieved for patients who had their chests opened on the unit in emergencies.
- There was appropriate seven day services provided by ICU consultants and physiotherapists, as well as seven day access to investigations and scans.
- Suitable processes and development opportunities were in place to ensure nursing staff working on the units were competent. We also saw training and learning opportunities for doctors on CTICU and GICU and feedback from these staff members was positive.
- Staff demonstrated good knowledge and understanding of the Mental Capacity Act and we saw evidence of this in practice on the units.

However:

- Arrangements for doctors' inductions on NICU were not robust and were not addressed when concerns were raised by staff. Feedback about teaching opportunities for doctors working on NICU was not positive.
- The provision of physiotherapists, occupational therapists, dieticians and speech and language therapists was not sufficient to meet recommended standards.
- We saw evidence the service was not fully compliant with NICE clinical guideline 83 as rehabilitation goals were not set. NICE clinical guideline 50 was also not fully met as the structured handover of care to ward staff did not cover all key elements specified in the guidance.
- Patient VTE assessments were not consistently completed at appropriate intervals, including on admission and reassessment after 24 hours, during their admission to the ICUs.

Evidence-based care and treatment

- The ICUs had a comprehensive audit programme in place to ensure audits were completed at appropriate intervals to monitor quality and safety. This practice was in line with recommendations from the FICM Core Standards for Intensive Care Units. Various members of the multi-disciplinary team, including pharmacists and physiotherapists, completed audits.

- There were specific guidelines referenced to evidence-based practice in place, such as the n invasive line insertion checklist and we observed that staff who inserted central venous lines used this.
- An evidence-based ventilator-associated pneumonia (VAP) prevention care bundle was in use throughout the ICUs. Hospital audit data from April 2016 showed 95.6% compliance with this care bundle on GICU and 99.6% compliance on CTICU. No data was available for NICU in April, however results from March 2016 showed 100% compliance.
- A booklet containing key evidence-based guidance for various treatments and procedures was available on GICU. This had been most recently updated in February 2016 and staff told us this was reviewed annually. A total of 137 references were cited in this booklet, including journal articles and data from a range of sources. Similar guideline information booklets were also available on CTICU and NICU, however these were dated as 2013 and 2012 respectively and no review date had been identified on the document, which meant staff could refer to out of date information. There were some references to evidence-based practice and national guidance in the CTICU and NICU booklets.
- In accordance with NICE quality standard 3, we observed that patients' risk of VTE were usually assessed at appropriate intervals (on admission and after 24 hours) and that suitable VTE prophylaxis was in place across critical care. Hospital audit data from January to March 2016 showed six out of nine trust identified quality standards had been met. However, the proportions of patients who had a VTE assessment on admission to CTICU (80%) and NICU (90%) were lower than the trust target (95%). The proportion of patients who had a VTE risk assessment after 24 hours was also slightly lower than the trust target (70%) on GICU (66.7%). Across the units, this was poorer performance than during the previous quarter when all units met trust standards, however reflected our inspection findings.
- We saw evidence the number and cause of unit-acquired pressure ulcers was audited in addition to being reported to the NHS Safety Thermometer. The number of pressure ulcers from 2013/14 was compared

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with the number of ulcers in 2014/15. A 'hot spot' poster initiative was introduced after 2013/2014 and initially showed a drastic reduction (53%) in pressure ulcer occurrence in 2014/15.

- Some members of the multidisciplinary team described difficulties in working according to Faculty of Intensive Care Medicine Core Standards for Intensive Care Units due to being managed by a senior from a different specialty, who insisted upon working to traditional standards for the profession.

Nutrition and hydration

- There were 0.6 WTE dietitian provided on CTICU, 0.8 WTE on GICU and 0.5 WTE on NICU. This provision was not compliant with the British Dietetic Association recommended numbers of WTE dietitians for the number of critical care beds that were available.
- All ICUs had emergency enteral feeding regimens that staff could initiate out of hours immediately. Staff were aware of the location of these regimens and when they should be started.
- Parenteral nutrition (PN) was started upon the agreement of the ICU medical team, the admitting consultant medical team (for example the patient's surgeon) and the ICU dietetic team. PN could also be started out of hours or at weekends by critical care staff if the ICU consultants deemed there to be an urgent need. A pro forma was in place to guide PN feeding.
- We saw evidence of comprehensive fluid balance monitoring on the daily care charts and clear documentation where a target fluid balance had been identified.
- Patients who were able to drink had water provided which was left within reach on their bedside table. Staff also offered hot drinks to patients at regular intervals.
- Patients who were able to eat could choose their meals from a designated menu. The menu offered options for those who required specific types of textures, for example patients on a soft or pureed diet.

Pain relief

- Patients who were able to communicate were asked about their level of pain on an hourly basis. The critical care pain observation tool (CPOT) was used in GICU and

CTICU to assess patients' pain when they were unable to communicate. This was in line with the Core Standards for Pain Management Services in the UK (Faculty of Pain Medicine, 2015).

- Staff on NICU told us there was no formal pain assessment tool which had been validated for use with neuro patients, however they were working to identify a suitable scoring system.
- Patients received pain relief via patient controlled analgesia (PCA), epidural, intra-venous or orally. Staff told us pain relief medicines were reviewed several times throughout the day to ensure pain control was optimised and pain relief medicines were reduced when possible.
- Patients on CTICU told us their pain was well managed and staff asked them about their levels of comfort frequently. They reported staff bringing them additional pain relief prior to completing physiotherapy or if they were uncomfortable at rest.

Patient outcomes

- The units contributed data to the ICNARC database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally. ICNARC data quoted relates to the period from April to December 2015.
- ICNARC data showed there were 119 patient deaths on GICU, 73 deaths on NICU and 107 on CTICU. This represented a unit mortality rate of 8.6% on GICU, 8.2% on NICU and 9.4% on CTICU, which was in line with the expected mortality rate for each unit.
- ICNARC data showed there were 20 unplanned readmissions to GICU with 48 hours of discharge, which represented 1.6% of patients admitted to the unit in this period. This was slightly worse when compared to other similar units (1.3%), although data showed an improving trend. There were four unplanned readmissions to NICU (0.5% of patients), which was better performance than in other similar units (1.4% readmission rate). There were nine unplanned readmissions to CTICU (0.9% of patients), which was better performance than in other similar units (1.3%).

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- The units contributed to the local critical care network which enabled further outcome and quality benchmarking, specifically against other local critical care units.
- Staff on CTICU told us they were able to surgically open patients' chests on the unit in an emergency situation rather than transferring the patient to theatre. Information provided by the hospital indicated that 29 patients had their chests opened on CTICU between June 2015 and May 2016. Of these patients, 22 (75.9%) survived.
- Patients suspected as having brain stem death or with a plan to withdraw life-sustaining treatment were referred to the specialist nurses in organ donation. The referral rate between April 2015 to March 2016 was 100% on CTICU and NICU, demonstrating compliance with NICE clinical guideline 135. The referral rate on GICU was 86%. A combined total of 170 organ transplants were completed as a result of organ donation from the intensive care units.
- A range of in-house training courses were available for critical care staff. Nurses could attend sessions including tracheostomy training days and the harm-free care course. Simulation sessions using state of the art technology to reproduce patient scenarios were also available.
- A foundation critical care nursing course was held 'in house' and was mandatory for new band five staff. Staff had to sign off key competencies in this period and complete an essay at the end of the course.
- The FICM Core Standards for Intensive Care Units recommends 50% of critical care nurses should be in possession of a post registration award in critical care nursing. All units met this target; 53% of nursing staff on CTICU had completed a critical care nursing course, 57% on NICU and 62% on GICU.
- There were also development opportunities available for health care assistant staff, including the health care assistant development day.
- Staff had annual appraisals with their line manager to review their performance and identify any learning needs. Data provided by the hospital showed that appraisals were up to date for 87.4% of staff on CTICU, 64.9% on GICU and 75.7% on NICU.
- Staff across the ICUs were allocated as link nurses for certain aspects of patient care, for example each unit had a learning disability link nurse and a tissue viability link nurse. There were 43 link nurses identified on CTICU.
- No formal process for rotating staff between the units was in place, however senior staff told us staff wishing to rotate could be accommodated. We spoke to a nurse who had worked on NICU and then rotated to CTICU to develop additional knowledge and skills.

Competent staff

Nursing Staff:

- New staff attended the trust induction prior to started work on the ICUs, where they then received a local induction and were allocated to a mentor. Staff were supernumerary for a period of up to four weeks while their basic competencies were reviewed and signed off as appropriate. Staff told us they had plenty of time to settle into the units and get to know ways of working before looking after patients independently.
- There were three practice development nurses on CTICU, two on NICU and three on GICU. Their roles were split between working clinically to supervise and train staff 'on the job' and completing formal teaching sessions with staff. Drop in sessions were available for staff to meet with the practice development nurses on an ad hoc basis.
- Specific self-assessment competency documents were in use for certain items of specialist equipment, for example the cardiac output monitors and specific types of ventilators. The practice development nurses addressed gaps in competence by providing additional training and support for staff. We saw that the practice development nurses maintained spreadsheets documenting staff competence across the ICUs.

Medical Staff:

- Doctors who were new to the trust completed the generic trust induction training prior to starting work in the hospital.
- Medical staff commencing work on GICU were provided with a comprehensive booklet outlining various important points about working on the unit, including timings of key activities and expectations relating to their role.

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- Staff on GICU and CTICU told us they received full formal inductions to the unit; however four doctors on NICU told us they had not had an induction. NICU senior staff told us doctors were inducted to the unit via an information email, followed up by a quiz at a later date.
- We reviewed induction records for NICU that showed the doctors received their induction email during our inspection week, which was several weeks after starting their NICU rotation. One doctor told us they had raised concerns about their lack of induction with a senior doctor and it was not taken seriously instead of being addressed.
- Doctors received structured teaching from one of their peers on a weekly basis, which was overseen by one of the critical care consultants. A weekly journal club was also held. Additional training was received one afternoon each month and medical staff were divided into 'tier one' and 'tier two' for this, depending upon their level of experience. Doctors on CTICU and GICU were positive about the training they received, however staff on NICU told us they received little formal training at the start of their rotations and ad hoc training was very variable.
- Consultants maintained a trainee database with details of the specialist trainees, including their activities and training achievements. There were also monthly assessment inputs from consultants supervising the trainees.
- Consultants were appraised annually by the clinical group lead in their area and data provided by the hospital showed 100% of critical care consultants had an up to date appraisal at the time of our inspection.
- A weekly multidisciplinary team ward round was completed to specifically review patients with tracheostomies. The tracheostomy ward round team also visited patients with tracheostomies on other wards to contribute to clinical care plans.
- A weekly 'rehab group' meeting was held for patients admitted to the ICUs. This group was attended by consultants, follow up nurses and critical care liaison nurses. We did not see evidence of attendance from other members of the multidisciplinary team, such as physiotherapists, or evidence of short-term or long-term goal setting. Therefore, this was not compliant with NICE clinical guideline 83.
- Staff told us patients received physiotherapy input from early on in their admission, to support airway clearance where needed and for early instigation of rehabilitation. In patient records, we saw evidence supporting this, however compliance with NICE clinical guideline 83 had not been audited.
- Each ICU was funded for 2.0 WTE physiotherapists; however, other physiotherapy teams in the hospital provided approximately 0.5 WTE additional input for clinical development and maintenance of competence. This meant the ratio of physiotherapy staff to patients was 1:7. ICS recommendations state a minimum ratio of one physiotherapist to four patients; therefore the service provision did not meet recommendations.
- There were no occupational therapists (OT) funded for the ICUs, however other teams within the hospital provided ad hoc cover. For example, the neurosurgical OT team reviewed patients and attended the weekly rehab round on NICU. The Intensive Care Society (ICS) recommends funding 0.22 WTE OTs per level three bed, therefore the service provision did not meet recommendations.
- There were no speech and language therapists (SALT) funded for the ICUs, however other teams within the hospital provided ad hoc cover, equating approximately 2.5 WTE. Recommendations from the Faculty of Intensive Care Medicine (FICM) state that patients should have access to SALT staff with critical care experience, therefore this recommendation was not being met because funding for these posts was not in place.

Multidisciplinary working

- The outreach registrar was responsible for reviewing patients in other areas of the hospital to determine their need for admission to critical care. Guidelines produced by the ICUs advised on who might not be suitable for escalation, for example those with a high frailty score or more than two unplanned admissions to hospital in the last three months. Other than review by the outreach registrar, it was unclear how staff in other areas of the hospital would know which patients would be accepted by the ICUs.

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Seven-day services

- Consultants completed twice daily ward rounds, including during weekends, which was in line with recommendations from Guidelines for the Provision of Intensive Care Services. However, physiotherapy and pharmacy staff attended ward rounds from Monday to Friday only, which was not compliant with these guidelines.
- Physiotherapy staff worked across seven days, with a minimum of 1.0 WTE therapist on each unit every day, including at weekends.
- All units could access emergency respiratory physiotherapy support 24 hours per day, seven days per week via a bleep referral. This physiotherapist could assist with patients requiring specific airway clearance techniques out of hours.
- Occupational therapists worked across seven days. Patients requiring OT support at weekends would be prioritised along with patients throughout the hospital.
- Direct access to an ICU trained dietitian was available five days per week, due to a lack of ICU trained dietitians. If ICU trained staff were working over the weekend, they could review ICU patients and answer any queries as necessary. If a non-ICU staff member was working, telephone assistance could be sought from the senior ICU dietitian.
- Access to an ICU trained pharmacist was available five days per week. Only generic pharmaceutical support could be obtained over the weekend, unless an ICU trained staff member was working. A full seven day pharmaceutical service was not available due to the skill mix within the department, however this provision was sufficient to comply with the FICM Core Standards for Intensive Care Units.
- Patients could access investigations such as blood tests, X-rays and CT scans 24 hours per day, seven days per week. Staff reported there were no difficulties accessing this type of support service and told us urgent investigations for critical care patients, were prioritised over other patients in the hospital.

Access to information

- Staff accessed policies and other key information on the hospital intranet. Staff on GICU told us the intranet was often unavailable and this was demonstrated when we

asked to be shown various policies online. This could mean staff would be unable to access key information to guide patient care on the computer systems when needed.

- Staff completed a discharge summary form when patients were discharged from the GICU, NICU or CTICU. All patients transferred to another hospital or who died within critical care had a discharge summary sent to their GP.
- A verbal handover between the discharging and receiving medics and nursing staff took place; however, transfers we observed did not fully meet NICE clinical guideline 50 requirements. For example, the structured handover of care did not cover all key elements specified in the guidance.
- A GICU Guidelines folder was available at each bed space on the unit. This folder contained a comprehensive list of hospital policies and practice guidelines, for example when to initiate use of a speaking valve with tracheostomy patients. The practice development nurses were responsible for updating information contained within these folders.

Consent, Mental Capacity Act and DoLS

- Staff recognised the need to ask patients for their consent when completing care tasks or interventions on the ICUs. We observed staff providing full explanations of procedures and asking patients for their permission before beginning the required task. Patients told us staff always asked for permission before doing anything to them.
- Knowledge of the Mental Capacity Act, 2005, was good across the ICUs. Staff knew that all patients should be assumed as having capacity unless assessed as contrary to this. They described making best interest decisions for patients who were unable to consent and provided examples where this had been implemented. For example, a patient who was sedated had positional changes every two hours to prevent pressure sores.
- Staff described discussing treatment options and care plans with patients' next of kin, however most staff were clear that the next of kin were unable to consent on the patients' behalf.

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- Staff were unsure about the use of independent mental capacity advocates (IMCAs) and told us they would seek support from the senior nurses or consultants.
- Staff knowledge of DoLS was variable throughout the units and between staff. Some staff demonstrated good knowledge of DoLS and were clear what actions were required when patients needed to be deprived of their liberties, including assessment of mental capacity and applications for DoLS orders. Other staff were unclear what DoLS meant or how this was relevant to their clinical practice.
- A senior GICU staff member told us mittens were used on the unit stop confused patient from pulling out their ventilator tube or intra-venous lines. They explained that putting a patient in mittens would only happen following a capacity assessment, multidisciplinary discussion and a prescription for the mittens had been written. The mittens would be used for the shortest amount of time available however no DoLS application would be considered in this scenario.

Are critical care services caring?

Good



We rated this service as good for caring because:

- Patient and relative feedback was very positive about the care provided across the ICUs, and staff were frequently described as considerate and respectful.
- Across all units, we observed many thank you cards and letters expressing gratitude and compliments from previous patients about the care they received.
- Relatives told us they felt involved in patient care and hospital feedback forms showed most relatives were as involved as they wanted to be in decisions about their loved one's care.
- We saw some specific examples where staff anticipated and met specific patient needs, such as nursing a patient in accordance to their religious beliefs on GICU and supporting a patient through a marriage ceremony on CTICU.

However;

- Staff were not always considerate of patients when completing tasks in the units. For example, we observed a member of nursing staff on CTICU very noisily place a box on a trolley directly next to an unconscious patient's bed.
- The door to CTICU A was frequently left open which meant anyone walking in the main corridor could potentially see the patients in a vulnerable state inside, which did not preserve their privacy and dignity.

Compassionate care

- Patients we spoke with were very positive about the care they received across the units, with two patients describing the service as "exemplary". Many patients told us staff were kind, considerate and respectful when caring for them.
- Relative feedback was also very positive and they told us they had confidence their loved one was being well cared for. They told us staff were polite and friendly when they visited the units.
- There were many cards and letters from previous patients expressing their gratitude on display throughout the units. Cards praised the care received ("I have never before experienced such amazing care") and the sympathetic approach from staff to patients and their visitors ("you showed great compassion, not only for your patient but his family too").
- Staff facilitated a wedding on CTICU for a critically ill patient. They helped prepare the patient for the ceremony, including styling her hair and dressing her in a wedding outfit. Staff spoke fondly of their involvement with this and told us it was "wonderful to be part of something so special, especially when it was so important to [the patient]".
- Staff took care to respect patient's religious needs and we saw an unconscious patient on GICU being nursed in a head scarf in line with their religious beliefs. Staff explained that they also tried to allocate a same sex staff member to care for the patient because of this.
- We observed thoughtful interaction between patients and staff, and staff tried to anticipate patients' needs. For example, we observed a nurse on NICU with four pillows and the nurse explained they were about to

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reposition their patient. The nurse told us the patient always liked to have many pillows supporting their back when laying on their right side and so she gathered the pillows in preparation.

- However, some staff were not always considerate of patients when completing tasks in the units. For example we observed a member of nursing staff on CTICU very noisily place a box on a trolley directly next to an unconscious patient's bed. We also heard a patient on GICU comment that a member of staff "scared the life out of [them]" when a staff member did the same thing. We also observed a staff member on NICU walking through the unit loudly calling a colleague's name to try and locate them.
- Staff worked to maintain patient privacy and dignity by drawing the bed side curtains prior to completing any care tasks or interventions, and keeping patients covered with a sheet to preserve their modesty. Patients told us staff were aware of maintaining their dignity even when completing assessments during ward rounds, where they had asked some members of the ward round to step outside the bed side curtain for part of the assessment.
- The entrance door to CTICU A opened onto hospital corridor. We saw this door was left open on several occasions and people walking past the unit could see the ICU patients in potentially vulnerable circumstances inside. This did not fully preserve patient privacy and dignity.

Understanding and involvement of patients and those close to them

- We observed doctors on ward rounds offering patients and their relatives the opportunity to ask questions and to clarify anything they were unsure of. We also noted nursing staff answering patient's questions about their plan of care. Answers provided by doctors and nursing staff were clear and concise. Patients and their relatives across the units told us they felt able to ask any questions they wanted.
- Staff ensured patients were fully informed before completing any intervention. For example, we observed staff removing a patient's chest drain on CTICU. The nurse and doctor involved provided the patients with a thorough and clear explanation of the procedure prior to removing the drain.

- Relatives were invited to assist with patient care where appropriate. For example, we observed a physiotherapist explaining some strengthening exercises for a relative to complete with their loved one. Relatives told us they had enough opportunities to be involved in the care of the patients.
- Results from a relatives survey completed by the hospital between October 2015 and March 2016 showed that 74.1% of relatives on CTICU, 80% on GICU and 89.5% on NICU felt they were involved as much as they wanted to be in decisions about their loved one's care. The survey also showed that when next of kin asked nurses and doctors questions about the patients' care, 82.5% of relatives on GICU, 81.5% on CTICU and 100% on NICU received answers that they understood.
- When patients were thought to have brain stem death or if there was a plan to withdraw life-sustaining treatment, the possibility of organ donation was discussed with patients' next of kin. The ICU team and the specialist nurse for organ donation did this collaboratively where possible. Audit data showed this collaborative approach was used in 94% of cases on NICU, 92% on CTICU and 66% on GICU.

Emotional support

- Staff told us they provided emotional support to patients routinely throughout their shifts and patients reported feeling supported by staff. Patients described staff offering words of encouragement prior to their physiotherapy session and reassurance when the patient was struggling with certain tasks, such as balancing.
- We observed staff holding patients' hands and taking time to speak quietly with them when they were upset or unsettled. Staff told us it was important to be comforting and help patients feel as relaxed as possible.
- A chapel and multi-faith room was available within the hospital and was open at all times for personal reflection or prayer. Services were held regularly and the chaplaincy team included representatives from different faiths.
- Staff knew of external support organisations, such as cancer care charities, which offered services locally and told us they would signpost patients and relatives to these organisations if required.

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Are critical care services responsive?

Good



We rated responsiveness of this service as good because:

- The service provided a flexible number of level two and level three beds, which were flexed according to patient need. The ICUs were also flexible to meet the needs of young people.
- Patients were admitted within four hours of the decision to admit being made and were reviewed by an ICU consultant within 12 hours of their admission.
- There were minimal non-clinical transfers out of the ICUs and few patients were discharged from ICU out of hours. Performance in this area was better than the national average for GICU and CTICU.
- ICU occupancy levels were in line with the national average and patient length of stay was considerably better than the national average for patient admitted to GICU and NICU.
- There were few elective operations cancelled due to unavailability of ICU beds between September 2015 and February 2016.

However;

- Facilities for relatives were limited and there was not enough seating available in waiting areas for visitors during busy periods.

Service planning and delivery to meet the needs of local people

- GICU admitted patients after elective or emergency operations or after becoming medically unwell, either in the community or on the hospital wards. ICNARC data from April to December 2015 showed the majority of patients were admitted after becoming medically unwell (46.2%). Patients admitted after elective surgery represented 35.3% of all admission and patients admitted after emergency surgery represented 18.5%.
- ICNARC data from April to December 2015 showed CTICU primarily admitted patients after elective surgery (64.4%). Non-surgical admission represented 27.1% of admission and emergency surgical admission were 8.4%.

- NICU acted as a tertiary referral centre for neurosurgery, neurology and stroke services, as well as a high dependency post-operative ward. Non-neuroscience patients were also accommodated on the unit when maximum capacity in the other ICUs was reached. ICNARC data from April to December 2015 showed most patients were admitted to NICU after elective surgery (49.7%). Non-surgical patients represented 36.9% and emergency surgical admission represented 13.4%.
- Each unit had a funded number of level two and level three beds, however staff across the units told us the number of patients care for at each level would be flexed to meet the needs of patients. For example, GICU was funded for 12 level three beds, but could accommodate 18 level three patients if required.
- Patients who required planned postoperative admissions to critical care were identified during their preoperative assessment clinic and booked into the relevant ICU, once a date for surgery was agreed.
- Between September 2015 and February 2016, 18 surgical cases were cancelled due to bed unavailability on CTICU, including a peak of nine cancelled operations in February 2016. There were 14 operations cancelled due to GICU bed unavailability, including a peak of six cancelled cases in February 2016. No surgical cases were cancelled due to unavailability of beds on NICU.
- Unplanned admissions to ICU were referred to the consultant on duty during working hours or to the 'outreach' registrar overnight. The consultant on duty was responsible for deciding whether patients should be admitted to the unit or cared for on the wards. Overnight the registrar completed the patient assessments and usually deciding the best course of action, although all patients were discussed with the consultant the following morning.
- Patient diaries were started for patients expected to stay on any of the units for three or more days. We saw that staff and patients' visitors completed diary entries outlining key events in patients' critical care stay, for example scans, physiotherapy and visits from key family members. Diaries were returned to patients once they were well enough to receive the information contained

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within them or offered to the next of kin of patients who died. Between March and May 2016, 41 diaries were returned to patients and an additional 26 were issued to patients.

- Patients admitted to any of the ICUs for four days or more were invited to attend a multidisciplinary follow up clinic once they had been discharged from hospital. Patients admitted for less than four days were invited if the team felt they would benefit from attending. Patients who had other forms of hospital follow up, such as patients with a traumatic brain injury, would not usually access the ICU follow up clinic. Hospital data showed 91 patients attended a follow up clinic between June 2015 and May 2016, and 75% of referrals were from GICU.
- Visiting times on GICU were between 10:30am and 12:30pm, and 3:30pm and 7:30pm. On NICU, visiting times were 10:00am to 12:00pm, 2:00pm to 7:00pm and 8:30pm to 9:30pm. On CTICU, visiting was between 8:00am and 1:00pm and 3:00pm and 8:00pm. Visitors told us the visiting hours were long enough to meet their needs and some relatives described a situation where staff had allowed flexibility of the visiting times to allow family members to see the patient after initial admission.
- Each ICU had a designated waiting area close to the unit entrance. There was seating for 20 visitors in the GICU waiting room, seating for 11 in CTICU and 8 in NICU. Staff told us feedback from relatives often commented on the poor facilities for relatives, such as lack of hot drink making facilities.
- During the inspection, we observed that the waiting areas were busy during visiting times and there were not always enough seats for all visitors who were waiting.

Meeting people's individual needs

- Staff told us patients aged 16 years or older would be accepted onto the adult ICUs, depending upon their personal circumstances. They told us that a discussion would be held with the paediatric team to determine the most appropriate location for each individual young person who required admission. A general 'rule of thumb' was that young people in full time education at school would usually be admitted to paediatrics but young people who were, for example, in a work-based training scheme would be admitted to the adult units.

- Information leaflets were available in the waiting areas for the units, covering a range of topics such as general unit information and hand hygiene. We saw patients had also been supplied with written information, such as a leaflet about what to expect from their stay on the ICU. Leaflets we saw were all written in English, however most staff were aware how to access information in other languages when needed.
- A translation service was available for patients and their visitors. Staff knew translators could be booked for face to face or telephone consultations and told us the translators were frequently available at short notice.
- Dementia awareness training was a mandatory topic for all trust staff and this had been completed by 81.2% of staff on CTICU, 81.8% on NICU and 81.1% on GICU. There were dementia link nurses on each ICU and the provider told us a Dementia and Delirium team was available within the hospital to provide additional support for staff looking after patients living with dementia. The provider also told us that patients living with dementia would be started on the 'Butterfly Scheme' which would highlight their specific needs to staff. However, unit staff we spoke with were not aware of formal support strategies which were in place for patients living with dementia during their ICU stay.
- A designated psychologist was available to review patients who had been admitted following trauma. Staff on GICU told us there was no access to psychological support for medical patients.
- Clocks on stands were available on GICU. Staff placed these at the end of patient beds to help orientate them to the time of day.

Access and flow

- Between March and May 2016 the average occupancy on CTICU was 89%. Occupancy rates on GICU and NICU in this period averaged 83.2% and 78.6% respectively. These occupancy rates were in line with the national average, however were greater than the Royal College of Anaesthetists recommendation of 70% critical care occupancy. The recommended occupancy rates allow units to be able to take in more patients should there be an emergency. If a unit is at a higher occupancy, it is unable to respond to emergency admissions and may find they are required to step-down patients too early or transfer patients to other hospitals out of their locality.

Critical care

- Notes we reviewed showed unplanned admissions were admitted within four hours of the decision to admit being made. Patients were reviewed within 12 hours of admission to critical care across the three units, which was in line with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. Although performance in these areas was not formally audited, the critical care leadership team were confident that these standards were consistently met due to the ICU consultant job plan arrangements that meant ward rounds were completed 12 hourly.
- ICNARC data showed patient length of stay on GICU and NICU between April and December 2015 was considerably shorter when compared with other similar units nationally. Mean length of stay on CTICU was in line with other similar units nationally.
- Recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units identify that patients should not be transferred to other units for non-clinical reasons. ICNARC data from April to December 2015 showed there were no patients transfers out of the unit for non-clinical reasons on GICU and NICU. Two patients were transferred out of CTICU for non-clinical reasons during this period, which was in line with other similar units nationally.
- Between April and December 2015, 2% of bed days on GICU, 2.2% on NICU and 3.8% on CTICU were provided for patients experiencing a discharge delay of 8 hours or more. This performance on GICU and CTICU was better in comparison to other units nationally, and in line with other units for NICU.
- Patients discharged from critical care 'out of hours' between 10pm and 7am are nationally associated with worse outcomes. ICNARC data from April to December 2015 showed 10 patients on GICU, 18 on NICU and eight on CTICU were discharged out of hours. This was better performance than other units nationally for GICU and CTICU and in line with national performance for NICU.

Learning from complaints and concerns

- Staff told us they tried to manage complaints at a ward level, by liaising with patients and their families to try and resolve any issues immediately. Any concerns from patients or their families were escalated to the ward matron, who would ensure a satisfactory result was achieved for the people concerned.

- Staff told us they directed formal complaints to the patient advice and liaison service (PALS) within the hospital. Between June 2015 and June 2016, there was one formal complaint on GICU, one on CTICU and two on NICU. All but one complaint was responded to and closed within an appropriate timescale.

Are critical care services well-led?

Good



We rated this service as good for well led because:

- The leadership team demonstrated appropriate responses to issues identified, such as gaps in the critical care service specification standards (D16) 2015, a review of the current outreach provision and increased in house training opportunities for staff.
- We saw examples where concerns from critical care were escalated appropriately within the trust, for example issues taken to the trust-wide Patient Safety Committee.
- We saw innovation across the units, including participation in research, journal publication, creation of a recruitment nurse post and use of social media to disseminate key information to staff.
- There was a positive culture across the service; staff spoke positively about the leadership team and felt confident to raise their concerns.
- A combined and integrated vision for the ICUs was in place and staff were aware of the overarching vision for the service.
- Suitable governance arrangements were in place and used effectively, and the leadership team had been involved in improving governance processes at a nearby hospital whose performance had been poorly rated during their own recent inspection.

However;

- Underreporting of incidents, including those situations evidenced in morbidity and mortality meeting minutes, had not been identified as an issue by the leadership team.

Critical care

- The risk register did not fully document all risks identified across the units and mitigating actions were not always sufficient to address risks.
- Other than feedback forms, we did not see evidence of engagement with patients or the public to develop and improve critical care services.
- The leadership team did not identify oversight of the satellite areas as an area for concern, despite us identifying some safety concerns in these areas (such as poor completion of resuscitation trolley checks on CTICU A).
- Staff on each ICU were aware of the overall aims for each unit, but were unclear how their role contributed to the plans identified.
- The leadership team identified the need for them to acknowledge that the redevelopment of GICU and NICU was not imminent and needed to implement a short term vision in the meantime. Some of the team felt that developments around the productive ward project had mitigated some of the risks associated with the environment and the continuation of this should be their short term vision on both units.

Vision and strategy for this service

- The overarching vision for the critical care service was to provide a world-class critical care service and to develop an internationally recognised research facility in critical care. The vision for critical care was displayed on posters throughout the units and staff were aware of the themes identified in the vision.
- In CTICU senior staff were working towards the development of veno-arterial (cardiac supporting) extracorporeal membrane oxygenation (ECMO) service. Their previous plans to commence a veno-venous (respiratory supporting) ECMO service had been turned down, however senior staff felt a VA ECMO service would also complement their cardiothoracic surgery caseload.
- Staff were also hoping to expand the CTICU A area to encompass the three beds still used as the coronary care unit. They described how the high levels of capacity within CTICU would be reduced if these beds could be obtained and explained that this would reduce the numbers of procedures cancelled due to a lack of CTICU beds.
- To achieve the desired vision, senior staff told us plans had been submitted for the expansion of NICU three years ago; however, this had been put on hold due to financial pressures on the trust. No other clear strategic plans for developing the NICU service were identified.
- The environment of GICU was seen as a major limiting factor for any kind of development of the service in this area, and so the vision for GICU related to an environment redevelopment. It was unclear what specific short-term vision was in place for GICU.

Governance, risk management and quality measurement

- Monthly directorate meetings were held to discuss issues affecting the provision of critical care across all units. This included discussion about safety and quality, as well as financial and strategic items.
- Monthly clinical governance or care group meetings were held on each unit. Minutes we reviewed showed a variety of quality, risk and safety topics discussed at each meeting. Senior staff told us the key information from these meetings was disseminated to ward staff in monthly staff meetings. GICU provided staff meeting minutes which demonstrated evidence that this occurred, however no staff meeting minutes were available for CTICU or NICU, indicating an informal approach to these meetings were used.
- Senior staff were confident staff were reporting incidents when required and had not picked up missed opportunities for incident reporting, for example situations highlighted in the morbidity and mortality minutes.
- The matron on CTICU told us some members of staff worked on night shifts full time (7.0WTE). To ensure these staff members received face to face governance updates, the matron stayed late one evening per quarter to meet with the staff and handover key information.
- Critical care outreach service meetings began in June 2016 and senior staff planned to hold these regularly to review the outreach service provided by critical care. Minutes from the service meeting indicated plans to complete mapping exercises and complete implementation plans to develop the service further.

Critical care

- Examples were noted where concerns identified by critical care staff were escalated to trust wide meetings, such as the results of the NEWS audits taken to the Patient Safety Committee.
- The environment on GICU was identified as a major challenge on several occasions throughout our inspection. Staff reported that the service had outgrown the area they were currently working in and many estates issues arose. For example, there were issues with night lighting on the unit and this was recorded on the risk register. Staff reported a variable response to estates issues although told us this had improved since the new director of estates had been in post.
- Senior critical care staff, including the clinical director and head of nursing and governance, were responsible for overseeing risk management, including the maintenance of the relevant risk register. There were a total of eight risks listed on the register and these appropriately reflected most concerns regarding critical care. However, risks regarding cross infection between patients in GICU were not fully documented.
- The risk register did not demonstrate that identified risks were fully mitigated. For example the risk listed as "...medication errors or medication being missed due to issues with computer hardware on NICU" was identified as being mitigated by reporting faults and keeping a log of issues. However, this did not address the problem of patients potentially missing medicines due to this issue. The risk of cross infection due to small bed spaces was also not fully mitigated.
- The unit had completed self-assessment of the critical care service specification standards (D16) 2015. This meant a gap analysis had been completed, allowing identification of any areas where the unit was not meeting current recommendations. The unit demonstrated full compliance with 69.5% and partial compliance with 30.5% of the standards measured. Some plans were in place to address the areas of partial compliance, for example the ongoing work regarding detecting and responding to deteriorating patients on the ward.
- In line with the trust's transformation project, critical care had recently begun a review of the 'outreach'

service provided by the hospital. Their plans included introducing more robust systems to recognise patient deterioration early on the hospital wards and to review staff responses to deteriorating patients.

- We identified a number of areas where the satellite HDUs were not up to the same standard as the main ICUs. We discussed the HDUs with the leadership team who felt the downfall of the HDU areas was poor efficiency rather than safety. However, we were concerned that the leadership team did not have oversight of some aspects of safety (such as poor completion of resuscitation trolley checks on CTICU A).
- Across the ICUs, the leadership team responded to difficulties in recruiting band six nursing staff by altering the skill mix through the recruitment of additional band five staff instead. They described how this had diluted the current skill mix, but explained that rosters were carefully considered and risk assessed to ensure there were sufficient senior staff on duty to support more junior nurses.
- The leadership team had recently visited other ICUs to compare practice and share learning.

Leadership of service

- Clinical leadership for the ICUs was the responsibility of the clinical director of adult critical care, with support from the general manager and care group leads for each unit. The head of nursing and governance, who was supported by a matron on each unit, provided nursing leadership for the ICUs. The supernumerary nurse in charge of each shift provided additional leadership on the units.
- We observed the leadership team on the ICUs. We noted that staff knew who they were and that the leadership team knew many of the unit staff members by name. Staff told us the leadership team were visible throughout the ICUs and they would feel comfortable approaching any of them with concerns or ideas.
- Staff at all levels, including senior nurses and housekeeping staff, told us their roles were valued by the leadership team and that the management cared about them as individuals. They felt their work was appreciated and acknowledged by the senior staff. The

Critical care

NHS Staff Survey 2015 demonstrated critical care attained the second highest score in the trust for the 'Recognition and value of staff by managers and the organisation' domain.

Culture within the service

- Staff told us they enjoyed their work and results from the NHS Staff Survey 2015 supported this, with critical care achieving the fourth highest staff satisfaction score across the trust. The survey also showed critical care staff reported the lowest rate of work related stress in the last 12 months throughout the trust.
- There was a positive and friendly culture on all units. We observed staff worked together to complete tasks and ensure suitable patient care took place, such as when administering medicines and during lunch breaks.
- Staff were keen to share their knowledge with each other and we observed staff asking each other for help and guidance on the units. Staff told us their individual strengths were recognised and used by other members of the team.
- Most staff felt able to constructively challenge each other, including more senior members of the team such as the consultants. The staff who were not confident challenging others personally, told us they would seek support from the nurse in charge and ensure that any concerns were raised.

Public and staff engagement

- Staff on NICU won a trust team of the year award in conjunction with staff from midwifery and neonatal ICU for their collaborative work caring for a mother and her unborn baby.
- Sisters' away days were held across the units to development staff skills, knowledge and teamwork. Annual away days were also organised for staff teams within each ICU.
- Staff on CTICU described organising team clinical days where staff from each team on the unit worked together during the same shift. They told us this promoted "team spirit" and helped boost morale.
- Senior staff on CTICU produced an annual report outlining the activity statistics for the previous year and any key messages, including welcomes to new staff and congratulations to staff who had completed various course or qualifications.

- Registrars, specialist trainee and foundation year doctors were invited to provide anonymous feedback about the ICU consultants every six months. The trainees were asked to comment on a number of key domains, such as supportiveness and friendliness of the consultants. Group results were provided to the ICU consultants, as well as their own personal results.
- Other than feedback questionnaires, we did not see evidence of engagement with patients or their relatives in terms of developing services to meet patient needs.

Innovation, improvement and sustainability

- Staff completed research on the critical care units and had articles published in medical journals, for example the 'Journal of Critical Care'. Staff also presented their work at international conferences, such as the 'International Symposium on Intensive Care and Emergency Medicine' and 'Euroanaesthesia Conference'. A number of research studies were ongoing at the time of our inspection, for example the '• The leadership team identified that most staff were unlikely to read lots of email sent to them with various reminders or clinical updates and recognised the opportunities that social media presented for disseminating information. A critical care social media group was set up to facilitate information sharing across the units, including messages of thanks from patients and updates on stock storage locations. Feedback from staff was positive, although this had not been formally assessed.
- To address the recruitment difficulties, a band 7 nurse was identified as the recruitment lead for all three units. This staff member was the contact point for all new starters and HR processes prior to any staff member commencing work on the units. Feedback from staff throughout the ICUs suggested this post had reduced the length of time posts were vacant for, although this had not been formally audited.
- The leadership team were involved in supporting governance and management processes at a nearby hospital whose performance had been poorly rated during their own recent inspection. They described their involvement at the other hospital as a key learning

Critical care







opportunity and explained that they had been able to introduce new processes, such as the critical care outreach governance meetings, off the back of their experience elsewhere.

- Staff identified that high levels of noise were a problem on the ICUs, particularly on GICU, largely due to the unit environment. At the time of our inspection, a member of staff was completing a research study relating to this, however no other mitigating actions had been put in place to reduce noise in the meantime.
- Due to the cost savings required at trust level, we were told several times that the education budget for critical care staff had been significantly reduced. Ward and senior critical care staff were concerned about the knock on effect this would have on staff development and skill mix. Senior staff described focusing the

education budget on ICU course completion to maintain compliance with the recommendation of a minimum of 50% of ICU nursing staff to be in possession of a post registration award in critical care nursing. They anticipated that maintaining this compliance with a reduced budget would be unlikely and they would fall below the 50% standard within one year. To mitigate these risks, they were focusing on 'in house' skill development and concentrating development opportunities on new or inexperienced staff. Senior staff also acknowledged this could have an additional knock on effect on the retention of more experienced staff.

- Staff described how ordering of supplies and consumables had been standardised across the units as much as possible to help cuts costs in these areas.

Maternity and gynaecology

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

Information about the service

St George's University Hospitals NHS Foundation Trust Maternity Unit provides both maternity and gynaecology services mainly to women in Wandsworth. The maternity unit is a regional referral centre for women with complex pregnancies. Some specialist gynaecology services are offered to a wider population.

The maternity service is a medium sized unit. There were 5161 births during 2015.

The maternity unit consists of an obstetric consultant-led delivery suite (84% of births) with a midwifery-led unit, alongside (16% of births). The delivery suite in the Lanesborough Wing of the hospital has two triage rooms and 14 delivery rooms. There are two dedicated obstetric theatres, a four bedded recovery bay and two high dependency rooms. There is a suite for bereaved women, their partners and family. The delivery rooms have access to gym balls and mats so women can move around in labour. Maternity triage operates by telephone line to the delivery suite. There are two assessment rooms for those who are asked to come into the unit for examination or monitoring.

The midwifery-led unit, the Carmen Suite, has three delivery rooms, with ensuite facilities. Two have birthing pools. There are about 70 deliveries a month on this midwifery-led unit. Five teams of community midwives run antenatal clinics in local GP surgeries and health centres. Community midwives visit women immediately after they

return home with their babies. A small home birth community team (Rainbow) supports women in Wandsworth and some parts of Merton who wish to have a home birth. Fewer than 2% of women give birth at home.

There are inpatient antenatal and postnatal facilities on the fourth floor. There are 12 antenatal beds and 32 postnatal beds on Gwillim ward. This includes eight single rooms, two with ensuite facilities and six 4-bedded bays. The maternity unit is supported by a level 3 neonatal unit at St Georges Tooting, for babies requiring medical care after birth.

A maternity day assessment unit, for women with pregnancy concerns, but not in labour, is open daily from 8am to 8pm. A fetal medicine unit sees women referred from South West Thames region and beyond. It is open from 9 am to 6 pm on weekdays.

The gynaecology service provides a walk in early pregnancy unit for women in early pregnancy, up to 14 weeks. The Early Pregnancy Assessment Unit (EPAU) is nurse-specialist led and has two treatment rooms including a room for scanning and is open 6 days a week from 9am to 11am on weekdays and Saturdays.

An acute gynaecology unit (AGU) provides an emergency service in which most patients are seen, scanned and treated during a single day for conditions such as ectopic pregnancies, pelvic pain or complications of ovarian cysts. Patients with gynaecology problems who present to A&E are referred to the AGU. It is open from 9 am to 8pm every day.

There are both emergency and planned gynaecology services, with outpatient and inpatient care. A team of gynaecologists receive support from specialist gynaecology

Maternity and gynaecology

nurses, general nurses and healthcare assistants. Outpatient clinics take place on weekdays for general gynaecology, colposcopy, outpatient hysteroscopy, treatment for miscarriage, termination of pregnancy services and pre-operative assessment. The hospital treats gynaecological cancer, jointly with another trust. The hospital is one of two centres in London able to offer all options for fibroid treatment. This includes 'keyhole' surgery, open surgery, uterus conserving surgery and hysteroscopy surgery. There is a 12 bedded ward, Champneys, for gynaecology in-patients.

The former urogynaecology service was suspended in 2015. Patients are now referred to another nearby trust. A Paediatric Adolescent Gynaecology service is run by the paediatric team, and is not covered in this report.

We visited all areas of maternity and gynaecology services and spoke with more than 50 members of staff, some individually and others in joint meetings, handover sessions and focus groups. This included staff of all grades including midwives, doctors, consultant obstetricians, domestics, maternity care assistants, receptionists, ward managers and members of the senior management team. We spoke with 14 women and 6 relatives from both gynaecology and maternity and reviewed in detail at 10 sets of patient notes in maternity and 5 in gynaecology as well as looking at patient observation charts. We observed the provision of care, staff interactions, the availability of equipment and the environment. We reviewed written material provided by the trust in advance, such as policies, guidelines and safety protocols and we reviewed formal arrangements for audit and the management of risk in order to evaluate the governance arrangements

Summary of findings

Overall we rated maternity and gynaecology services as good although we judged some aspects of the services to be outstanding:

- Year on year reductions in key indicators for maternal outcomes, often exceeding national norms.
- The acute gynaecology service offered a highly effective and timely service in acute gynaecology and early pregnancy.
- There was outstanding performance in relation to supporting women who had pregnancy loss.
- The service provided safe and effective care in accordance with recommended practices.
- There were well-developed care pathways in maternity services for women identified as being 'at risk' because of medical conditions or vulnerability and the service had staff with expertise in several specific conditions of pregnancy.
- Staff were confident about reporting incidents and said learning from these was shared with staff.
- Midwives and doctors worked well together as a team without hierarchy.
- There were clear pathways for all pregnant women to access the right services for their needs, with excellent access to specialist midwives.
- Staff demonstrating compassion and patience towards women.
- Staff were conscious of the need to protect the dignity and privacy of women in all areas of the service.
- Antenatal clinics were available at many locations in the community thus minimising women's need to travel.
- There were many good examples of pioneering work and innovative practices such as home monitoring of hypertension in pregnancy, using a mobile phone app.

However:

- Not all women received continuity of care from midwives.
- The experience of midwives in the maternity unit was not being used in developing the hospital strategy for maternity in line with evolving national developments.

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- Midwives felt concerns they had expressed about the management of the service were not listened to at executive level or board level.

Are maternity and gynaecology services safe?

Good



We rated safe as good because:

- The service had established systems in place for reporting, investigating and acting on incidents and serious adverse events. Information was collected and reviewed around standards of safety, and learning was shared with staff to make improvements.
- Medicines were stored and managed appropriately.
- The environment in which women received care was suitably safe and clean.
- Staff planned and provided care and treatment safely. Women had confidence in the in the skills of midwives, nurses and doctors.
- Midwives and doctors worked well as a team without hierarchy. There were clear handovers of care at shift change.
- Staff followed safety guidance for infection prevention and control.
- Over 80% of staff in maternity and gynaecology had completed their mandatory training updates, in areas such as infection control and prevention, health and safety and emergency procedures. Over 90% of doctors had completed their mandatory training in 2015.
- There were sufficient maternity, gynaecology and nursing staff. There were plans to increase the number of consultants to provide 168 hours a week cover in maternity.
- Records related to the care of each woman were completed accurately. Safeguarding procedures were operating well.
- Equipment had been safety checked and was clean and readily accessible.
- The infant abduction policy was up to date.

However:

- Mortality and morbidity meetings were held regularly in the maternity service but no minutes were taken to help to spread learning beyond those attending.
- Ward clerks were not available 24 hours.

Incidents

Maternity and gynaecology

Maternity

- There was a never event in 2015 relating to a retained swab after cervical cerclage (a procedure in which stitches are used to close the cervix during pregnancy to help prevent pregnancy loss or premature birth). Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. They have the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
- Following the Never Event we saw staff had put measures in place to avoid retained swabs in future. A new standard operating procedure had been introduced in February 2016: swabs must be counted and double signed after every delivery including when there was no perineal trauma repair. Swabsafe trays had to be used to dispose of all swabs. Compliance was being audited monthly and in July 2016 stood at 99.8%.
- The Patient Safety Committee reviewed action plans from serious incidents. We saw evidence of trust wide dissemination from learning on the retained swabs. There was also evidence that doctors were being held to account where adverse events had occurred, although staff said this had not always been the case in the past.
- There had been one indirect maternal death reported by the trust. This was not due to maternity care but a pre-existing condition.
- In 2015 there were 26 serious incidents requiring investigation within the maternity service. There had been a reduction in such incidents over time, from 46 in 2011, to 34 in 2014. Staff considered this was because they had learned from incidents and changed practice as a result. Serious incidents (SIs) where investigation had identified quality of care as a causal factor had reduced over time from 29 in 2011 to four in 2015. Since April 2016 seven serious incidents had been declared, although one had been de-escalated. Supervisors of midwives (SoMs) were involved in investigations on SI panels and at risk meetings. There had only been one incident involving misinterpretation of cardiotocography (CTG), a technical means of recording the fetal heartbeat to assess possible deprivation of oxygen in the fetus. This had been achieved through mandatory competency testing on CTG interpretation and focussed training on patho-physiology of risk incidents involving CTG interpretation.
- Serious incidents were reported to the Local Supervising Authority (LSA), an organisation that monitors the standards of midwifery practice, as well as to the national reporting system.
- There was a clear investigation process, beginning with presentation at a Serious Incident Declaration meeting. Women and families were offered opportunities to input to the investigation. There were two standing multidisciplinary panels to review incidents in line with trust policy for standing panels. The director of midwifery told us the concept of standing panels was under review. The panels co-opted other staff as needed. Relevant staff had training in root cause analysis including panel members. Progress and action plans were reviewed at a monthly Patient Safety Committee which reported into the Quality and Risk Committee. The process was managed by the governance midwife who chaired the panel. Extensions to the time were rarely requested. We were told there was no particular pattern in the timing of incidents. In the four incidents we reviewed there was a description of the incident, a detailed chronology of events, what staff recorded or did not record about patient care and treatment and listed findings and recommendations. The panel considered if the actions taken at each stage were appropriate in the circumstances.
- We saw the investigation reports included a section on the arrangements that should be taken for sharing learning and feedback with colleagues. Staff learned from incidents through discussion at perinatal meetings, discussion at training sessions and in Band 7 and unit meetings. The maternity risk newsletter reported anonymised summaries of incidents to encourage debate. Learning was also shared with the south west London maternity network. Staff we spoke with were aware of this. We saw a similar process in place for a serious incident in gynaecology.
- Other incidents were also reported: 1811 incidents were reported between June 2015 and May 2016. There was a trigger list for reporting incidents. Monthly risk meetings took place to discuss incidents and risks with the lead consultant, clinical director, SoMs, matrons and students in attendance. 75% concerned labour and delivery, consistent with the normal pattern of incidents

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in maternity. No specific themes stood out among the high number of no harm routine clinical and non-clinical incidents reported. Matrons reviewed incidents in their areas. Staff said they received feedback by email when they reported incidents.

- Mortality and morbidity meetings were held but not minuted, although a record of attendees was made.
- The maternity unit had not been closed since May 2015 when there had been a short closure (14 hours) because of lack of capacity in the neonatal unit.

Gynaecology

- The gynaecology service reported 124 incidents between June 2015 and May 2016. The main themes were laboratory investigations, patient treatment and patient falls but for other incident topics were held monthly Mortality and Morbidity meetings, known as Risk meetings, which discussed cases of concern. The meetings were minuted so records were available for future reference.
- There had been no serious incidents in termination of pregnancy.
- The safety of maternity and gynaecology services was enhanced because reporting, analysis of incidents and learning from these was well promoted.
- We saw action was taken to fulfil the trust's responsibilities under the Duty of Candour, and that SI reports contained a section on being open. Letters were sent to the women involved informing them of the investigation, the timetable and the process. Women and their partners were invited to discuss the findings of the investigation and they were offered a copy of the full report on completion. Post mortems were offered to families. We were told that many women chose not to be involved in investigations. The incident reporting system flagged incidents where duty of candour was likely to apply. We saw evidence of that staff had been trained on the duty of candour. There were one hour training courses for all staff, and half day courses for senior staff and consultants.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for identifying harm free care. The hospital used a variant of this called the Heatmap. The maternity ward, birth centre and delivery suite showed 100% harm free care against the Heatmap measure for the year up to May 2015. The national average was 94%.

- The maternity safety thermometer was not used by the trust.
- On the gynaecology ward heatmap we saw that there had been one patient fall in the past month, but otherwise harm free care. There had been no pressure ulcers or cases of methicillin-resistant *Staphylococcus aureus* (MRSA) or *Clostridium difficile*, also known as C.diff.

Cleanliness, infection control and hygiene

- We observed all areas of the hospital providing maternity services and gynaecology including the obstetric theatres. We found the standard of cleanliness to be good. There was evidence of domestic staff following guidance in regard to the required cleaning standards, practices and frequency of cleaning. Cleaning schedules and cleaning scores were on display in wards. We found stickers on equipment indicating they were clean and ready for use.
- We saw staff using the hand sanitisers on the wards and in the corridors. Visitors to the wards were invited to use the sanitising gel to clean their hands on entry to the ward. We observed staff washing their hands and using hand gel between examining women and giving care.
- Staff adhered to the trust's 'bare below the elbow' policy, and there was ready access to personal protective equipment, such as gloves and aprons, which we saw disposed of appropriately.
- Midwifery staff were aware of cleaning and infection control procedures for birthing pools. We saw that blood pressure cuffs were cleaned between patient uses.
- Hand hygiene audits of a sample of staff were carried out in all areas of maternity and gynaecology every six months. Results showed high standards of hand hygiene and use of personal protective equipment, 100% in maternity services and 95.4% in gynaecology.

Environment and equipment

- The midwife led birth centre provided a calm and quiet environment, with artwork on the walls. The physical appearance of the environment was recognised as important to encourage women to choose to use the birth centre. There were two birthing pools and beds and couches to support active labour and provide relief from pain. There were other birthing aids such as a birthing support 'rope' and birthing balls to promote the comfort of women in labour.

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- The unit had scored 100% in Patient Led Assessments of the Care environment (PLACE) scores for cleanliness and condition. 2016 PLACE assessments had been carried out but the scores were not yet available.
- The decor in the delivery suite, antenatal, postnatal wards and gynaecology wards was slightly worn but visibly clean. The PLACE scores in 2015 were 96% for cleanliness, 87% for condition and 97% for privacy. The national average was 90% for that year. The PLACE scores for the condition and cleanliness of the birth centre were 100%.
- Midwives told us there was enough equipment on the delivery suite although there were not always enough leads for the STAN machines (machines for monitoring the heart rate of the unborn baby). We saw CTG machines in each labour room.
- There were four single rooms, two with ensuite bathrooms, which were allocated to women with a clinical priority but could also be used as paid amenity rooms when they were not on in use by priority women.
- We noted that the temperature of the milk fridge on the post-natal ward where mothers stored breastmilk was not signed as checked daily: 7 days had been missed in June and 15 days were missed in May. If no temperature check was done it was possible that old or unlabelled milk might not have been discarded. However, we saw that when women stored milk, this was recorded in patient notes, and we did not see out of date milk in the fridge.
- Medical devices had been tested for electrical safety and calibrated recently.
- Resuscitation trolleys were checked regularly and checks recorded. The policy was that unless seals were broken, daily checking was not required although records showed that checks were done on most days.
- Staff checked resuscitaires daily and we saw evidence from signatures in a book.
- The gynaecology ward had an electronic whiteboard giving staff easy oversight of details of women on the ward and improving staff communication about patient care. In the delivery suite a handwritten board was used, although staff told us there were plans to introduce a whiteboard that would enable automatic display from the computer record.
- There were estates issues on the risk register. No clinical areas in maternity or gynaecology were affected during our inspection. However, we were shown evidence of past water leaks in some offices. The staff room on the

delivery unit was only partly useable, as half was cordoned off. There had been condensation leaks from hot water tanks in the roof space above. Estates had disconnected the overhead lighting to eliminate electrical risk. Staff told us since a new estates team had taken over, action was being taken to address these problems.

- There was a medium term plan to move the gynaecology and maternity wards from the Lanesborough Wing because of ongoing issues in relation to the maintenance of the estate. However, an inspection by the fire services had carried out an inspection of the wing following the CQC inspection and had deemed the area safe. Extra fire safety training had been arranged for staff. A water treatment inspection had provided assurance that water was safe.

Medicines

- We saw that medication was stored appropriately in locked cupboards in inpatient areas both for maternity and gynaecology. Medicine administration was recorded and signed for, with two signatures for controlled drugs. The keys were always with the named midwife or nurse in charge.
- We checked the drugs cupboards on the delivery suite and the gynaecology ward. Drugs were in locked cupboards and controlled drugs were locked and checked twice a day. We saw this recorded and drugs were correct in relation to the stock. There were books to record room temperature in places drugs were stored and we saw that temperatures were in the range 16-22 which was an acceptable range. We noted one occasion when the temperature was higher and pharmacy was informed. This was the correct procedure. However drug fridge temperatures were not checked and recorded daily, which was contrary to national guidelines.
- In one delivery room we saw 12 ampoules of lignocaine (a local anaesthetic) left open on a shelf. This should be stored in a locked cupboard.

Records

Maternity

- All pregnant women carried their own hand-held notes, mainly handwritten. There was also an electronic set of hospital notes. The triage service used a paper based

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log that was scanned and stored electronically. There were plans to move to an electronic record in triage. New sets of records were opened for women postnatally in the community. These were paper notes.

- We reviewed ten sets of maternity records. We saw that initial risk assessments were made and revisited in the antenatal period. Notes were legible, signed and dated. They recorded demographic data, multi-disciplinary care planning and appropriate documentation by medical team when they had reviewed women. An audit the previous year had found the majority of the labour ward notes were completed to a good standard, MEWS charts were started and drug charts were used correctly.
- The local CCGs provided red books, My Child's Health Record which staff gave local mothers. Red books are used nationally to track a baby's growth, vaccinations and development.

Gynaecology

- We reviewed a small number of patient notes on the gynaecology ward. These had been completed with relevant clinical information, including risk assessments for VTE, falls, and nutritional status, as well as planning and evaluation was taking place. They were legible, signed and dated in accordance with guidelines. Record keeping was part of mandatory training. We saw that patient records were stored securely on the gynaecology and maternity wards.
- Staff in gynaecology clinics reported sometimes not having medical records for patients attending for clinic appointments, despite the online tracking system for notes
- A mother's decision about pregnancy remains in the event of pregnancy loss or termination was recorded in her medical notes. HSA1 forms were also kept in patient notes.

Safeguarding

Maternity

- There was a named midwife for safeguarding. All midwives we spoke to were aware of the safeguarding midwife to whom they would report concerns. The Chief Nurse was the named nurse for Safeguarding.

- Safeguarding alerts were made on the maternity system. A purple dot in a woman's notes was used to indicate a safeguarding concern. Mothers who missed antenatal appointments were followed up and an alert was put on the maternity IT system.
- There were also specialist midwives for domestic violence and for Female Genital Mutilation (FGM). We noticed signs about domestic violence in bathrooms and noticeboards in antenatal and post-natal areas.
- We spoke to midwives about safeguarding vulnerable women at risk in the antenatal, labour and postnatal period to support the service in reducing harm to the mother, the unborn/new born baby and any other children in the family. Community midwives told us they assessed vulnerability of women early in antenatal care.
- Midwives from the delivery unit and the community discussed pregnant women misusing substances at weekly liaison maternity meetings. These involved the liaison health visitor and a hospital social worker. Where relevant, pre-birth child protection conferences were held.
- Staff told us that both FGM and child sexual exploitation were a priority for the service. The trust had a multi-agency forum for FGM which was addressing how to increase training and awareness among staff. Within the trust, an audit was planned to test awareness and action in the maternity and gynaecology services. All women who said they had had FGM were offered an appointment to attend the Opal Clinic which provided care and support for women experiencing problems as a result of FGM either in England or overseas. There was an FGM policy that staff knew about. We saw evidence of midwife training materials covering child sexual exploitation and FGM. Midwives and medical staff were required to attend level 3 safeguarding children training updates.
- Safeguarding training updates were at 88% for safeguarding children Level 3 and 75% for safeguarding adults. The audit of compliance with Section 11 of the Children Act 2004 corroborated the good understanding of safeguarding we found in speaking to staff.
- The Jade team of midwives ran a teenage pregnancy clinic. Historically Wandsworth had a high teenage pregnancy rate although this had fallen due to improved services and education. There were specific pathways for teenage parents supported by health visitors and colleagues from social services. There was an obstetrician for teenage pregnancy.

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Gynaecology

- We saw from records that all gynaecology staff were up to date with adult safeguarding training.
- The TOP clinic saw a small proportion of young people under 16 (55 in a year). In 2015/6 seven of the young people were under 15. Staff told us for children under 13 a safeguarding referral always involved police as well as social services.
- Staff asked mothers about domestic violence at booking, at 28 weeks and after the birth. We saw information about support services on display. They were also aware some women would find it difficult to disclose. There was a clinical nurse specialist for Domestic Violence and an Alcohol liaison nurse.

Security

- Access to each area of the maternity and gynaecology wards was restricted by use of swipe cards. A member of staff released the door to visitors once it had been confirmed who was entering the ward. There was receptionist on the delivery suite most of the time and always at night. Reception cover on the postnatal ward was only between 8am and 4pm Monday to Saturday, and until 8pm on Wednesday to Friday. The shortage of reception staff was on the risk register. When there was no receptionist midwives had to let people in and they were not easily able to see who was coming in from the small screen on the desk. There was no check on who visitors were coming to see. Staff might not see if someone was tailgating the person entering.
- The presence of a security guard outside the postnatal ward during visiting hours, 3 -8pm, partly mitigated the risk of too many visitors around the bedside or unwanted visitors on that ward. The abduction policy had recently been reviewed to ensure that it was fit for purpose and in line with NHS Protect standards. It had been reissued in June 2016.

Mandatory training

- The practice development midwives had an overview of training for midwives, booked staff on mandatory training and monitored the uptake of training which was over 80%. Training was partly on line, and partly face to face. Extra multidisciplinary skills and drills training took place on wards periodically.

- For all clinical staff working in the delivery suite, training in the use of fetal ECG (STAN) monitoring was compulsory, as were annual updates. Initial training was a full day and updates were half day. This was also a part of obstetricians' induction.
- Mandatory training for midwives included colostrum harvesting and milk storage on the postnatal ward.
- Agency midwives did not receive mandatory training from the trust, but had training from the agency. They had a named SoM.
- All obstetric consultants and obstetric anaesthetic consultants had yearly skills and drills training.
- Over 80% of nurses in gynaecology were up to date with mandatory training updates.

Assessing and responding to patient risk

Maternity

- There was a proactive approach to risk management.
- The hospital had agreed with commissioners to limit the number of births to about 5000. Before the cap was introduced there had been high demand from women living in north east and south east London who wanted to have their babies at a renowned teaching hospital. However the maternity unit had been built for 3500 births a year. Capping bookings at 5000 had enabled the unit to assure higher standards of safety and improve the experience of women. Women from Croydon, South East and North East London were no longer accepted for bookings. The limitation on numbers had enabled clinical staff to monitor women more effectively. The number of women having stillbirths at term had halved.
- For women using maternity services the booking appointment included a detailed risk assessment. Health records we reviewed showed that risk assessments were carried out for all women, to determine if a pregnancy and labour were likely to be low or high risk and whether a home birth or midwife-led birth was appropriate in all the circumstances. Risks considered included maternity history, multiple birth, previous caesarean section, weight, age, blood pressure and conditions such as diabetes, high BMI and complex medical disorders. We saw that on-going risk assessment was documented at subsequent antenatal visits so we were assured that referral to the obstetric team would be made if risk factors were detected.

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- Senior staff monitored activity and staffing on all maternity ward every day to assess the workload. An escalation meeting, which we attended, was held each morning with representation from midwives in all maternity areas and the neonatal unit to review any concerns about staffing, bed and cot availability, inductions, caesareans and safeguarding concerns over the next 24 hours.
- We attended the midwives morning handover and the obstetrics handover. These took place by the board showing women currently in the delivery suite. There was a possibility that discussions could be overheard if a woman or partner walked by, but we recognised there was no other suitable space on the unit to have these meetings. The meetings had a clear emphasis on risk and safety and the discussions were thorough and comprehensive with detailed cover of high risk patients.
- All women were offered ultrasound examination at 11-14 weeks and an anomaly scan at 20-23 weeks. The fetal medicine unit had pioneered non-invasive prenatal testing (NIPT), known as the SAFE test which could detect chromosomal conditions like Down's syndrome. All women booked at St George's with an increased risk on their first trimester screening were offered this test.
- Chorionic villus sampling (CVS) (testing cells from the placenta), amniocentesis (sampling of the fluid surrounding the fetus), and cordocentesis (blood sampling from the umbilical cord) was available for women who might benefit from additional tests for potential chromosomal abnormality. Fetal medicine cases were discussed in a Fetal Medicine MDT.
- When women were admitted to the delivery suite they received an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool.
- Women that had problems in pregnancy were reviewed on the DAU. From here, they could be admitted to antenatal ward for short periods of time to be reviewed regularly by the obstetric staff.
- Midwives mentioned a rise in inductions of labour and that there were occasionally more than the agreed limit of four a day. There were strict criteria for assessing women as suitable for outpatient inductions which were not a regular occurrence and were still being trialled at this hospital.
- Observations of women in recovery were recorded on the trust-wide standard recovery chart. Nurses not midwives staffed recovery.
- In maternity, they used the modified early warning score (MEWS) to monitor women to detect an ill or deteriorating woman. From observation of notes the charts were being used correctly and escalation took place as appropriate. The last MEWS audit had found the documentation of maternal observations to be consistently good and where there were changes or concerns this was generally escalated in a timely manner.
- Surgical safety checklists were used for obstetric procedures and their use audited from a sample of cases. The scores for all fields audited: Sign in, Time out, Sign out, Briefing and debriefing were 100% for planned caesarean section.

Gynaecology

- In gynaecology staff used the national Early Warning Score (nEWS) for monitoring women to detect deterioration. Compliance with nEWS was monitored trust-wide six monthly. Staff on the gynaecology ward had improved their escalation rate in response to changes in nEWS scores in response to nEWS score in January 2016 compared to November 2015 results.
- In the period from January to March 2016 compliance had fallen to 91% from the score of 100% in the previous three quarters. Data was missing for that quarter for planned caesarean sections although previous quarters had been high averaging 99%.

Midwifery staffing

- There were 202 midwives budgeted for, of which 189 provided direct clinical care.
- The ratio of midwifery staff to births within the service at the time of our inspection was one midwife to every 27 births. This was better than the London standard of one midwife to 30 births and the England average of one midwife to 28 births. This met the requirements of CQUIN. CQUIN stands for commissioning for quality and innovation and makes a proportion of trust income conditional on demonstrating improvements in quality and innovation in specified areas of patient care, in this case midwife to birth ratio.
- The staffing levels on the delivery suite were always maintained but the service was reliant on agency staff to achieve this, particularly at night and weekends when we saw from rotas that sometimes 50% of midwives might be from agencies. This was not the case on our inspection. Staff told us that the pay rates for the

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midwives working on the staff bank were not sufficient to attract them to take up bank work at St George's, because agency work was better paid. A pilot scheme had been run to assess potential financial savings by offering a more competitive bank rate, like some other local trusts. The stasis in decision making at the top of the trust meant that this had not been taken forward. Midwives worked both day and night shifts.

- One-to-one care of labouring women was prioritised and staff said this was provided in all but exceptional circumstances. At times of staff shortages, managers and supervisors of midwives were available for advice. Midwives from the Carmen suite could support on the delivery unit if they were not busy. The delivery suite coordinator was supernumerary on 98.5 % of shifts in 2015 and 2016. This was in line with best practice and contributed to efficient running of the delivery suite. A Band 7 bleep holder had a similar coordinating role on the postnatal and antenatal wards out of hours, to support staff.
- Midwives and doctors working on delivery suite were aware of the escalation process for when the unit was very busy or acuity was high. Escalation to consultants worked very well but we were told midwifery managers and supervisors of midwives did not always come in when on call. There was always a manager and an SoM on call.
- The trust ran a daily staffing check that wards in all areas completed to confirm that, after any adjustments, staffing was safe to prevent women from avoidable harm. There was a Safe Nursing Staffing Escalation Policy which we saw in use on the delivery suite.
- There were consultant midwives, one supporting and encouraging normal birth and one for maternal medicine. There was a vacancy for a consultant midwife for public health. There were specialist midwife roles for safeguarding vulnerable women, mental health, domestic violence, governance and risk, infectious disease and bereavement.
- There was a strong practice development team of midwives to provide support and training.
- The supervisor to midwife ratio was 1:15 which met the recommended ratio. Midwives said they were well supported by their supervisors. The hospital is one of two London trust's employing a full-time SoM who could focus solely on improving midwives professional standards and protecting the public.
- There were midwife shortages as a number of staff were on maternity leave and were due to return after the birth of their babies. These were covered by agency staff. Staff were not aware of a plan for recruiting over establishment to cover maternity leave and sickness, although the director of midwifery said there was a plan to reduce agency use. Staff also felt that the HR processes for filling vacancies were cumbersome which meant it could take a long time to fill vacancies.
- A separate high dependency unit (HDU) on the delivery suite took some women with complex conditions often transferred in from other trusts. It was staffed from a rota of 15 WTE midwives who had extra training in HDU work. These were mainly band 6. There was a plan to supplement staffing with HDU nurses. The unit was a level 2 unit but did not provide airway management, which is commonly the case in maternity HDUs.
- There was some rotation of midwives to work in other areas of the maternity service. Band 5 midwives rotated every three to four months, Band 6 midwives less frequently.
- The skill mix was sometimes sub optimal because of the high proportion of Band 5 midwives combined with the use of agency staff. Both these groups were restricted in what they could do which led to more senior staff sometimes feeling overstretched. Agency staff were not able to access computers or guidelines because they were not given passwords and could only access computer with the help of another midwife. An agency midwife said she had been shown around but they had not been given an induction checklist covering local procedures. This midwife had previously worked at the trust and was frustrated about the limitations on the work she was allowed to do as an agency member of staff, which made her less effective.
- There were 38 WTE community midwives supported by five maternity support workers.
- The director of midwifery said the service would be reviewing staff capacity, including scope for wider use of maternity assistants with appropriate training.
- Midwives considered the midwifery establishment to be at a safe level on the wards, including the delivery unit, albeit that this could only be achieved with the support of agency staff. They said they had breaks during their shifts. Community midwives felt more staff were needed. The maternity service was, at the time of inspection, exceeding the trust's cap of 10% of agency staff to ensure safe staffing.

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- We were told that external training had been reduced although staff we spoke with had been able to attend training they were interested in.
- The midwife vacancy rate of was 15% for the period January to March 2015. Safe staffing was met by bank and agency staff.
- Staffing on the postnatal ward was one staff member to eight women and their babies. All shifts were filled during our inspection. Staffing included a nursery nurse and a maternity support worker.
- Turnover in maternity was running at almost 9% for the year to date. Sickness rates were at 3.5% year to date which was above the target for the service of 2.5%. Senior managers told us they were working on retention strategies to reduce the turnover.

Theatre staffing

- Obstetric theatres were staffed by main theatres, and there was an induction checklist in use for staff who had not previously worked there. Maternity staff pre-booked planned caesareans, external cephalic versions and cervical cerclages on a spreadsheet. Information was later transferred to the theatre management system. A recovery nurse was allocated to the maternity unit.

Obstetric staffing

- There were 145.2 hours of resident consultant cover on the delivery suite per week, an increase from 110 hours in 2014. This ensured the high risk delivery suite had 24/7 cover Monday to Friday. All medical staff worked 12 hour shifts to improve continuity of medical care for women. A resident consultant was in the unit until midnight but then on call from a room on site. There was a long term plan to increase the cover to 168 hours thereby meeting the national standards for obstetric staffing as defined by safer childbirth, Royal College of Obstetricians and Gynaecologists (RCOG) in 2007. This was felt to be right for the complexity of births in the unit. There were two obstetric registrars at night. This enabled senior input to the management of women with complex medical and obstetric conditions to ensure a high standard of care.
- There was 12 hours of consultant cover at weekends.
- There was a second consultant for elective caesarean section lists every day. Sometimes there were four planned caesareans a day.
- Unlike many maternity units, St Georges had no GP trainees and no foundation year doctors. This had been the case for 10 years. There were always two registrars,

- one of obstetrics and one for gynaecology. There were 10 obstetricians, all working solely in obstetrics, of which seven worked on the wards and all did some out of hours cover, although two provided only occasional cover as they also held research posts. Ten consultants provided out of hours and weekend on calls for both obstetrics and gynaecology. Three of these did not provide day time cover on labour ward.
- Two clinical fellows provided medical cover for the day assessment unit and the antenatal and postnatal wards.
- A case was made, and documented in the risk register, in April 2015, for three new consultant posts. At that time the risk register entry indicated the unit was not achieving the national standards for obstetric staffing as defined by safer childbirth, Royal College of Obstetricians and Gynaecologists (RCOG) in 2007. Two new locum posts had been agreed. So, by July 2015 there were: 13 substantive consultants contributing to obstetric care, two locum consultants in post, one full time obstetric delivery suite lead and two combined obstetrics and gynaecology posts. There was a plan to increase consultant cover in the future to 138 hours a week and have a consultant resident overnight on a Thursday, the busiest night on the delivery suite.
- There was a separate 24/7 anaesthetic rota for the delivery suite.
- The delivery suite consultant was different each day but cover for the women in the High Dependency Unit had a different medical rota to give continuity of medical care to women.
- There were no junior doctors in maternity or gynaecology. One trust grade doctor rotated between gynaecology and the post-natal ward.
- The names of staff on call, including the consultant anaesthetist for obstetrics were displayed in the delivery suite.

Gynaecology staffing

- Nine gynaecologists worked at the hospital of which five did gynaecology out of hours on calls so there was regular night cover to provide a gynaecology service to ensure women were safe and protected from avoidable harm.
- There was a gynaecologist on the gynaecology ward on weekdays. The gynaecology medical team reviewed all patients each morning.

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- Some of the consultants within the specialty worked in both obstetrics and gynaecology (O&G). But others worked as sub specialists, with all of their work concentrated in a specific area of practice such as fibroid treatments or fertility.
- A doctor staffed the acute gynaecology unit and had oversight of the specialist nurse- led early pregnancy unit.
- The gynaecology outpatients unit had eight sonographers and two midwife sonographers. There was a shortage of sonographers which was affecting diagnostic performance in gynaecology. A recruitment drive was being run, but in the meantime agency staff were being employed, and consideration was being given to the need for other staff to support clinics.
- Sickness rates on the gynaecology ward were 6.5% in April which was high. Agency staff were being used to cover absences and vacancies. Acuity and staffing were reviewed daily in line with hospital policy.
- Clinical staffing in the termination clinic was stable.
- Healthcare assistants (HCAs) had been trained to support hysteroscopy.

Major incident awareness and training

- During discussions with staff, we found not all staff had undergone specific fire safety refresher training, although staff told us that this was covered to some degree in manual handling training with which they were all up to date. The midwife in charge understood the process in the event of fire.
- Staff were aware that there was a major incident procedure on the intranet and a corporate business continuity plan. The delivery suite and post-natal wards were identified as critical and essential services which would need to be maintained, and where significant failure would trigger the corporate plan. A service level business continuity plan outlined arrangements for other services.
- There was a process to cancel elective caesareans to prioritise emergencies in the event of a problem with theatres.

Are maternity and gynaecology services effective?

Outstanding



We rated effective as outstanding because:

- A strong obstetric team focused on effective intrapartum care and staff used innovative and pioneering approaches to care with excellent outcomes.
- Staff had high level training and skills in fetal monitoring to detect babies at risk of oxygen deprivation. The hospital was the national centre for training in the use of computer analysis if the baby's heart rate and heart muscle function, known as STAN monitoring. This was reflected in outcomes for women.
- The service benchmarked itself against London and national standards. It was achieving year on year reductions in emergency caesarean sections, a key measure of success. The caesarean section rate at the unit was already very low by comparison with other units nationally.
- The rate of breastfeeding on discharge was 89% and this level had been consistently maintained.
- Senior managers monitored patient outcomes continuously through the use of a rolling maternity dashboard and national and local audits thereby having a clear assurance of quality against clear goals.
- There were well-developed care pathways in maternity services for women identified as being 'at risk' because of medical conditions or vulnerability and the service had staff with expertise in several specific conditions of pregnancy.
- A multidisciplinary approach ensured women with pre-existing medical conditions had an integrated approach to antenatal care.
- The unit was strong in fetal medicine and had done pioneering work in non-invasive testing.
- Staff working in maternity and gynaecology services had access to evidence-based guidelines to inform care and treatment, and had pioneered some pathways such as the treatment of fibroids.
- Staff had many opportunities to develop their professional skills and experience.
- The gynaecology department offered a very effective acute gynaecology service, seven days a week. Women

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were often diagnosed and treated on the day. The walk in early pregnancy unit, which ran six days a week, guaranteed that all women attending before 11 am would be seen that day.

- Women's care and treatment was planned and delivered in line with current evidence-based guidance, standards and legislation.
- Women seeking termination of pregnancy were all seen by a doctor after a consultation with a nurse, to make a judgement about the grounds for termination. Staff proactively followed up women after termination to ensure the procedure had been successful.

Evidence-based care and treatment

Maternity

- Policies were based on national guidance produced by NICE and the Royal Colleges. Staff had access to guidance, policies and procedures on the trust intranet.
- Care was provided in line with Royal College of Obstetricians and Gynaecologists guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service. One of these standards was one to one care in labour. Such care increases the likelihood of a woman having a normal vaginal birth without interventions and contributes to reducing the length of labour and the number of operative deliveries. Staff told us and records confirmed that they were providing 1:1 care in labour and the postpartum period for women on almost every occasion. In any unit there will be occasions when the number of women exceed the scheduled workload.
- An induction of Labour expert advisory group had been set up to establish safe woman focused pathways and reduce workload. The induction policy had been amended in line with NICE Quality Standards on Induction of Labour QS60 (2014). Outpatient induction of labour was being developed, in line with the NICE quality standard that women can have their labour induced as outpatients, if the right safety and support procedures, including audit, are in place, and women want it. Currently most low risk patients were induced on the antenatal ward. High risk patients had their induction in the delivery unit.
- There were well-developed care pathways in maternity services for women identified as being 'at risk' because of medical conditions or vulnerability and the service had staff with expertise in several specific conditions of pregnancy. For example St George's Hospital was the referral centre for south west London for serious placental adhesion complications and supported training of other hospital staff in London
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was managed in accordance with the NICE Quality Standard (QS32).
- There was evidence to indicate that NICE Quality Standard 37 guidance was being followed for postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- There was evidence that staff audited delivery suite activity. For example a five year analysis had been carried out on the likelihood of first time mothers, and those expecting more than one baby, having a caesarean section.
- We reviewed the audit schedule for 2016 which included local audits of risk assessments at booking, VTE assessment, induction of labour, consent and postnatal breastfeeding, Maternity Early Warning Scores (MEWS) and bladder care. We reviewed audits done in earlier years and saw that there had generally been improvements from one year to the next.
- The maternity HDU on the delivery suite worked informally but effectively with the Critical Care Unit of the trust. The critical care unit provided training. Doctors said critical care staff were always available for advice. The maternity HDU was funded at a critical care tariff and operated at level 2 but did not use techniques such as CPAP (continuous positive airway pressure to keep the airways open). A named consultant anaesthetist supported the MDU. There was a lead clinician of the week to give continuity for women.
- The service took part in national audits for example the national diabetes in pregnancy audit in which 100% of consented women were audited. Last year the hospital had increased the number of women participating. The trust contributed data to the National Neonatal Audit

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Programme (NNAP) and to the Mothers and Babies:

Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK), as well as measuring Key Performance Indicators required by commissioners, such as screening and unborn safeguarding.

- A maternity guidelines group oversaw the updating of the maternity guidelines online manual. We saw evidence that this had been updated in response to external change, for example screening guidelines had been amended as part of an action plan from a recent screening review. A monthly report of changes to the manual was circulated. Most aspects of maternity services had been audited against NICE quality standards.
- The service was aligned with almost all the 27 London Quality Standards for maternity. Consultant cover was not yet 24/7 and there was not a consultant midwife for every 900 births because of financial constraints. The service had in the past used the birthrate plus acuity tool to provide guidance on staffing levels.
- The hospital was a regional centre for fetal medicine and complex gynaecological services. These services had been assessed as compliant with, or exceeding the standards of care expected of specialised services and were involved in some of the most recent developments in evidence-based treatment.
- There was evidence available to demonstrate women using the services of the trust were receiving care in line with the National Institute for Health and Care Excellence (NICE). For example, routine antenatal care was delivered in accordance with NICE guideline 62 – Antenatal Care; Routine care for the healthy pregnant woman, March 2008. The antenatal screening tests for fetal anomalies were conducted according to the Fetal Anomaly Screening Programmes Standards and there were high levels of compliance, over 98%.

Gynaecology

- The gynaecology service offered a comprehensive diagnostic service including colposcopy (for abnormalities detected on smear tests), outpatient hysteroscopy, specialist gynaecological ultrasound and biopsy. Patients could receive many of these diagnostic tests, and often treatment, in one visit. The radiology department provided imaging services (including MRI, CT and ultrasound technologies) and an onsite pathology service analysed blood, cells and tissues. A recent quality review (January 2015) had made 18

recommendations about pathology services. One of the issues was laboratory testing which was of concern both to obstetrics and gynaecology staff. We saw an action plan to improve this.

- Ectopic pregnancy was managed conservatively for 30% of women. There was little use of methotrexate to stimulate abortion. For suitable women, two pregnancy hormone tests were taken before a decision for intervention. Audit, which we reviewed, had shown this was successful for 73% of cases managed this way. All women with concerns were seen within 24 hours in line with NICE quality standard 69 which also supported the expectant management used at the clinic.
- There are few nationally required audits for gynaecology, although there are opportunities to take part in national studies. One national gynaecology study in which the unit participated was on heavy menstrual bleeding (HMB). The national recommendation was for one stop HMB clinics supplemented by a wide range of information, both of which were in place at St George's.
- There were regular local audits on the gynaecology ward covering VTE assessments, nutritional assessments and frequency and completeness of patient observations. We
- RCOG guidance and RSOP 13: 'Contraception and Sexually Transmitted Infection' (STI) Screening suggest that information about the prevention of sexually transmitted infections (STI) should be made available and all methods of contraception should be discussed at the initial assessment. A plan should be agreed for contraception after the abortion. We found contraceptive options were discussed at the initial assessments and a plan was agreed for contraception after the abortion. Patients were provided with contraceptive devices at the. These included long acting, reversible methods of contraception (LARC), which are considered to be most effective by the National Collaborating Treatment unit for Women's and Children's Health. Other contraceptive methods were also offered such as condoms, combined oral contraceptive pills and progesterone only pills.
- Women seeking termination of pregnancy were screened for chlamydia and gonorrhea (sexually transmitted bacterial infections) and for HIV (a virus that attacks the immune system). Women with positive test results were referred to sexual health services.

Maternity and gynaecology

- The processes in operation for the termination of pregnancy service met the guidelines set out by the RCOG and by the Human Tissue Authority. There was no current audit programme for the TOP service.

Pain relief

Maternity

- Staff told us that they were able to obtain pain relief or other medication for women. All the women we spoke with told us that they had received pain relief they wanted and in a timely way.
- In the birth centre, entonox (gas and air) and pethidine injections were available if required, as well as birthing pools. In the birth centre 65% of women used the pool for pain relief and about 30% had water births.
- Anaesthetists provided 24 hour cover for epidurals for pain relief where appropriate, and aimed to provide women with epidurals within 30 minutes. A continuous audit showed that between January and March 2016 82% of women had epidurals within 30 minutes and 96% within an hour. We saw an on-call anaesthetist had come in to give a woman an epidural on a weekend evening because the duty anaesthetist was attending an emergency in theatre.

Gynaecology

- Ward staff recorded pain scores in patient notes and women told us staff regularly asked about whether they needed pain relief.
- The hospital acute pain team provided advice to wards on managing patients' pain.

Nutrition and hydration

Maternity

- Women on the postnatal ward told us they had help with breastfeeding. Breastfeeding rates were high compared to the national average, with an average of 89% of women breastfeeding on discharge for the past year. The unit held full accreditation (Stage 3) from the UNICEF baby friendly initiative. This was externally assessed by UNICEF. This assessment involved interviewing mothers about the care they had received and reviewing policies, guidance and internal audits.
- Women on the postnatal ward told us it was possible to get hot food out of hours. There was also a microwave in the parents' room which women could use to heat meals bought from home.

Gynaecology

- We saw on the gynaecology ward that mealtimes were protected, and this was confirmed by audit which also showed women were weighed and showed that women had fluid and nutrition charts where appropriate.

Patient outcomes

Maternity

- The RCOG Good Practice No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity dashboard. The Maternity Dashboard serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance in a maternity service. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care.
- The trust used a dashboard that had been developed by RCOG and was also used within the South West London Maternity Network. This enabled comparative data to be used across maternity units in South West London for benchmarking and peer review, as well as being used for internal monthly monitoring.
- We reviewed the dashboard for 2015 and also up to March 2016. On the most important indicators the service was successfully meeting or exceeding national goals. For example, the dashboard showed:
- The maternity unit had the lowest caesarean section rate in London, 22.7%. (The London average was 28%). This was also lower than the UK average of 25%.
- The emergency caesarean section rate was only 7.8% compared to the national average of 14.7%. This reflected a high standard of intrapartum care. The unit had continued to reduce this rate, from 8.7% in 2014, despite the increasing complexity of births at the unit.
- The unit had continued to maintain the lowest emergency caesarean section rate in London for failed instrumental births (3%). They had reduced the rate from 2014 (5.5%), which reflected the success of their Hands On training programme in instrumental delivery for obstetricians.
- The unit had a good uptake of vaginal birth after caesarean section (VBAC) at 57.5% exceeding their goal of over 30% by a wide margin.

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- The delivery unit were succeeding in keeping general anaesthetics to a low level, 1% of women had a general anaesthetic for a caesarean section which minimised toxicity to the woman and respiratory depression in the new born baby.
- The hospital was the only teaching hospital in London to have had no cases of peripartum hysterectomy for atonic or traumatic post-partum haemorrhage, (removal of the womb at the time of birth) for the last five years.
- The hypoxic ischaemic encephalopathy rate (a type of brain damage that occurs when an infant's brain does not receive enough oxygen and blood) was 1.35 in every 1000 births. This was significantly lower than the nationally reported rate of 2.25 per 1000 births. The rate at St George's for babies with no pre-existing damage to their oxygen intake was less than half the nationally reported rate. The hospital had decreased this rate since 2014.
- The rate of babies stillborn at birth was 1.35 per 1000, lower than their stillborn rate in 2014. They had one of the lowest neonatal mortality rates in the country. The stillbirth rate for women expecting more than one baby was the same as for singleton births, which illustrated the skills of the multiple pregnancy teams. The perinatal outcomes for women with multiple pregnancies were better than nationally reported rates.
- The normal delivery rate for March 2016 was 64%, which is significantly better than the mean national figure of 45%.
- The third or fourth degree tear rate was 2.1% of women. RCOG recommended below 1.5% of deliveries but adjusted for the case mix at St George's Hospital, less than 5% was a good score.
- The proportion of induced labours was 27% against a trust goal of fewer than 28% of women having inductions. The national mean is 30%. This meant at this unit proportionately fewer women were having inductions, which carried risks of a more painful labour and a higher risk of caesarean section.
- The unit recorded postpartum haemorrhage above 1.5 litres on the dashboard and there were 140 such haemorrhage between April and November 2015 which equated to 3% of patients.
- CQC's Intelligent Monitoring had found no maternity outliers for this trust.
- The hospital performed above the national standard for retinopathy of prematurity screening in the National Neonatal audit 2014 (the latest data available) and 60% of premature babies had breastmilk at discharge.
- There had been three maternal admissions to intensive care since April 2016, against a goal of keeping this below 10 cases in a six month period.
- There had been no early neonatal deaths since April 2016.
- We saw documentary evidence, following investigation, that 7.7% of term babies were admitted to the Neonatal Unit from April 2014 to March 2015 and of these 14 babies (with a gestational age of over 35 weeks and weighing more than 1800 grams) admission was due to avoidable events.
- The goal for the unit was to have no more than four cases of meconium aspiration syndrome in six months. There had been only one case since April 2016.
- The fetal medicine unit supported the identification of serious placental adhesion complications in which the placenta grows deeply into the wall of the uterus and cannot detach after childbirth. This affects 7% to 10% of women worldwide. The maternity service had developed a new surgical technique, the Triple P procedure, which it had used on 44 women. There had only been two hysterectomies for placenta percreta (the most serious level of placental adhesion in which the placenta has penetrated the entire uterine wall) which was a positive outcome.
- The fetal medicine centre carried out endoscopic in-utero fetal surgery with good outcomes resulting, for example in improved survival, gestational age at delivery and birthweight for women with pregnancies complicated by twin to twin syndrome.
- Other regional services were provided for the management women with complex cardiac, neurological, respiratory, renal and other conditions that might be affected by their pregnancy, and the service for women with increased body mass index (BMI), a condition associated with higher maternal and neonatal mortality. 17% of women delivered at St George's had a BMI greater than 30.
- The maternal medicine team offered a multidisciplinary approach. Midwives who ensured that women with pre-existing conditions such as epilepsy or diabetes had their medical care integrated with their maternity care.
- The maternity service was involved in 14 research studies some as a collaborator and others on which they

Maternity and gynaecology

were leading. One study women (AFFIRM) was looking at whether increasing clinicians and mothers' awareness of fetal movements could reduce stillbirth. Women had the choice whether to have their anonymised data contributed to this study.

Gynaecology

- The gynaecology ward admitted women with hyperemesis, extreme nausea and vomiting in pregnancy which can lead to dehydration.
- Examinations, scans, treatment plans and assessments were carried out in the gynaecology outpatients during the week. Emergency scans and assessments were available out of hours.
- We were told that there were planned gynaecology operations scheduled on four days a week.
- The clinic organisation and outpatient care for the termination of pregnancy was effective in supporting women with serious medical conditions because there was access to other specialists, if necessary. Disposal of fetal tissue was in line with national guidance.
- There was a low failure rate for termination of pregnancy, 0.1%. All women having surgical termination were scanned after the procedure to ensure there were no retained products. Women were given sufficient information on discharge about what to expect and were given an emergency number to call if they experienced complications. Women who had medical terminations had a telephone consultation post procedure and if they had not passed any pregnancy remains were invited for a scan next day. Women were invited to return two weeks later for a check-up.

Competent staff

- Supervisors of Midwives (SoMs) were available to help midwives provide safe care of the mother, baby and her family. SoMs are experienced midwives with additional training and education which enable them to help midwives provide the best quality midwifery care. They made sure that the care received met women's needs. In February 2016 95% of midwives had had an annual review with an SoM. Those who had not completed a review were on sick or maternity leave. Group supervision was liked by student midwives, but more experienced midwives preferred one to one supervision. Student midwives and women were aware of how to contact the SoM.

- Midwives reported they were well supported by their SoM particularly in relation to safety and assisting junior staff. SoMs ran monthly breakfast meetings to raise the profile of supervision as a learning forum.
- In the Womens and Children's Directorate 73% of staff had had appraisals.
- All newly qualified midwives followed a preceptorship programme which was externally recognised as an effective programme. This enabled new midwives to become competent in cannulation and perineal suturing and gain experience in all areas of the maternity service.
- Community midwives said they were encouraged to take up training and development. Other midwives gave examples of training they had attended, although some staff mentioned that cost constraints had restricted training availability. For example, there had been no mentorship training the previous year.
- Clinicians told us the trust was very committed to training and provided excellent training on cardiotocography (CTG) interpretation and fetal ECG (STAN monitoring). STAN is a type of CTG that uses computer analysis of the baby's heart rate and heart muscle function, to give clinicians an idea of how the baby is coping with labour, and assists in reducing the risk of unnecessary intervention. There was mandatory one to one testing of competency in CTG training and situational awareness for midwives and obstetricians working in the delivery suite. There were frequent CTG refreshers, and case discussions to keep skills current. The unit is the Designated Competency Centre for STAN training in the UK.
- Staff had many opportunities to develop their professional skills and experience. Some locum clinicians told us they chose to work on the delivery unit to maintain their skills in complex situations.
- Doctors had 'Hands On' training on instrumental vaginal births.
- Nursing and support staff in gynaecology services told us they had the additional training they needed to carry out their roles safely and effectively. New staff told us they had had effective induction.

Multidisciplinary working

- Obstetricians, anaesthetists, neonatologists, interventional radiologists, haematologists and other clinicians worked effectively together with no hierarchy, each respecting the others' expertise.

Maternity and gynaecology

- We saw evidence of multidisciplinary working in fetal and maternal medicine, including with the neonatal unit.
- Consultant midwife clinics were run to provide additional support for women requiring coordinated specialist care because of medical conditions such as diabetes, epilepsy and hypertension. Links were made with the relevant specialists elsewhere in the hospital, to ensure that a joint approach met women's needs. If women with gestational diabetes were considered to be at risk of developing type 2 diabetes appropriate follow up was arranged. Staff mentioned that the number of women with diabetes had increased considerably in the past few years.
- Many staff members praised the communication and teamwork of midwifery and support staff on the inpatient wards.
- There were team handovers on the delivery suite twice daily. We noted that there was no obstetrician attendance at the midwife handover and no midwife at the obstetric handover. However, it was clear that medical and midwifery staff worked well together and respected each other's skills and knowledge.
- Physiotherapists worked with midwives in the care of women on the postnatal ward.
- Communication with the community maternity team was effective. Community midwives we spoke with told us morale and team working was good and that staff felt part of the trust, and were invited to meetings. Two staff members told us they had the opportunity to rotate of the inpatient maternity services but due to staff shortages they could no longer do this.
- No problems were reported about communication with GPs during antenatal care and discharge.
- MDT meetings were held to decide on treatment for women with gynaecological cancers.

Seven-day services

Maternity

- A number of antenatal clinics for women were run seven days a week, including weekend booking clinics run both by hospital-based and community midwives.
- The Day Assessment Unit was open every day.
- Women could ring the delivery suite at any time if they thought they were in labour. There was no dedicated member of staff to take calls, but midwives answered calls and recorded details in a book.

- Consultants worked seven days a week and a consultant was on site for 12 hours a day at weekends on the delivery suite.
- There was access to scanners, interventional radiology, pharmacy and the outreach services seven days a week.
- The two dedicated obstetric theatres were fully staffed, Monday to Friday. Out of hours theatre staff were on call.

Gynaecology

- The early pregnancy unit was open six days a week and the acute gynaecology unit was open seven days a week.
- Imaging and interventional radiology were available during the week and from on call teams out of hours.
- Consultants carried out ward rounds every day of the week.

Access to information

- There was an electronic maternity manual containing all policies and guidelines to which staff had access.
- 'ICLIP' was the internal branding for the Electronic Medical Record (EMR) at St George's which recorded patient information and test results. Midwives said this did not interface with the maternity software they used.
- Several midwives commented on the duplication of paper based and electronic systems which was inefficient. Many staff mentioned that the underdevelopment of information technology across the trust was an obstacle to electronic communication and record keeping. However, the unit had upgraded the maternity IT system in April to provide better functionality and improved reporting capabilities, and the system was now able to produce electronic documents when women were discharged. Staff reported this was an improvement.
- Community midwives told us they had to travel to the hospital to input data into the maternity software as they did not have electronic links to that system in the community. This meant they could not offer the first official antenatal appointment, (often called the 'booking appointment'), in the community. They had been told that a medium term plan was for them to have mobile devices. However, they could access the electronic medical records from the health centres.
- Gynaecology staff showed us the relevant policies were stored on the intranet. Gynaecology staff shared the same frustrations about IT systems and IT support as other staff in the hospital.

Maternity and gynaecology

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Arrangements were in place to seek consent for surgery and other procedures, including screening. We saw that consent forms had been appropriately signed in the notes we reviewed. Women told us clinicians had explained the risks of surgical and medical treatment and we saw leaflets explaining the risks and benefits of specific procedures to supplement information given verbally.
- Midwives had access to advice from specialist midwives when they had concerns that pregnant women might not have capacity to make specific decisions.
- A midwife told us some women decided not to have screening or scans and their choice was respected.
- Consent was audited trust wide. The latest annual consent audit (June 2016) demonstrated good compliance with explanation of risks and benefits as part of the consent process.
- We asked about the consent process for young people in relation to termination of pregnancy. Clinicians used a checklist to assess competence to consent to treatment, in line with Trust policy. A copy of the completed checklist was included in the young person's medical records to show the doctor had made the assessment based on Gillick competence and Fraser guidelines. (Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. It is lawful for doctors to provide contraceptive advice and treatment without parental consent providing certain criteria are met. These criteria are known as the Fraser Guidelines.

Are maternity and gynaecology services caring?

Good



We rated caring as good, although some aspects of care, such as for women who had suffered pregnancy loss or bereavement were outstanding. The reason for our rating was:

- All women we spoke with on the postnatal ward reported very positively on their experiences, and the

kindness, skill and supportiveness of staff. It was notable that even women who had had a more difficult labour than expected were full of praise for midwives and obstetricians.

- The Friends and Family Test is a measure of patient satisfaction. Feedback from this showed women and their families had a good experience in the maternity services and women and their partners told us they would recommend the service.
- The postnatal ward had a board where mothers could write comments about their care and make suggestions for improvements. The comments we looked at were very positive and echoed the views of women we spoke with.
- We saw staff behaving compassionately and with patience towards women.
- Staff were conscious of the need to protect the dignity and privacy of women in all areas of the service.
- Partners were made to feel welcome and involved in their partner's pregnancy, labour and birth, and able to stay with their partner and baby on the post-natal ward.
- Specialist staff offered sensitive management of loss for women suffering miscarriages or stillbirth.
- Women were involved and encouraged to be partners with clinicians in their care and were supported in making decisions. Both maternity and gynaecological patients told us they understood their care and treatment and were able to ask staff if they were not sure about something.
- Women seeking termination of pregnancy were offered counselling from an accredited psychotherapist.
- Gynaecology patients who had day surgery spoke highly of the kind and supportive staff in the day surgery unit and the admissions lounge. 100% of day surgery patients said they would recommend this service to friends and family.

Compassionate care

Maternity

- Women we spoke with reported that on the delivery suite they had been treated as individuals and were well supported by all staff. One woman said 'nothing is too much trouble for the staff and they made even the tense times enjoyable' and spoke of midwives' good humour and patience.

Maternity and gynaecology

- A woman who had given birth at the birth centre said she had chosen to deliver in the unit and would recommend it to a friend as she was extremely happy with the support she received.
- The postnatal ward staff offered women comment cards to express in free text what they felt was good and what could be improved. We saw some of these on display on the ward. There were many positive comments, and very few negative ones.
- Doctors and midwives prided themselves on individualised care and woman we spoke with told us how much they appreciated this
- We observed staff responding promptly and respectfully to requests for help, even when they were busy.
- Maternity services were added to the Friends and Family Test (FFT) in October 2013. In the year before our inspection scores in Womens and Childrens services had been around 93%. 100% of women recommended the birth centre, 80% recommended antenatal care, 88% were extremely likely or very likely to recommend the care the maternity ward and 87% women would recommend the postnatal service.
- The CQC maternity survey of December 2015 surveyed women who gave birth in February 2015. A total of 130 women returned a completed questionnaire. It showed that most outcomes were similar to the national average. The trust scored just below the average in response to the question about feeling they were given the information and explanations they needed after the birth.

Gynaecology

- Women spoke highly of the nursing staff on the gynaecology ward and told us care had been 'very good'.
- In the Friends and Family test 95% of women said they would recommend the service (July 2016). The response rate was 23%, although we noted in some previous months the response rate on that ward had sometimes been as low as 11%. Ward staff were working to improve response rates.
- Women were asked to complete a post care satisfaction survey after termination of pregnancy.

Understanding and involvement of patients and those close to them

Maternity

- A woman we spoke with on the postnatal ward who had come from outside the catchment area said she could not have had better care. She said that staff on the delivery suite had also been 'wonderful' and that she had good quality care and kindness from staff when the birth had not been the straightforward experience she had hoped for.
- We spoke with three mothers in community antenatal clinics. All reported they were very happy with staff support and said they had received clear and helpful information. They said they had had helpful information from midwives to help them make their birth plans.
- We observed an antenatal appointment and saw good rapport between the midwife and the mother's child. The midwife asked how the mother was feeling and answered questions about sickness, vitamins, the value of exercise and healthy eating in pregnancy, hydration, and also discussed fetal movement. They discussed national recommendations for vaccination and the benefits of breast feeding. Women told us that they felt well informed and able to ask staff if they were not sure about something.
- One woman told us that she felt the staff took her pregnancy complications seriously and involved her in all reviews of her care.

Gynaecology

- Gynaecology patients we spoke with in clinics and on the ward told us that they felt well informed about their condition and that clinical staff had explained procedures clearly.
- A patient who had a procedure said the anaesthetists had explained what would happen and checked their understanding before going ahead. The surgeon had given a full explanation of what would be done, and the risks and benefits of treatment.

Emotional support

Maternity

- Women we spoke with and their partners commented on the supportiveness of the midwives before, during and after birth.

Maternity and gynaecology

- The specialist bereavement midwife said she helped couples with emotional and practical support, and also provided support to midwives involved in bereavement. This service extended to women when they became pregnant again and they could be offered support and reassurance, including additional scans and tests. She supported about 80 women a year. Counselling was available for women suffering loss, and the consultant and bereavement midwife visited women after three months. The chaplaincy service was also available and this service was provided exceptional compassionate, personalised care to meet women's social and emotional needs. Midwifery staff and women told us they valued the support of the bereavement midwife.
- The chaplaincy team supported people of Muslim, Jewish and Christian faiths (Free church, Roman Catholic and Anglican) and had volunteer representatives from other faiths. The team supported women in discussions about funerals for their babies. Chaplaincy staff also discussed options with women who had pregnancy losses at any time in their pregnancy.
- The hospital had a contract with a sensitive funeral provider that could provide simple ceremonies for babies in various locations.
- There was an annual Neonatal Memorial Service for those of all faiths and none. This was said to be well-attended by families, some returning for a number of years after their baby's death.

Gynaecology

- Women we spoke with said they felt able to speak to staff if they were worried or anxious and had found nurses supportive. The chaplaincy service offered spiritual support.

Are maternity and gynaecology services responsive?

Good



We rated responsive as good because:

- Women's individual needs and preferences were considered when planning and delivering services. There were arrangements in place to support people with particular needs.

- There were clear pathways for all pregnant women to access the right services for their needs, with excellent access to specialist midwives.
- Antenatal clinics were available at many locations in the community so minimising women's need to travel.
- Gynaecology services were responsive to women's needs, particularly through one-stop and rapid access clinics. They were now meeting the two week referral time for patients with suspected cancer.
- Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately. Action plans were developed and monitored in response to complaints to prevent similar problems recurring.

However,

- Not all women currently received continuity of midwife care.
- Although the service specialised in births to women with a high BMI, there were no facilities on the postnatal ward for these women.

Service planning and delivery to meet the needs of local people

Maternity

- Women were given a choice of times and dates for antenatal clinic appointments. Most women had a named midwife whom they saw at their first appointment. Women might not see that midwife at every appointment but would see one of a small team at that clinic. It was not yet possible to provide a named midwife throughout pregnancy and beyond. A continuity of care audit was planned. Mandate 13 in the NHS England Mandate 2014/15–2016/17 specifically states that "every woman has a named midwife who is responsible for ensuring she has personalised, one-to-one care throughout pregnancy, childbirth and during the postnatal period, including additional support for those who have a maternal health concern".
- Women received texts to remind them of appointments and midwives told us they were vigilant where a woman missed appointments and would follow up with home visits to ensure that women were safe. The introduction of text reminders had reduced failed attendances from 50% to 10%.

Maternity and gynaecology

- We saw a range of information on display in community clinics including about FGM, sexual health, safeguarding, how to complain and neighbourhood midwives parenting course.
- Antenatal clinics for the first main antenatal appointment took place at the hospital in the Fountain Suite, although women planning home births had their booking appointments at home.
- Experienced midwives ran a Birth Talk clinic to support women who requested Caesarean Section to inform their choice through discussion,
- We saw that there were effective and comprehensive processes for screening for fetal abnormality. In the FMU we observed a team of fetal medicine doctors and midwives who were supported by health care assistants and administrative staff. The service had multi-disciplinary clinics in for fetal cardiology, congenital birth defects, genetics, and fetal growth restriction. The clinics also provided services for the management of multiple pregnancies and their complications, and for women with sickle cell disease and thalassemia. The consultant team comprised individuals who were nationally recognised as leaders in the field of fetal medicine.
- The Mulberry team for maternal medicine ran a number of joint clinics for example a renal/obstetric clinic, a neurology/obstetric clinic, a rheumatology/obstetric clinic and a specialist epilepsy (nurse and midwife) clinic which enabled women to have good continuity of care in the antenatal period while having joined up treatment for their medical condition.
- The antenatal ward could admit women needing bed rest for hypertension, bleeding or early labour.
- Following a consultation with staff and women, the unit was developing a business case for a telephone triage to ensure women received consistent advice from a single dedicated midwife or team when they telephoned. At the time of the inspection many different midwives answered phone calls and although calls were recorded in a book, there was not always time to refer to this when giving advice.
- A woman could have one person stay with them overnight in a reclining chair. There was a separate shower and toilet for visitors on the postnatal ward.
- Visiting times on the antenatal and postnatal ward were 3 pm until 8 pm; however, partners could visit at any time. This enabled new parents to spend private time with their babies.
- Two visitors were allowed at a time (including the partner or support person for the mother). A security guard was outside the ward during visiting hours to manage the flow of visitors so wards did not become too full and noisy.
- Parenting classes were offered, run on a contract with the National Childbirth Trust (NCT). There were free workshops for expectant fathers on Saturdays to help them reflect on the impact that a baby will have on their lives. This was facilitated by a male midwife.
- For women in hospital after the birth of their baby there were daily classes, for example exercise classes with physiotherapists, or classes to help with infant feeding. There was a midwife for breastfeeding supported by two other staff. When mothers went home there were comparable services in the community.
- The postnatal ward had a model of transitional care which enabled women and babies to remain together rather than being cared for in the neonatal unit. A registered nurse was employed to support this service and care for between eight and twenty babies a day

Gynaecology

- Women needing treatment for hyperemesis (extreme morning sickness in early pregnancy) were admitted to the gynaecology ward.
- Many gynaecology procedures did not need women to stay overnight stay in hospital, so a high proportion of women had procedures in the day surgery unit. This was a self-contained unit separate from the main theatres, with five theatres, a recovery area and seats for patients waiting to be discharged.
- There was a clear care pathway for termination of pregnancy for women referred by their GP or family planning clinic. The service was for women in Wandsworth, Sutton and Merton, and also saw women with medical conditions that had associated high risk factors. An external provider ran the booking service under contract. There were two clinical sessions (Monday and Friday) and one operating list a week. Emergency referrals were seen at the next clinic day and all other women within 10 working days. Fetal medicine patients requiring termination did not need to wait for an appointment and were seen as soon as possible.
- Counselling was available. Women could wait a few days before making their decision to terminate the pregnancy. A very small percentage changed their minds.

Maternity and gynaecology

- Women could choose between a medical termination of pregnancy (known as MTOP), a surgical termination of pregnancy (known as STOP). Between 9 and 15 weeks the method offered was a surgical method using suction. Women found to be more than 15 weeks pregnant were referred other providers.
- From April 2015 to March 2016 there were 491 medical terminations and 129 surgical terminations. The total numbers had fallen from a total of 740 in 2014/15. Contraception was arranged for women having terminations. The doctors performing terminations were employed by the trust. Locums were not used.
- A medical termination means taking two sets of pills, orally, over two visits, usually 48 hours apart, which ends the pregnancy. Women would have their first tablet at the clinic and have their second tablet by visiting the TOP nurse on the gynaecology ward. Surgical terminations were carried out as day surgery, by a lead consultant or registrar.
- Women had two months from their date of discharge to decide on the disposal of pregnancy remains whether they had pregnancy loss or termination, or when a baby was born with no signs of life. The decision followed thorough discussion with the nurse, midwife or chaplain. In all cases under 24 weeks gestation the chaplaincy/spiritual care team could make arrangements for communal cremation, or for individual cremation or individual burial in a shared grave, either of which the mother could attend. The mother could make her own arrangements if she wished. Chaplains for people of different faiths, or none, could provide an individual funeral service, religious and non-religious, depending on people's wishes that was free to mothers. All the options were in line with the guidance of the Human Tissue Authority (HTA).
- Average length of stay on the antenatal ward was less than a day.
- There was an enhanced recovery process for caesarean section so many women went home the following day. In addition, there was 24-48 hour following up by a community midwife. There was a leaflet for women explaining the process to support verbal explanations.
- Occasionally it was necessary to delay an induction of labour or elective caesarean if the delivery suite was very busy. This affected one or two women a month, compared to a goal of under four a month.
- The unit had taken steps to reduce the number of women that it was unable to accept for in utero transfer for medical conditions by better mapping of clinical activity. In 2015 there were 32 women whom they could not accept, compared to 42 women in 2014.
- The service was expecting increased demand for maternity services especially from Wandsworth where the birthrate was rising. St George's were discussing future plans for the area with Wandsworth and Merton CCGs, as part of a subgroup of the wider South West London collaborative commissioning project.
- Wandsworth was one of NHS England's 'Maternity choice and personalisation pioneers', following the National Maternity Review, which would involve St George's maternity service in some changes.
- One area of the service that staff were finding it difficult to meet was ensuring most women booked their first antenatal appointment before 12 weeks and six days. This timing was to ensure some screening tests, such for an inherited condition such as sickle cell disease were detected early in pregnancy. The service was booking 83% of women by that date. The 90% target was challenging as there are elements over which midwives had limited control such as delays in referral by GPs and women's choices when booking. Work was taking place to improve information for women pre-conception so they recognised the importance of early screening tests.

Access and flow

Maternity

- Midwives were trained in examination of the new born and at least two women were discharged before 11am each day. The service was also achieving an average two day length of stay for normal deliveries and 3.5 days for caesarean section. Most women who gave birth on the midwife led unit were discharged from there. Examination of the new born was available to women after they had been discharged from hospital. This helped to maintain access and flow.

Gynaecology

- The gynaecology diagnostic and outpatient treatment unit included the Emergency Pregnancy Unit and the Acute Gynaecology Unit as well as a range of clinics many of which operated on a one stop basis where conditions were diagnosed and treated in one visit.
- The gynaecology service had exceeded the 93% standard for two week waiting times for suspected cancer in June 2016. The score was 96%. Although the

Maternity and gynaecology

service had not met the standard earlier in the year, extra clinics had been arranged for colposcopy, (a medical diagnostic procedure to examine the cervix) and hysteroscopy (a procedure used to examine the inside of the womb). Ensuring all relevant patients were seen within two weeks was part of a trust wide recovery and sustainability action plan, which was reviewed weekly by the Trust cancer performance meeting and externally by commissioners and NHS England.

- In June the gynaecology service did not meet the 62 day cancer target, although in April it had achieved the target (for 85% for people with gynaecological cancer to start treatment within 62 days). On average over the past six months the score had averaged 77%.
- The number of cancelled gynaecology procedures averaged two a month, although the numbers had risen in the first three months of 2016 to four a month. Agency staff were being used to increase gynaecology ultrasound and a significant reduction in breaches of national cancer targets had occurred since April 2016. Records showed improvements against the agreed trajectory.
- Gynaecology patients told us that call bells were answered promptly and that they were well cared for during their inpatient stay.

Meeting people's individual needs

Maternity

- All women with pregnancy concerns could refer themselves to the early pregnancy unit (EPU), even if they simply had anxieties rather than symptoms. The EPU was for women up to 14 weeks gestation. 44% of women self referred. A woman seen in EPU had a consultation, a diagnostic transvaginal ultrasound scan and any management required. Follow up appointments were offered. All women arriving before 11am were guaranteed to be seen that day. In many other units they would have been asked to return next day. The one day service was much appreciated by women who were keen to have an answer to their concerns as soon as possible.
- Women between 14 and 19 weeks gestation were directed to the Acute Gynaecology Service. After 20 weeks gestation they could attend the Day Assessment Unit.
- There was an interpreter service which was used for face to face appointments over 40 minutes, and for complex

appointments. The trust reported translation from over 60 languages. For shorter appointments staff used a telephone language service. Sign language help could also be arranged. There was a film in English, Arabic, Tamil, Greek, Japanese, Polish and Spanish on the hospital's website to help women understand the procedure for epidurals.

- We also saw some information in different languages on display in wards and clinics. Staff told us they were able to print out many leaflets in other language from the intranet, and we saw this done. However, the DVD provided for women about discharge with advice on caring for their baby at home was only in English.
- The range of written information we looked at covered a broad range of topics and was clearly written. A good example was a booklet midwives gave women at 20 weeks gestation: A guide to your baby's movements in pregnancy. This had advice on monitoring fetal movements and the importance of a woman seeking help if she had concerns.
- There was support for women with mental health issues. Two perinatal mental health midwives had their own caseloads of women in pregnancy so these women saw the same midwife regularly. There was also access to a perinatal psychiatrist and psychologist through the mental health trust.
- Women coming to the birth centre did not need to go through triage. In 2015, 754 women gave birth in the birth centre (Carmen). This equates to about 62 births a month. The birth rate in the centre had been 14.5% in 2015 but had risen in June 2016 to 16% at the time of our inspection. The goal, in line with that of the South West London Maternity Network, was for 20% of births to be midwifery led in the birth centre by April 2017. This was in line the NHS Five Year Forward View 2014. Clinics were held for women who had experienced FGM, perineal tears and bladder problems related to pregnancy.
- If women wanted greater pain relief or if there was a significant delay in the second stage of labour, they could be transferred to the delivery suite. An audit of 74 transfers showed nearly 24% of women were transferred, the majority because they decided they wanted an epidural. The use of the pool was being audited monthly and there was evidence that when more experienced midwives were present there were fewer transfers.

Maternity and gynaecology

- Women booking from out of area were all seen at the hospital by a dedicated team, and not in community clinics.
- Specialist midwives supported women with infections such as HIV and hepatitis, women with multiple pregnancies, women with mental health conditions and those who had perinatal loss. Community midwives could refer women to these services. The service also had specialist community midwives to support vulnerable women including a specialist midwife for mental health and substance misuse and domestic violence.
- Postnatal booking for local women were routinely made with community midwifery services following the birth. Staff said the system worked well and it was very rare for the first postnatal visit to be missed. For women from outside the local area, the hospital faxed discharge information to their local community midwifery team.
- A birth reflections clinic had been set up in November 2015 by the SoMs for women to discuss and understand their birth experiences. Staff told us the feedback from this had been very positive. There was also an obstetrics-led debriefing clinic for women who were identified after birth and offered an appointment at 6-8 weeks later.
- Women who suffered bereavement were given sensitively designed bereavement packs including a photo album.
- The trust offered a range of gynaecology outpatient clinics for problems such as heavy menstrual bleeding, fibroids, endometriosis and polyps.
- There was a bedside tongue tie service for women whose babies had trouble feeding, in line with NICE guidance.
- Women reported that the food was reasonable and there was a choice. Meal times were protected so women could eat their meals without interruptions for clinical purposes. A hot meal was available at any time if women on the postnatal ward wanted this. A microwave in the parents' room enabled women to heat meals they had brought from home if they preferred.
- The antenatal clinic accommodation at the hospital had a small waiting area with very limited space for women who had baby buggies.

Gynaecology

- There were rarely women on the 12 bedded gynaecology ward who were not gynaecology patients.

- The gynaecology clinic waiting area became quite crowded during the day. We were told the trust was considering moving some clinics to another part of the hospital to relieve the crowding.

Learning from complaints and concerns

- Women's services had the highest number of complaints in the trust. Complaints were reviewed weekly and distributed to responsible officers for investigation and response within 25 days. A quarterly report was submitted to the Board.
- We saw evidence that Duty of Candour was observed.
- We saw an information leaflet for patients and those close to them informing them of how to raise concerns or make complaints displayed in all patient areas.

Maternity

- During 2015 the maternity service had received 55 formal compliments which was an increase on the previous year (45). However, there was only one complaint due to poor staff attitude and behaviour of staff in 2015, a reduction from five in 2013. This was achieved through a zero tolerance policy on poor behaviour and attitude of staff towards women and their families. There were also complaints about the condition of the estate and temperature control. Actions in relation to complaints were audited.
- The maternity service, as is common in other trusts, had a slightly higher proportion of complaints relating to clinical treatment and care, some of which related to their birth experience. In response we saw that the birth reflections clinic had been set up for women to reflect on their birth with a member of the obstetric or midwifery team.
- The Patient Advice and Liaison Service (PALS) analysed contacts from people about maternity services each month. Many were simple enquiries. In the first two months of 2016 there were 20 contacts but only two complaints. Information about how to contact PALS was seen on wards.
- Of 17 formal written complaints received between January and March 2015, 53% had been responded to within the standard timescale.
- Complaints about gynaecology mainly concerned communication, including scheduling of appointments and procedures, clinical treatment and cancellations (there had been 20 cancellations of surgery on the day in 2015/16).

Maternity and gynaecology

Are maternity and gynaecology services well-led?

Good



We rated well-led as good because:

- Staff were proud to work a maternity and gynaecology service that was well-respected by the public and praised by the CCG, and respected by other London hospitals for its outcomes for women, and for its training.
- Gynaecology services had been reorganised during the past year with a focus on delivering high quality care in a focused range of services. Staff understood the direction for the service.
- Risks and issues were being managed as far as possible within the constraints finance.
- There were some excellent innovations in maternity services, to improve the safety and the experience of women and their families.

However:

- Although we were told that a vision and strategy to was being developed, nothing was in writing and there was no evidence it was being jointly developed with senior midwives and obstetricians.
- There was no member of the maternity and gynaecology team at the hospital on the trust board and no named non-executive lead to champion their services.
- Some staff felt that trust management were distant from the needs of frontline staff in maternity in particular, and undervalued their achievements. Midwives reported that concerns they had expressed about aspects of the management of the service were not listened to at executive level.

Vision and strategy for this service

- There was no written strategy for gynaecology or maternity. In 2015 the long term strategy had been for the hospital to become the lead provider of maternity and gynaecology services in the region. This would have involved growth of the service. However, changes in senior staffing and trust wide cost challenges had put many plans on hold.

- The director of midwifery told us that maternity services were being reviewed in the light of the National Maternity Review (February 2016) and that this was one of the corporate objectives of the trust board. However, there was no evidence that the senior midwifery team who would be involved in delivering a strategy, were involved in developing this.
- Midwives told us in the absence of a new strategy their objectives were continuous improvement in the quality of patient care, and providing responsive, woman-centred care. They were keen to maintain the excellent clinical outcomes for which the service was known and wanted to play an active part in service development.
- The recently appointed group care director expressed clear plans for gynaecology and in discussion with staff we found these were generally well understood.

Governance, risk management and quality measurement

Maternity

- The chief nurse had board level responsibility for professional nursing and midwifery issues as well as risk management responsibility. Professional leadership was through the director of midwifery.
- The Children, Women's, Diagnostic and Therapies (CWDT) Division was headed by a divisional chair. An acting divisional director of operations had oversight of the division including its finances and human resources. A clinical director for women's services covered both obstetrics and gynaecology and each of these areas had a consultant clinical care lead. In gynaecology there was a matron and a governance lead. In midwifery, the director of midwifery was responsible for the hospital and community midwives.
- A lead midwife for clinical governance was supported by an audit and risk assessment midwife. The team looked at compliance with guidelines, performance and outcomes. There was a maternity risk management meeting fortnightly where identified themes were discussed. Recent themes had been labelling of blood samples and recognising deterioration of women promptly on the wards.
- Processes had been introduced for guideline review but the Women's division still had a backlog.
- The risk register reflected risks we became aware of on inspection, such as the need to improve the reliability of

Maternity and gynaecology

IT, the availability of sufficient hardware in the hospital and connectivity in the community. This impacted on timely recording of patient care and possible inaccuracies from the mix of paper and electronic records. Capacity for induction of labour was a high risk on the risk register. A group had been to review options in the absence of funding. Another risk had been water leaks in the offices but this had been addressed by recent roof repairs.

- Managers were aware that although the hospital was regional bariatric referral service for maternity there were no postnatal bariatric facilities. Most doors and bathrooms could not accommodate hoists. This was a high risk on the risk register. The mitigations were to provide slide sheets and train staff on the hoist and slide sheets but the space could not be improved without capital funding which had been denied.
- Midwives had not been informed about the trust workforce strategy and the impact on their organisation. They did not feel included in governance.

Gynaecology

- Changes of senior staff and in the focus of the gynaecology service meant that governance was still developing. We were told there were plans for a gynaecology scorecard to give an overview of outcomes.
- There was no specific risk register for gynaecology, although this is not uncommon in women's services. We were told a risk register was now being developed. We had identified some risks in relation to referral to treatment times for the 62 day standard, and to space in the gynaecology clinic area.
- Legislation requires that for a termination of pregnancy to be legal, two doctors must agree in good faith, that the grounds for abortion in the Abortion Act are met, and documented in a certificate of opinion. Arrangements were established to ensure that certificate(s) of opinion known as HSA1 forms, were signed by two doctors in line with the requirements of the Abortion Act 1967 and Abortion Regulations 1991. All women saw a doctor for their final consultation and consent, and that doctor signed the HSA1 form. Both doctors signing the form had full access to the woman's notes in line with good practice. Copies of the HAS1 forms were kept in patients' notes.
- The Department of Health (DH) requires every provider undertaking termination of pregnancy to submit

demographical data following every termination of pregnancy procedure performed by completion of HSA4 forms. Staff explained to women that this anonymised data was submitted. This data contributes to national reports on the termination of pregnancy. HSA4 forms were submitted by post, not electronically.

- The TOP service was carried according to RCOG guidelines; however we noted there was no current audit programme to provide assurance about the range of processes, although basic statistical information was available. For example, staff told us they believed referrals of complex cases from outside the local area had increased but no data was collected to monitor this
- Staff were not able to locate the contract with the external provider running the booking service or details of KPIs required by the CCG commissioning the service which indicated loose oversight of this service.
- A concern raised by the chaplaincy team in relation to TOP was the heavy workload was the workload involved in burial and cremation arrangements for mothers who had terminations at the hospital.

Leadership of service

Maternity

- There had been many recent changes in the trust executive team. Staff said the current team was not very visible or approachable. Decision-making was perceived as extremely slow.
- The maternity and gynaecology services related to the trust board through the chief nurse. There was no member of the maternity and gynaecology team at the hospital on the trust board and no named non-executive lead to champion their services. Staff were unsure how well the board understood maternity. It was a recommendation of Better Births that hospitals should designate a board member as the board level lead for maternity services. Some senior midwives we spoke with were concerned about understanding of maternity services at Board and executive team level.
- Midwives felt there was little senior level appreciation of the different roles in midwifery such as consultant midwives and the role of SOMs in supporting the excellent intrapartum care for which the service was well-known. They were frustrated that in an

Maternity and gynaecology

environment where cost cutting was needed midwives had not been asked for suggestions about how to make the service more sustainable. The reported a lack of success in having their concerns listened to by the head of HR.

- Ward staff and community midwives spoke positively about matrons and consultant midwives and the support they offered. We saw good examples of leadership and teamwork at ward level. Midwives said the matrons, consultant midwives and the SOMs were supportive, wore uniform and were hands-on when necessary
- There appeared to be a difficult relationship between senior management and the risk and audit team. Some senior midwives felt new management was undermining their confidence in their skills and experience. We were told of prospective changes to the governance of serious incidents to ensure that the process was managed more speedily, that a wider range of staff were involved and that all staff would need to respond more quickly to information requests. This appeared to be related to trust wide changes in risk management, but changes had not been discussed with midwives.
- Some midwives had benefited from the trust's leadership programme.
- The Staff Friends and Family Test showed that although a very high percentage of staff would recommend St George's as a place to receive care, a lower proportion would recommend it is a place to work which presented a challenge to leadership in retaining high quality staff.

Gynaecology

- There was a new group care lead in the gynaecology team after some restructuring following a strategic review. Staff said the changes had brought the team together effectively. The unit was proud of the safety record of its services, and of treatments for endometriosis and fibroids.
- Gynaecology oncologists worked at both St Georges and another local trust.

Culture within the service

Maternity

- Midwives were proud to work at the hospital and were committed to providing a good service. Many members of staff commented on excellent teamwork, respect for each other and shared values. They told us that a

number of staff who had left the service, then later returned because they valued the empowerment of midwives at this hospital. Some staff travelled long distances to work in the unit because of the opportunities provided. However because of the current skill mix with high proportions of Band 5 and agency staff, senior midwives reported feeling under pressure.

- Staff at the focus groups said there were effective working relationships between midwives, nurses and doctors. Midwives on the unit felt empowered and felt able to work on equal terms with doctors, each respecting the others' expertise. We saw that medical staff were visible on the wards.
- Some midwives were disappointed that an element of apportioning blame in incident investigations had emerged over the past six months. Previously there had been a non-punitive and trusting atmosphere when the purpose of incident investigation had been seen as an opportunity to learn and develop. They considered there was a risk that this would damage the open reporting culture which they valued.

Gynaecology

- Staff morale among obstetricians and nursing staff in gynaecology was good.
- Nurses and midwives in maternity and gynaecology reported doctors at all levels were very approachable and staff worked together without hierarchy.

Public engagement

- There was a maternity services liaison committee known as the Maternity Forum which met every two months. We saw the notes of the meetings in January 2016 and saw that this was well attended by senior midwives, clinicians and users of the service. Current themes and issues were discussed and the forum had input into work on revising maternity notes. There was also a postnatal forum.
- A Birth Centre working party had been set up to improve the environment through consumer engagement. Links had been made with a local art college to develop art work with the community through local students. This had been launched on International Midwives Day in May 2016

Maternity and gynaecology

- Women and their families could give their feedback on their experiences on comment cards on the post-natal wards. 'You said we did boards' were seen demonstrated that staff listened to patient's views and acted on them.
- The unit was aware that there were some women in the area from whom it was hard to seek views on how to improve the service and staff were considering how to reach some of these women.

Staff engagement







- Some midwives told us they felt their knowledge and experience was not valued by senior leadership, although they were unanimous in praising the support of the cohesive operational teams in the community, the delivery suite and postnatal ward.
- The director of midwifery had not involved her matrons in developing the midwifery strategy. Staff did not feel they were engaged in making efficiency changes.
- Cost pressures on the trust had prevented IT improvements and affected improvements to the estate. This was a frustration to staff and affected morale.
- Some gynaecology staff mentioned that they did not always know about changes to the service much in advance, although they also mentioned that the clinical lead had an open and practical style of management which they valued.

Innovation, improvement and sustainability

- Medical care for women in labour was individualised and intervention was kept to a minimum consistent with protecting women and babies from harm. Staff who had worked elsewhere were very impressed by this and intrapartum care was a good experience for most women.
- The daily escalation meeting on the delivery suite was an effective and efficient means of ensuring that all operational managers were aware of the overall position for the next 24 hours: staffing, bed and cot availability, inductions and caesarean sections planned, transitional care and discharges.

- The service had piloted home monitoring of hypertension in pregnancy, using a mobile phone app. This demonstrated an improvement in patient experience by reducing their travel and childcare expenses and empowering women to become involved in their own care. This also reduced pressure on the DAU. This had been awarded the most innovative quality improvement project at a Trust Excellence in Education event in March 2016. This had led to a reduction of 334 appointments in the DAU and reduced the time of other appointments and saved 587.84 hours of midwife time.
- Introduction of the VTE clinic by midwifery led maternal medicine (Mulberry Team) to monitor compliance was a positive. Midwives had participated in a trust wide group to drive improvement in VTE prevention. Pharmacists were verifying VTE risk assessments when clinically screening postnatal discharge prescriptions.
- A working group had been set up to review triage arrangements, and consider a dedicated manned phone line. This included working with the ambulance service to reduce emergency admissions by ambulance.
- A Birth Talk clinic supported women who requested caesarean sections to ensure that they made informed choices in discussions with expert midwives.
- Anaesthetic department staff had made a video explaining epidurals (spinal anaesthesia) which was available in different languages.
- A midwifery consultant had produced a video of women's stories outlining their experience of complicated pregnancy and birth.
- The Research Centre for Fetal Medicine was active and nationally and internationally known. A change in practice resulting from research was the move to expectant management of ectopic pregnancy.
- A business case had been made to extend robotic surgery in gynaecology.

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

Children's services at St George's Hospital, Tooting comprises three inpatient wards, a day-case unit and a paediatric intensive care unit (PICU). There is a total of 57 beds. The trust provides outreach clinics for tertiary specialties including respiratory medicine, diabetes, gastroenterology, infectious diseases, oncology (as a joint Principal Treatment Centre) PTC with the Royal Marsden Hospital), neurology, endocrinology, surgery, urology, neurosurgery, trauma and orthopaedics, ear nose and throat. Paediatric outpatients are seen in the paediatric outpatient department located in the Dragon Centre which also houses the Child Development Centre.

The trust provides a paediatric service to the local population as well as providing highly specialised regional services to a population of 3.4 million. There are two paediatric medical wards, Frederick Hewitt Ward which is general medicine; and Pinckney Ward which cares for children with infectious diseases and oncology. Children were cared for in single rooms with lamina airflow to reduce the risk of infection for oncology children whose immune system was impaired. There were 15 beds comprising 11 single room cubicles and one four bed bay.

Nicholls Ward is a paediatric surgical ward caring for patients from the local population and also provides specialist and tertiary surgery for patients further afield. There was a four bed medical high dependency unit on Nicholls Ward. Jungle Ward is a day case unit which provides routine and specialist medicine and surgery.

There is a paediatric Intensive Care Unit (PICU) which comprises six PICU beds and six HDU beds and supports local and tertiary services. The neonatal service at St George's Hospital is the regional centre for the South West London Neonatal Network. The service includes a foetal medicine unit and some expectant mothers who required complex care are transferred to the trust in anticipation that their baby may require neonatal after delivery.

The intensive care service provides medical and surgical care for neonates referred from South London, and counties to the south and east of London. It is able to provide all levels of intensive care except extra corporeal membranous oxygenation (ECMO), used for babies with heart or respiratory conditions and renal replacement. Community neonatal nurses provide follow up care to mothers and babies living in the Wandsworth area. There were developmental clinics for babies born prematurely.

There were 6,462 admissions in 2015-2016. 45% were day cases, 14% were planned admissions and 42% were admitted as emergencies.

We visited the paediatric intensive care unit (PICU), Frederick Hewitt, Nicholls and Pinckney wards, the neonatal unit, the child development centre and outpatient department in the Dragon Centre. We also visited the Jungle Ward which cared for children before and after their day case surgery. We talked to 12 parents and six children, seven consultants, 10 nurses and managers. We reviewed information provided by the trust and looked at nine sets of patient records.

Children's services were managed within the women and children, therapeutic and critical care division. There were

Services for children and young people

four clinical divisions within the trust responsible for the management of all clinical services. There was a school staffed by teachers from the local authority which supported children with their education whilst they were in hospital. The hospital employed 4.8 WTE play therapists who were based in the play room adjacent to the wards. The play room was organised into areas suitable for young children through to teenagers and young adults.

Summary of findings

We rated this service as requires improvement because:

- There was a high level of staffing vacancies on the neonatal unit and paediatric wards, which meant the service had high use of agency and bank staff. Agency staff were not able to carry out all the procedures undertaken by permanent staff and contributed to delays in caring for patients.
- Children and young people with mental health conditions were cared for on Frederick Hewitt Ward, but an environmental risk assessment had not been carried out to identify ligature points and other risks to their safety.
- 53% of medical staff had not completed level three safeguarding training, which is a requirement for all staff working with children. Safeguarding training was identified as a risk on the services risk register. Access to training was a problem; there was no dedicated trainer and no safeguarding supervision for staff.
- There was a resident pharmacy service available for paediatric oncology patients out of hours or at weekends for children admitted as emergencies or whose condition required changes to their medicines.
- Equipment stored in the Pinckney Ward storeroom was not routinely checked. Equipment could be returned or removed without checking if it had been cleaned.
- Staff were not always able to access clinical information about a patient whilst records were being transferred across to the new electronic patient record system resulting in delays providing children with their medicines.
- Nursing staff did not feel supported by their leaders. They had not received feedback from their appraisals and felt support was inconsistent. They told us the culture did not feel open and staff were sometimes reluctant to raise issues.

However:

Services for children and young people

- Children were monitored to identify any deterioration in their condition.
- The results of investigations into incidents were discussed in departmental and governance meetings and action was taken to follow up on the results of investigations
- Staff could access clinical guidelines and policies which were regularly updated and based on national guidance.
- The service contributed to a wide range of national audits and undertook local audits on the quality of services provided.
- There was effective multidisciplinary working between teams based in the trust and with other organisations and networks.
- Overall levels of mandatory training were good and staff were supported with training.
- Parents and families all spoke positively about the care provided and the support they received.
- Governance structures were in place at ward level through to the new divisional structure and beyond to the board.

Are services for children and young people safe?

Requires improvement



We rated safe as requires improvement because:

- There was a high level of staffing vacancies on the neonatal unit and paediatric wards which meant the service had high use of agency and bank staff. Agency staff were not able to carry out all the procedures undertaken by permanent staff and contributed to delays in caring for patients.
- Children and young people with mental health conditions were cared for on Frederick Hewitt Ward, but an environmental risk assessment had not been carried out to identify ligature points and other risks to their safety.
- 53% of medical staff had not completed level three safeguarding training which is a requirement for all staff working with children. Safeguarding training was identified as a risk on the services risk register. Access to training was a problem, there was no dedicated trainer and no safeguarding supervision for staff.
- Only 81% of nurses had completed infection prevention and control training. This fell short of the trust's target for mandatory training. There was a risk that not all nursing staff were following the trusts infection prevention and control policies. Senior nurses were aware that not all eligible staff had been trained and told us they were responsible for ensuring infection prevention and control measures were in place and to encourage staff to complete the training as soon as possible.
- There was no pharmacy service available for paediatric oncology patients out of hours or at weekends for children admitted as emergencies or whose condition required changes to their medicines.
- Equipment stored in the Pinckney Ward storeroom was not routinely checked. Equipment could be returned or removed without checking if it had been cleaned.
- Staff were not always able to access clinical information about a patient whilst records were being transferred across to the new electronic patient record system resulting in delays proving children with their medicines.

However:

Services for children and young people

- Children were monitored to identify any deterioration in their condition.
- The results of investigations into incidents were discussed in departmental and governance meetings and action was taken to follow up on the results of investigations

Incidents

- There were four serious incidents reported to the regional Strategic Executive Information System (STEIS) in 2015-2016. The incidents related to; a serious medication incident, two were about abuse or the alleged abuse of a child by school staff and the fourth incident was a surgical error. The two incidents where there were allegations of abuse related to medical services provided by the trust to a school for children with special needs.
- There had been one serious incident on the neonatal unit in the last 12 months (medicine error). A review was completed on how the unit had handled the incident. There had been a delay in informing parents about the incident. The key learning from the incident was the importance of information passed on at handover and through the notes of meetings. There was a guideline for preparing the medicine. The incident was discussed at governance meetings and the process was reviewed at an IV study day.
- Staff told us incidents were reviewed monthly to assess their severity and monitor progress with the investigation and report. The types of incidents were monitored to identify trends.
- Records of clinical governance meetings confirmed incidents were reviewed and action taken to change practice based on the findings of investigations. For example, as a result of feedback following an unexpected oesophageal perforation, during the introduction of a new nasogastric tube, the tubes were to be warmed in future to reduce the risk of a similar incident occurring again.
- One member of staff told us a patient safety lead held open forums with staff to share feedback on the themes identified from incident reports, which they had found informative. However, another member of staff told us not all issues on the ward were always reported as incidents.
- Staff were able to tell us about incident reports they had submitted. For example, for one told us they had reported delays to a transfer. The baby was due to be

transferred to another trust but the transport was cancelled three times. The baby did not suffer any lasting effects, but the staff member was concerned about the length of the delay and the impact this might have on the baby's condition.

- We spoke with one nurse who had recently joined the trust. They said they had reported an error to their manager straight away, who had been very supportive. The incident was reported and the ward was waiting for a report on the results of the investigation.
- Incidents in the neonatal unit were discussed at the monthly neonatal clinical governance meetings and in the clinical governance sessions which were held every other Monday. Staff on the unit told us they knew how to complete Datix reports and when they had submitted an incident report they received feedback on any subsequent investigation. The minutes of governance meetings were emailed to all medical staff including doctors in training. They said they felt able to raise any concerns about quality and safety.
- We saw the notes of a mortality and morbidity meeting for paediatric surgery for the period July to September 2015. There had been no deaths, but eight cases were discussed where there were complications associated with surgery. Learning points were identified and disseminated throughout the department.
- Staff were familiar with the trust's duty of candour policy. All patient safety incidents graded as moderate and severe required the 'being open' fields on Datix to be completed, once the harm had been discussed with the patient and an apology given. The trust monitored the level of compliance across all divisions.

Safety thermometer

- We saw examples of children and young person patient safety thermometer reports for November 2015 and January 2016. The safety thermometer was used to monitor potential and actual harm which had occurred as part of a child's treatment.
- Harms identified would result in a multidisciplinary (MDT) huddle and Datix reporting. The November report showed there were a total of nine harms identified; these included extravasation, omission in monitoring pain and the identification a pressure ulcer.

Services for children and young people

- The trust scored worse than other trusts in one of the four safety questions in the 2104 children's survey for appropriate equipment or adaptations. The other safety scores were similar to other trusts. There were no pressure ulcers.

Cleanliness, infection control and hygiene

- The wards we visited were visibly clean and there were policies and procedures in place to make sure clinical and patient areas were clean. Cleanliness audits were carried out. We saw the schedule for 'saving lives' audits. The schedule included audits of catheter care, cleaning and decontamination of equipment, which took place every month together with monthly hand hygiene audits. The 'saving lives' scores were displayed on the ward notice boards at the entrance to wards.
- Infection control training was part of the trust's mandatory training programme, however, only 81% of nurses in children's services had completed the training. This meant 56 nurses had not completed the training. This fell short of the trust's target for mandatory training. There was a risk that not all nursing staff were following the trusts infection prevention and control policies. Senior nurses were aware that not all eligible staff had been trained and told us they were responsible for ensuring infection prevention and control measures were in place and to encourage staff to complete the training as soon as possible.
- Staff used personal protective equipment, such as gloves and aprons when caring for patients.
- Hand sanitising gels were available at the entrance to wards and there were notices to remind visitors to use these. One of the dispensers was empty when we arrived, but was refilled by staff when we brought this to their attention.
- Children with infectious diseases were cared for on the same ward as oncology children. Children with an infectious condition received their care in single isolation rooms. A lamina flow air system ensured air from these rooms did not circulate outside the rooms on to the main ward area.

Environment and equipment

- We were told that there were problems with the heating in the winter, air conditioning in the summer and problems with the electricity and water supply on the wards.

- We observed the resuscitation trolley being checked on the paediatric intensive care unit (PICU) The trolley was checked daily to ensure the equipment required in an emergency was available. We saw there was a record of the checks which showed these were carried out daily. Staff on the unit had signed to confirm the checks had been completed. Similar checks had been carried out on the equipment on other wards.
- Medical equipment for the whole children's department was stored in a room on Pinckney Ward. There was no record of checks being carried out and we saw copy of a report which highlighted the lack of a system for checking items were cleaned before being returned to the store.
- We saw an environmental audit for Jungle Ward which scored 69.5%. The audit reviewed infection control procedures and the general ward environment. The audit identified that the sinks in the drug and play rooms were not elbow operated and many areas on the ward were dusty including clinical areas. Actions were identified and allocated to staff with dates for achieving improvement.

Medicines

- Staff told us there were sometimes delays in children receiving chemotherapy if needed out of hours and at weekends. There were also concerns about access to chemotherapy for newly diagnosed and critically ill paediatric oncology patients out-of-hours. There was no dedicated paediatric oncology pharmacist. To mitigate the risks, staff anticipated what chemotherapy might be required. The medicines would be held by pharmacy and only sent to the ward if required by the oncology team. Guidelines had also been developed for the management of newly diagnosed patients who might require emergency treatment at the weekend. The risk register showed this was still under discussion in February 2016 and had not yet been implemented.
- There had been a significant increase in the volume of chemotherapy treatments prepared from 290 in 2013 to 379 for the six months of 2015 up to the end of September. Paediatric chemotherapy was provided to patients in the Paediatric Oncology Shared Care Unit (POSCU) and as joint Primary Treatment Centre (PTC)

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working in partnership with the Royal Marsden Hospital. The complexity of patients had increased; more patients required paediatric intensive care facilities and specialised, complex chemotherapy regimens.

- With the PTC, there was no electronic chemotherapy prescribing system for paediatrics as there was for adults. Some prescriptions relied on being sent by fax machine from the Royal Marsden Hospital. Following the inspection, the trust told us that they were awaiting a decision from NHS England on standardisation of e-prescribing for paediatrics.
- The paediatric oncology pharmacy service had identified the increase in workload, lack of a dedicated pharmacist and lack of electronic prescribing as a high risk on the pharmacy risk register.
- In the Neonatal unit, we found that some emergency medicines were not stored in locked drawers/cupboards at all times. There had been site specific risk assessments done to allow for this, due to the operating nature of the department and the need to access medicines in a timely manner to meet patient needs.
- Medicines were stored appropriately on the other children's wards we visited including controlled medicines (CDs). CD stocks and records were checked daily and we saw records of these checks being carried out.
- Thermometers in the clinic room on Frederick Hewitt Ward showed the temperature of the room where medicines were stored was above 28 degrees. Staff said they had been told to report when the room temperature exceeded 28 degrees, but they said in warm weather, it always exceeded 28 degrees and they were not aware that anything untoward happening as a result.
- Staff understood how to recognise and report medicines related safety incidents. This was reflected in the higher than average reporting rate of incidents at the trust (14% vs 10% nationally). Medicines errors and safety incidents were reviewed by the medicines safety committee and the pharmacy team on a quarterly basis. We saw examples of medicines incident reports which were discussed at clinical governance meetings and team meetings.

Records

- We reviewed five sets of care records and prescription charts on the neonatal intensive care unit and found there were good standards of record keeping. Record entries were dated, timed and signed and all the information was legible apart from some staff signatures. Medicines were clearly written up and test results all recorded.
- Several staff we spoke with on the paediatric wards expressed concern and frustration with the electronic patient information system being implemented by the trust. They told us there were eight different IT systems in use across the trust. Some patient information was stored in paper notes and some on the electronic records system IClip. The electronic records system had not been fully rolled out across the trust. Children's records were being scanned on to the system but the process was not complete and there was confusion about accessing records waiting to be scanned. There were plans to complete the roll out the system over the next six months. Staff told us the system was down on occasions which meant they could not access children's drug charts leading to delays in children receiving their medicines. Temporary notes were not merged with the main notes, which meant not all patient information were filed together.
- The risk register recorded a risk around locating permanent sets of notes for patient care. This meant temporary records were provided instead, which may not always contain all relevant information.
- We spoke with one consultant who was assessing children with a complex disability. The IT system was not available at the time and they were concerned about recommending treatment without access to the child's records and test results.
- There were delays in issuing NHS numbers for babies. This was included on the service's risk register as leading to possible delays to treatment. Following birth, babies details were entered on to the electronic patient record system. In some cases the demographic details for the mother were not in the correct format or have missing fields. This led to an NHS number not being issued. A member of staff had to check and update the missing details. The service was working with the IT department to resolve this problem.

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Safeguarding

- Level 1 child safeguarding was part of the trusts mandatory and statutory training programme (MAST) on line, mandatory for all staff each year. Whilst level 2 child safeguarding was available as both face to face sessions and e learning. In the hospital, two face to face training sessions were provided each month at level 3.
- One nurse we spoke with told us they had received level 3 safeguarding training and neonatal life support training within the last 12 months.
- Another member of the nursing staff told us there was a safeguarding discussion every week on their ward concerning patients who might be at risk or where staff had concerns. Similar arrangements were in place on all the wards. We observed a meeting which took place on one of the wards when safeguarding concerns were discussed.
- Teaching and play staff had all attending level three safeguarding training.
- The risk register recorded a risk of staff not having required knowledge to safeguard children due to the required safeguarding children training not consistently being undertaken. There was a concern that staff might not recognise a potential safeguarding issue, putting a vulnerable child at risk of harm.
- The trust had set a target of 85% for safeguarding training. 84% of nurses and 48 % of medical staff had completed level 3 training. 65%% of medical staff had completed level 2 training.
- The 2015 safeguarding annual report highlighted difficulties providing all the training required and the trust was considering appointing a safeguarding trainer. The trust was also unable to provide routine safeguarding supervision for staff working in children's' services.

Mandatory training

- Staff told us they were supported to complete mandatory training. Figures provided by the trust showed 94% of nursing staff in children's' services had completed conflict resolution training, 94% had received training in equality and diversity. 62.6% of nurses and only 23% of medical staff had completed intermediate life support training, 85% of nurses had completed basic life support training.

Assessing and responding to patient risk

- Escalation processes were used to monitor babies and children if their condition deteriorated. Use of the escalation procedures was audited to ensure children were not at risk of avoidable harm.
- The neonatal unit used neonatal early warning system (NEWS) for monitoring the condition of neonates and identifying if their condition deteriorated.
- The children wards used the Paediatric Clinical Assessment tool [PCAT]. This tool assessed children in three key areas: airway and breathing, circulation and disability. Health professionals used a traffic light system for identifying and monitoring children. All staff including healthcare assistants and bank and agency staff were required to operate equipment to record patient's observations. Observations were recorded on the trusts electronic patient record system, IClip
- We observed an escalation meeting on the neonatal unit. These meetings were held three times a week to review staffing, the number of babies on the unit, labour ward activity and babies in other hospitals who might require admission.
- The trust were auditing paediatric triggers. The audit reviewed data for discharges between September 2014 and Feb 2015. For this six month period, there was an increase in the number of triggers and a decrease in adverse events. 327 triggers and 19 adverse events were identified. The rate of harm was assessed as similar to the results of previous audits. There had been an improvement in comparison with the previous six months.
- We saw the trust's policy for observing patients and responding to patients when their condition deteriorated. The policy stated that all patients admitted to the trust, whether elective or emergency should have observations initiated including temperature, respiratory rate, heart rate blood pressure, level of consciousness, oxygen saturation, pain and PCAT scores. Staff were familiar with the content of the policy and we saw examples of patient monitoring which had been completed on the electronic record system.

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- We also saw examples of escalation plans for children with long term conditions. Some local trusts were not always able to support children with complex needs if their condition deteriorated and the plans supported their transfer to the service at St George's Hospital.
 - Whilst visiting Frederick Hewitt Ward (medical ward) we became aware that there were seven children and young adults with a mental health condition being cared for on the ward. We asked about the admissions policy for the ward, which showed the ward accepted children with mental health conditions. We saw a patient pathway for children with mental health conditions and two examples of risk assessments which had been completed for children being cared for on the ward. The risk assessments showed these children required specialised one to one support by a health professional trained to care for people with a mental health condition. The service engaged mental health agency staff when a child required this support. Staff had received training to help them provide appropriate care. Whilst agency nurses were trained to care for people with a mental health condition, they were usually trained to care for adults, not children. A healthcare assistant from the ward was assigned to work alongside the registered mental health nurse to support them. One healthcare assistant was trained in caring for children with challenging behaviour.
 - Whilst the risk assessments took account of the child's mental health needs we had concerns about the ward environment being suitable. There were no assessments of risks such as ligature points; the ward area had not been adapted for accommodating young people with a mental health condition. There were light pull cords on the ward, which could be used as ligature points. We drew this to the attention of managers who said they would have these replaced with self releasing cords as soon as possible. There was a problem accessing beds in specialist child and adolescent mental health units, which meant they presented through the emergency department and were admitted to the ward. Staff told us there were sometimes problems with security on the wards, there were no panic alarms and staff sometimes had to call the security service for assistance.
 - There was a policy for pressure ulcer prevention. We saw examples of completed assessments which showed the risks were being monitored and recorded.
 - Staff we spoke with on Jungle Ward told us they were trained to record what they knew about the child and what they had learned about them and make sure they passed all relevant information on to the anaesthetist.
- ## Nursing staffing
- We spoke with three staff on Nicholls Ward who told us they were concerned about the high use of agency staff and the lack of permanent staff on the ward. They said there were usually two agency staff on duty on every shift plus bank staff. They said agency staff were unable to undertake some procedures for example setting up IV infusions, which increased the workload for permanent staff. As a result there were often delays in patients receiving care, for example their medicines. They said there had also been a number of complaints about the attitude of some agency staff. One member of staff said the pressures had been the same over the last two years with no improvement. Staff told us there were high levels of stress for staff and staff often had to stay for up to an hour after their shift had finished. They said pressures on staff meant safety checks, for example of resuscitation equipment were not always completed and medicines were sometimes left on worktops unattended.
 - We spoke to managers about this, who told us ward staffing levels were reviewed daily across the hospital at 8.30am every morning. Matrons and bed managers attended the meeting where bed and staffing pressures were discussed and staff redeployed in response to need. Similar meetings were also held at 10am, 1pm, 4pm and 7pm, to discuss staffing or bed issues in the hospital.
 - Managers also told us there was a plan in place to fast track students from their final student placements into jobs to address staffing pressures. The matrons were working closely with the universities to encourage newly qualified nurses to join the trust. The matrons had some concerns about the high number of newly qualified, relatively inexperienced staff on the wards. They said there was a high number of band five, newly qualified staff. There were high sickness levels on the paediatric intensive care unit. The level was running at 7% and the service relied on agency staff.
 - The neonatal unit did not fully meet the British Association of Paediatric Medicine (BAPM) staffing standards for units providing neonatal intensive care.

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The unit was 92% compliant with BAPM standards. The chief nurse had agreed to provide funding to achieve full BAPM compliance. Managers told us there was a 19% vacancy rate on the neonatal unit, 30 posts in total. Three nurses were due to leave shortly, but four were due to start work later in the month and the service had offered posts to another 22 nurses from a recruitment drive overseas. They told us senior managers had agreed to over recruit to mitigate the effects of high turnover particularly amongst recently qualified staff. All the new recruits were band five and would require further training. The divisional risk register recorded the impact as affecting patient safety with staff having to look after two or more intensive care babies, potential for delay or missed drugs, low morale, higher levels of sickness and increased turnover.

- Escalation processes could be triggered when staffing levels were low. These included booking bank staff, continuous assessment of the bed state to optimise space and allow babies to be transferred to the special care unit, declining admissions from other trusts and finally closing the unit to internal referrals.
- BAPM standards required 70% of staff working in intensive care and high dependency units to be qualified in the specialty (QIS). 40% of staff on the unit were qualified in the specialty. This figure increased to 55% if bank staff were included in the figure.
- It was noted that nationally, only 15% of units met recommended nursing staffing levels. St George's did not meet the recommended standard.
- Frederick Hewitt Ward was staffed to support 13 beds, but when we inspected, 17 beds were open to admissions. Managers had intended to reduce the number of beds on the ward to 13 by closing four, but found the number of emergency admissions resulted in the four beds being required. The trust had concluded the four beds were needed and staff told us managers had confirmed that funding would be available to recruit to the additional posts required.
- Staffing levels of the main paediatric wards was also recorded as a risk in the divisional risk register. Failure to provide safe paediatric nursing care at all times and meet required standards was recorded as a high risk. The main mitigating actions taken by the trust was a recruitment campaign to appoint to vacant posts. Five

band five nurses and two band six nurses were being recruited for Nicholls Ward and two band six and two band five nurses were being recruited for Pinckney Ward. Four band five nurses and one band six were being recruited for Frederick Hewitt Ward.

- Staff used the SBAR tool at handover. This was a tool developed nationally which prompted staff to provide key pieces of information to new staff coming on duty. The SBAR handover included information about the patients situation, background assessment and recommendation (SBAR).

Medical staffing

- Consultant paediatric medical cover was available during the day from 9am to 5pm. Between the hours of 5pm and 9pm, there was a resident on call consultant and from 9pm to the next morning, consultants were on call from home for telephone advice for respiratory, gastroenterology, infectious diseases, neurology, endocrinology and diabetes.
- There was one specialist registrar (SPR) to cover the emergency department and other SPRs attached to the wards during the day. Between 5pm and 9pm, there were two SPRs on site, one for ED and one for the wards. Between 9pm and 9am, there was one paediatric SPR on site. At weekends, there were two SPRs from 9am to 9pm and one at night after 9pm.
- There were two junior doctors (FY1/FY2) between 5pm and 9pm; one in ED and one for the wards and after 9pm, there was one junior doctor on site. At weekends, there were two SHOs on duty during the day between the hours of 9am and 9pm, one covering surgery and ED and one covering the wards. One SHO was on duty at night.
- We spoke to one senior doctor in training who told us it was an 'excellent' place to train and described a close working team. They said junior medical staff felt confident about seeking guidance from consultants. They said everyone was supportive and approachable. They described a number of learning opportunities for example, perinatal mortality and morbidity meetings, X-ray meetings, foetal medicines, case based presentations and discussions with junior medical staff and Thursday's grand round.
- Medical cover for oncology children was jointly provided with the Royal Marsden Hospital.

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- Staff skill mix figures showed the trust had a higher proportion of registrars than the England average, but lower for junior and middle career doctors.

Major incident awareness and training

- 91.8% of staff had completed fire safety training. Senior staff were familiar with the trust's major incident plan, where to find this and what actions were required. Junior staff and staff who had joined the trust recently were not familiar with the major incident plan and said they would rely on directions from senior staff.

Are services for children and young people effective?

Good



We rated effective as good because:

- Staff could access clinical guidelines and policies which were regularly updated and based on national guidance.
- The service contributed to a wide range of national audits and undertook local audits on the quality of services provided.
- There was effective multidisciplinary working between teams based in the trust and with other organisations and networks
- Overall levels of mandatory training were good and staff were supported with training.
- Results for the 2013-2104 paediatric diabetes audit showed the trust performed slightly better than the England average.

However:

- Rates of multiple emergency readmissions within 12 months for asthma and epilepsy for children aged one to 17 years were worse than the England average.
- The multiple admission rate for St George's was 41.0% (worse), compared with the England average of 28.6%.

Evidence-based care and treatment

- We saw the trust's policy used for observing a child's condition and identifying if they were deteriorating. The policy was based on National Institute for Health and Care Excellence (NICE) recommendations, the National Institute for Innovation and Improvement and guidance

from the Royal College of Nursing (RCN), which recommended physiological track and trigger systems should be used to monitor all children and young people in acute hospital settings.

- Staff on the neonatal intensive care unit showed us how they accessed clinical guidelines. These were stored online within the neonatal handbook, which was last updated in March 2016. For example, guidelines on neonatal seizures were up to date.
- St George's participated in a number of national audits. These included the national diabetes audit, PICANet (Paediatric Intensive Care Audit Network) and the Neonatal National Audit Programme. (NNAP). The trust submitted data for 2,243 babies to the neonatal audit. The audit found that the trust's performance was largely similar to the national results and neonatal intensive care units for the key standards. The results had been maintained or improved from 2013 for all measures, other than babies being fed with mother's milk at discharge, which had fallen.
- St George's submitted data for 129 patients aged between 0 and 19 years to the national diabetes audit. Of these, 90.7% of cases were Type 1 diabetes. The results showed there was much variability within the south east region with a tendency for higher blood sugar values within London than elsewhere. The reasons for poorer diabetes control in the local population were unclear. The service had reviewed the data and found ethnicity and deprivation which were usually cited at factors, did not account for the prevalence of poor diabetes control.
- Standards for seven aspects of care were measured for all cases of CYP aged 12 and over, with HbA1c applicable to all ages. The trust submitted 100% of BMI and HbA1c results, and were seen to perform better for the other five criteria when compared to national and regional average.
- We saw a report of the main findings for the PICANet (Paediatric Intensive Care Audit Network) annual report published in November 2015. These contained comparisons with national average and other PICUs for key indicators such as mortality rates and length of stay. The report showed that the service performed well on readmissions within 48 hours with minimal readmissions compared to other trusts.

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- The report identified that length of stay was increasing nationally. Length of stay at St George's had increased from 2.4 days in 2012 to 3.4 days in 2015, which was similar to other units. The report stated that this was due to changes in expectations, increasing palliative care work (22%) and improvements in managing chronic disease. For the first time in the last four years, the PICU had a standardised mortality rate (SMR) greater than one, but this was not regarded as significantly different to the national average.
- The results of the national report were presented and discussed at the PICU governance meeting.
- The emergency readmissions rates within two days of discharge for all emergency admissions were lower than the national average for children under one and for children aged one to seventeen years apart from paediatric medical oncology, which was above the England average.
- The median length of stay at St George's was one day for babies under one year and for children and young people aged one to eighteen, which was the same as the England average.
- The neonatal unit had achieved accreditation as a stage 3 UNICEF baby friendly initiative and were working towards new standards introduced in 2015, which they planned to achieve in 2016.
- We saw the results of regular audits on the neonatal unit, which included name band checking and medicines management.

Pain relief

- We saw copies of age appropriate leaflets about managing children's pain at home which described how parents and carers should observe their child, advice of assessing whether their child was in pain or not and information about the different types of appropriate medicines.
- The patient records we reviewed showed pain was monitored. The assessment of pain was audited as part of the paediatric safety thermometer process.
- The 2015 CQC survey results for children in hospital found most children thought staff did everything they could to help their pain and parents and carers also reported that staff did all they could to ease their child's pain. The results were similar to other trusts.

Nutrition and hydration

- Records showed children's hydration was monitored frequently.

Patient outcomes

- Results for the 2013-2104 paediatric diabetes audit showed the trust performed slightly better than the England average for the number of children with HbA1c < 58 mmol/mol and worse than the average for mean HbA1c mmol/mol. HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE quality standard QS6 states people with diabetes agree a personal HbA1c target with their healthcare professional usually between 48 mmol/mol and 58 (6.5% and 7.5%).
- Rates of multiple emergency readmissions within 12 months for asthma and epilepsy for children aged one to 17 years were worse than the England average. The multiple admission rate for St George's was 41.0% compared with the England average of 28.6%.
- The median length of stay at St George's was one day for babies under one year and for children and young people aged one to seventeen which was the same as the England average.

Competent staff

- Appraisal completion rates had remained relatively static for all staff between 2014/2015 and 2015/2016 (70.6% versus 69%).
- There were two days of mandatory training for all paediatric staff. We saw examples of the agendas for these events. For example the Frederick Hewitt team day on 27 January 2016 where safeguarding and managing head injuries was discussed.
- We also saw minutes of the neonatal unit multidisciplinary meeting held on 11 January 2016, where the monthly safety thermometer, annual PICKER survey results, friends and family test, patient satisfaction on discharge, mattress audit, name band audit, fridge audit, matron's quality round infection control environmental audit, leaning audits, medicines storage audit, antimicrobial ward round saving lives audit were all discussed.

Multidisciplinary working

- Joint meetings were held between the neonatal unit and the obstetric service every week to discuss babies

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requiring admission to the neonatal unit. Consultant medical staff, junior doctors nurses and midwives met to plan the care babies required. Safeguarding concerns were discussed as part of the meeting.

- Staff from the neonatal service participated in the London neonatal network which had been set up and was due to meet shortly to discuss quality issues and share good practice.
- The trust's paediatric endocrine service served a population of approximately 2.5million providing secondary level endocrine unit for local patients and a tertiary centre for patients from Surrey and the northern part of West Sussex. Outreach clinics supported the district general hospitals (DGHs) in The South West Thames Region.
- The oncology service provided a level two service for the local population and was also a shared Principle Treatment Service (PTC) jointly with the Royal Marsden Hospital, diagnosing and treating children with cancer from a wide catchment population which extended across the south of England.

Seven-day services

- There were delays in children receiving chemotherapy if needed out of hours and at weekends. Staff anticipated the medicines children might need which were made up in advance and used if required.

Access to information

- We saw a handover folder used by staff on the neonatal unit and saw this was used at handover meetings which were held twice a day in the morning and the evening. We observed staff discussed the care of each of the babies, with staff passing on key information about their condition. Clinical governance issues were also discussed, The results of recent audits and any actions required to change practice resulting from the audit findings, for example adjusting the medicines were discussed.
- Staff on the day case unit, Jungle Ward, showed us the discharge summaries sent to the families GP and community staff. They said 90% of these were sent out within 24 hours of the child being discharged.

Consent

- We saw four sets of records on Jungle ward and four sets of records on other wards which contained completed consent forms.
- A trust wide consent audit had been carried out for 2014-2015. This audit was carried out regularly. Sixty paediatric cases were audited. Of the 60 cases reviewed parents signed the form in 98.3% and children had signed 26.7%. The sample size was 222 cases.

Are services for children and young people caring?

Good



We rated caring as good because:

- The service surveyed children and families view about their experiences in hospital and acted on the results.
- Feedback from survey results showed high levels of satisfaction with the service.
- Parents and families all spoke positively about the care provided and the support they received.
- The service gathered feedback from children during their stay highlighting the things they liked best and least.
- We observed staff interacting with children and their families. Staff made sure children's views were taken into account and involved family members in plans for the care provided.
- Parents were supported to stay with their child on the ward or in the parents' residential unit provided on the hospital campus.

Compassionate care

- The service carried out regular surveys when patients were discharged. The most survey results were for the four months between December 2015 and March 2016. The survey found 58% of patients would recommend the service to friends and family if they needed the same help. This was lower than previous survey results in previous quarters when 94% of patients would have recommended the service. The figure over four quarters from April 2015 to March 2016 was 93%.
- 76% of patients felt they were given enough privacy when discussing their condition, 52% felt they were involved in decisions about their discharge, 79% felt

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they were treated with dignity and respect and 44% felt they had found a member of staff they could talk to about their fears. 93% said they would be happy for friends and family to have the same treatment they had received.

- The results of the CQC 2015 children's inpatient survey showed the service scored about the same as other hospitals for children having an appropriate care plan, help to relieve pain, staff working as a team and staff aware of their medical history.
- The trust scored similarly to other trusts for a range of indicators about the care children received measured as part of a national survey about children's experience in hospitals. The questions asked children and parents about the availability of staff to respond to children's needs, privacy, and whether staff listened to the child.
- The survey also asked parents and carers about the information they received about the child's treatment, whether they had confidence in the staff treating their child, the extent of their involvement in treatment decisions and if they received information to take home after their treatment had finished.
- The service had developed an action plan in response to the results of the 2014 Picker patient experience survey. The action plan included organising an event about teamwork, kindness, professionalism and improving communication and provide more training on the electronic system to improve patient documentation.
- A bed board had been introduced into the inpatient wards to improve communication between staff and with patients and parents. We saw an example of this on Pinckney ward. A Children's Futures project had been undertaken to improve teamwork.
- We spoke with three mothers attending a clinic for premature babies who told us the care their babies received was 'excellent'. They described how a nurse from the neonatal unit supported them in the community which they found extremely helpful. One mother told us the nurse encouraged them to text them with any concerns. They said they had texted them on several occasions and always got an answer sometimes immediately. Another mother said they were anxious about taking their baby home from the unit because they were used to highly trained staff caring for their

baby, but knowing they had the help of a nurse to call on was reassuring. They said the unit had told them they could ring at any time if they had any questions or concerns which was also reassuring.

Understanding and involvement of patients and those close to them

- We spoke with a parent who had a baby on the special care baby unit (SCBU). Their baby had spent one week in intensive care, one week on the high dependency unit and had recently transferred to the SCBU. They said, 'The doctors are all really 'hands on', making sure the babies are okay and they talk to us and keep us informed.' They said, 'we feel listened to and everyone is so welcoming when we are on the unit.' They also said staff had helped with breastfeeding and staff had been really supportive. Another parent said 'Staff explain procedures and I understand why they are doing what they do.'
- Jungle Ward offered families the opportunity to visit the ward every other Saturday to familiarise themselves with the facilities and ask staff questions about their time on the ward. Some of the families we spoke with had visited the ward beforehand and found it helpful to know what to expect.
- We spoke with a family whose child was being cared for on Nicholls Ward. They said if they asked to see a doctor they came quickly and they felt free to ask anything. Another family was referred for specialist treatment which was not available at their local trust. They said the service was very good and they could not fault the staff. They said, 'All the staff have a really good manner which helps put the children at ease.' They said they always ask if 'it's okay' before they did anything with them.'

Emotional support

- We observed staff supporting children and families. Children's emotional needs were assessed and staff were aware of the need to support children and other members of their family. Comments received from families as part of a survey carried out by the service included remarks such as, 'staff were approachable and friendly, attentive and kind. 72.2% of the comments received were positive about families feeling able to speak to staff about their worries and concerns.

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Are services for children and young people responsive?

Good



We rated responsive as good because:

- Access to day case surgery was good. Children who required access to surgery because of an accident or injury were treated the day after or within a few days of the accident.
- Parents were informed via text, when the child came out of theatre following surgery.
- There were effective arrangements in place for children growing up with complex conditions being transferred to services provided for adults.

However,

- Children shared ward areas with other children of a different gender or age group. Parents were asked to sign a disclaimer confirming their acceptance that their child could share an area with children of a different age or gender.

Access and flow

- 42% of admissions to the wards were via the emergency department. A further 45% were day cases planned in advance.
- Children under one to age 17 were admitted to Jungle Ward for a range of day case surgical procedures. The unit was increasing the range of treatments to provide some medical day case procedures such as allergy testing. Jungle Ward was located next to the operating theatres and staff from the unit were able to accompany the child to the anaesthetic area and care for them when they awoke in the recovery area. The unit was open until 8pm in the evening to allow children operated on later in the day time to recover before returning home.
- Staff on Jungle Ward tried to ensure children were suitable for day case surgery before offering treatment on the unit. Surgeons prescribed medicines in theatre which the child might need to go home which meant these were ready for collection later that day. Jungle Ward monitored the number of readmissions three days post discharge. Minor trauma patients were fitted on to

the operating lists in the day case unit, which meant they sometimes had to wait for their surgery. Staff on the unit were aware this was frustrating and were looking at ways of improving the process.

- Children with a mental health condition who required admission to one of the main inpatient wards from the emergency department(ED) continued to be cared for on ED until the inpatient ward had obtained mental health nurse support.

Meeting people's individual needs

- There were transition leads in most specialties. These were clinical staff who supported children with particular conditions as they approached adulthood when their care transferred from the paediatric to an adult service. For example, we saw a plan for managing the transition of young adults with health and special educational needs from children's to adult services. Staff from the community team worked with local authority staff to plan services for young people. We also saw a description of plans for managing the transfer of young people's care from consultants who specialised in the treatment of paediatric conditions to consultants who specialised in the treatment of the condition in adults. For example, young people with gastroenterological conditions between the ages of 16 – 19 years were seen in clinic two or three times before they transferred to the adult team completely. Young people were able to stay in the transition clinic as long as they felt they needed to. A member of staff was identified as a link person for the young person who was present at transition clinic appointments. Similar arrangements were in place to support young people with other conditions.
- The children's wards were not able to provide single sex accommodation. We saw children of different ages and genders sharing the same bays on the wards. However, staff explained the situation to parents and asked them to sign a disclaimer agreement. This arrangement had been agreed with the commissioners. We observed one bay where babies, young children and teenagers were accommodated together.
- There was a family centred care co-ordinator on the neonatal unit who supported families with travel and accommodation whilst their baby was on the unit.
- Jungle Ward texted parents when their child came out of theatre. One family we spoke with told us they

Services for children and young people

thought it was a really good idea and meant they could go to the canteen whilst they waited. The ward were able to provide parents with vouchers they could use in the canteen.

- Children had access to Wi-Fi on Jungle and other wards.
- We spoke with a ward hostess on one of the wards who told us their role was to ensure children were offered appetising food. They said they got to know what children liked and were able to make sure they had what they liked. We spoke with two families who told us their children were offered choice and said the food was good.
- The national children's survey asked if parents and carers had access to hot drinks, about access to overnight facilities and about the choice of admission dates. The responses from parents to these questions were similar to the responses made by parents at other hospitals.
- The service planned to raise awareness about parking concessions which was a source of frustration to parents.

Learning from complaints and concerns

- We spoke with a parent on the neonatal unit who said they spoke to the sister in charge if they had any concerns and if they had anything further they wanted to raise they spoke to one of the consultants.
- The number and type of complaints were monitored monthly. The information was contained in a monthly clinical governance report for the children, women, diagnostics and critical care division. Although this was a large directorate with several specialties, the issues for paediatrics were identified separately.
- The trust provided us with information about complaints they had received for the period March 2015 to March 2016. There were 33 complaints about paediatric services including neonatal services. Problems over communications with parents or between health professionals was the most common theme in some and the adequacy of treatment and staff attitudes were other themes. Where the trust had upheld the complaint in part or in full, we saw that actions were put in place to check procedures, for example incorrect information had been recorded in a patients notes copied incorrectly from the report of a

diagnostic investigation. Medical staff had reviewed the previous months reports to make sure the same error had not occurred elsewhere and there were plans to complete a similar review every six months.

- 60% of complaints were responded to within the timescales identified in the trusts' complaints policy and staff apologised for any failures in procedures or for any distress families had experienced.

Are services for children and young people well-led?

Requires improvement



We rated well led as requires improvement because:

- There was no clear strategy for the service, although leaders in the new structure recognised the need to develop one and were committed to involving clinical staff in its development.
- The environment on all the children's wards needed improvement. Staff had been involved in plans for re-developing the ward accommodation, but the plans were on hold and staff were unclear what was happening.
- Nursing staff did not feel supported by their leaders. They had not received feedback from their appraisals and felt support was inconsistent. They told us there was not an open culture and staff were sometimes reluctant to raise issues.

However:

- Governance structures were in place at ward level through to the new divisional structure and beyond to the board.

Vision and strategy for this service

- A strategy had been developed for the paediatric service in 2011, but this was no longer regarded as appropriate and there were plans to develop a new strategy with greater clinical involvement. The strategy needed to consider the role services at St George's played in networks across south west London. The process had begun with an away day in May 2016 to identify the key issues. They said the board recognised the issues and the difficulties of providing the service in the current location.

Services for children and young people

- We met with the children's' matrons who told us the vision for the service was partly dependent on the wards on level five being redeveloped. They said achieving significant cost improvement savings was a high priority but they were trying to achieve these without reducing quality and safety standards and not reducing staffing levels. They told us achieving the savings required would be challenging.
- The trust had an ambitious transformation programme for 2016-2017 to deliver significant productivity gains with likely changes in service and workforce profiles.
- Divisional managers told us the ward environment and facilities was one of the main challenges. Plans had been developed for relocating the paediatric wards, but it had not been possible to carry these out.

Governance, risk management and quality measurement

- There were neonatal governance meetings six times a year. The minutes of these meeting were stored on the shared drive for staff to access.
- We saw the notes of joint governance meetings with the Royal Marsden Hospital for the PTC.
- We also saw the minutes of the children's clinical governance half day, with the theme of patient safety across children's' services.
- We saw minutes of the divisional governance board, which showed risk, safeguarding training and incidents were discussed.
- We saw the services risk register which was updated monthly. The key risks included delivery of sub-standard care to sick and premature infants due to insufficient neonatal trained nurses on the neonatal unit which was rated as high risk. Theatre on LNS 5 used for surgery was isolated from supporting services, making access difficult and maintaining patient safety difficult. Major issues highlighted regarding emergency situations and patient welfare were recorded as being high risk.
- Some organisational development work had taken place during the year 2014-2015. Staff working in children's' services had participated in a programme of improvements to staff education and learning, supporting staff to improve recruitment and retention, develop medical and nursing teams, reporting relationships and accountability. This included

encouraging effective multidisciplinary working and shared decision making at ward level and performance improvement. The report highlighted that Nicholls Ward supported a wide range of surgical specialties but accountability was not clear. There were concerns the current model as not working and was a continuing cause of concern due to the number of sub-specialities and lack of accountability.

Leadership of service

- Managers told us there had been a number of changes to the management structure. Services for children, women, diagnostics, critical care, therapies and outpatients had been brought together into one of four clinical divisions. The divisional chair for had been in post for three weeks when we inspected. Managers told us the key challenges were building relationships following an extended period of organisational change.
- Managers on the neonatal unit told us the chair of the trust had visited the unit twice. They said staff felt more listened to since the new chair had taken over. They saw the new leadership changes as positive and had a strong emphasis on governance. Divisional managers told us staff felt more engaged following recent changes to the management structure.

Culture within the service

- We spoke with three senior nurses who told us they felt unsupported by their managers. They had been appraised, but had not had any feedback about the outcome of the appraisal. Staff also described an incident where a member of staff had been assaulted by a visitor. The incident was reported and had been investigated but there had been no debrief for staff.
- A band five nurse told us they had worked at the service since qualifying. They said they had received excellent support since they started working there. They said they had previously had a student placement on the unit and had applied for a job when one came up because they had enjoyed working there. They said they had completed their safeguarding training two weeks ago, but had not yet had a supervision meeting. They thought the culture was open and felt able to raise any concerns they had or anything they were unsure about.

Services for children and young people

- Staff on the paediatric wards participated in two training and development days. We saw the programmes for these training days which included discussions about clinical issues and service improvements.
- We spoke with specialist nurses who described how they cared for children with a long term condition and carried out annual reviews. They said they enjoyed their work and there was a strong, effective, clinical team. One described how they had been encouraged to study for a master's degree and was being supported by the trust. They said they were fully supported by their consultant colleague who supported their development. They said they were involved in service improvement, for example developing links with community teams to provide more support for children closer to home.

Public engagement

- Children were encouraged to use cards cut into the shape of pants and tops to provide feedback on their

experience with tops used to record good things and pants for the things they did not like. These were on display in Jungle Ward. The play therapy team had analysed the feedback and responded to the issues raised. For example, someone had highlighted that the lay team could not be bleeped if a child needed distraction and the team had obtained a bleep to address this.







Staff engagement

- All the matrons produced a monthly newsletter for their teams which they used to communicate important information about the service.

Innovation, improvement and sustainability

- We saw a schedule of quality and service improvement projects being undertaken by doctors in training. This included reviewing the pathway for children with an eating disorder, an audit of ward discharge processes and how to improve this and developing an oral allergy syndrome patient leaflet.

End of life care

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

Information about the service

End of life care relates to patients who have been identified as having entered the last 12 months of their life or less. It refers to care of patients in the final hours or days of their lives, and to the care of all those with a terminal illness which has become advanced, progressive and incurable.

Palliative care is a multidisciplinary approach to specialised medical care for people with serious illnesses, both cancer and non-cancer. It focuses on providing patients with relief from the symptoms, pain, and both the physical and mental stress of a serious illness. The goal is to improve quality of life for both the patient and their family.

End of life care at St George's Hospital is provided by a specialist team of doctors, nurses and others who work together with other health service staff to support people at the end of their lives.

The palliative care team is made up of 10.2 whole time equivalent (WTE) clinical nurse specialists, 2.4 WTE consultants, and 2.6 WTE other staff including an administrator, counsellor and a specialist registrar to provide care for patients in the final phase of life.

There were 1,615 referrals to the palliative care team in 2015-16. There were 1,582 deaths during 2015/16, which equated to 4.3 deaths per day. 55 % of deaths result from a cancer diagnoses and 45% from a non cancer diagnoses. The trust does not have any dedicated hospital beds for patients who are dying. Patients in the last days or hours of life were cared for in a side room on the main wards when possible. The palliative care team works closely with the

patient and those close to them, the hospital doctors, ward nurses and other allied health professionals in supporting the patient's needs. They also liaise with hospices and other community support agencies to facilitate fast track discharge to patients' preferred place of death.

During this inspection, we spoke with 48 members of staff which included members of the palliative care team, ward nurses, health care assistants, trainee doctors, consultants, allied health professionals, porters, the chaplain and staff from the patient advice and liaison service (PALS), the bereavement officers and the Macmillan Cancer Centre. We spoke with 26 patients. We reviewed 22 sets of patient records and 19 do not attempt cardio pulmonary resuscitation (DNACPR) records. We observed staff interactions with patients and those close to them. During and prior to the inspection we requested a large amount of data in relation to the service which we also reviewed and considered when making our judgements.

We visited a number of the medical and surgical wards, the mortuary, the PALS office, the bereavement office, the Macmillan Cancer Centre and the spiritual centre.

End of life care

Summary of findings

We rated this service as requires improvement because:

- We found the palliative care team to be highly skilled and knowledgeable. However, whilst the team reviewed all dying patients, they were not able to provide specialist palliative care. The palliative care team was an advisory team who offered guidance, education and training to the medical specialities. The team reported that their remit was not to 'take over the care' of dying patients but to support the generalist medical teams in their delivery of good end of life care.
- Numbers of patients being referred into the palliative care services had increased year on year; the trust had responded to the increased demand by securing additional charitable funding to support two additional whole time clinical nurse specialists. and which made the service unsustainable unless they provided a specialist services.
- Whilst incidents were reported, the staff weren't always able to locate incidents on the datix system to show us.
- Patient records were not securely stored.
- We found no evidence that patient pain assessments scales were used.
- The palliative care out of hours service was provided by way of a tripartite agreement between three providers including Trinity Hospice,. We noted that no formal did not have a formal service level agreement was in place. at the time of the inspection.
- The end of life care strategy was an action plan not a strategy and there were no clear pathways to achieve the results detailed within the document.
- The 'nursing daily evaluation last hour and days of life' document was a prompt sheet, which was not backed up by either assessment tools or any evaluation tools to show whether the prompt had been addressed.
- There was lack of strategic direction for the palliative care from the top of the organisation. The lack of

multidisciplinary team meetings (MDT) with colleagues from medical and surgical departments and other allied health professionals was an area of concern.

However

- There was an open and transparent culture within the service. Incidents were mostly reported and learning was shared.
- Patients were treated with dignity and respect and staff were caring and supportive. The relatives we spoke with were happy with the care that they and their family members were receiving.
- Anticipatory medicines were prescribed in a timely manner and were available when required by patients.
- 85% of patients on fast track discharge were able to go to their preferred place of care last year.
- The Macmillan Cancer Centre offered advice and support to patients with cancer and their relatives.
- The spiritual centre provided for people of faith or those of no faith, remembrance services were held annually and services of many faiths were held on a regular basis in the centre. The chaplain attended both the end of life programme board and operational groups, which demonstrated the trust recognised the importance of religious and spiritual input to the delivery of the end of life care service.
- The trust had appointed an end of life non-executive director one moth prior to our inspection.

End of life care

Are end of life care services safe?

Requires improvement



We rated safe as requires improvement because:

The lift access to the mortuary had been broken for a number of years resulting in difficult access for people with mobility difficulties.

- Nurses and doctors reviewing patient notes had not documented their name or grade.
- Decisions of appropriate levels of treatment were not always documented.
- Patient notes were kept in unlocked trolleys around the nurse's station.

However:

- There was an open and transparent culture in regards to reporting incidents and learning was shared across the palliative care team and trust.
- Infection prevention controls were adhered to, including the use of personal protective equipment and hand gels.
- Anticipatory medicines were prescribed and available when needed.

Incidents

- All staff we spoke with told us they were encouraged to report incidents using the electronic reporting system. We were told feedback from incidents was given at staff meetings.
- During the period from 1 May 2015 – 30 April 2016, the trust reported one incident in the mortuary services, related to an infection control issue. The incident was investigated and appropriate procedures were followed.
- Incidents were a standing agenda item and discussed at each end of life care programme board meeting.
- When we spoke to staff they were able to describe the rationale and process of duty of candour. The duty of candour regulation was introduced for all NHS bodies in November 2014 to ensure organisations act in an open and transparent way in relation to care and treatment provided to patients. Staff were able to provide

examples of situations when an incident had occurred, how they had informed the patient and their relatives of the incident, made an apology and explained what investigation and actions had resulted from this.

- Whilst reviewing patient reports, we found information about a syringe driver incident regarding prescribing by a junior doctor. We asked staff for the datix number, but this could not be produced.

Environment and equipment

- The trust used T34 syringe drivers for delivering measured doses of pain medication. These conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia. The syringe drivers had in-date annual maintenance checks and/or corrective maintenance in line with the manufacturer's recommendations.
- We were told there were no problems in accessing syringe drivers whenever they were needed for patients. We saw evidence of the availability of syringe drivers and all the nursing staff we spoke with were trained on how to use them.
- In response to a recent report from the Human Tissue Authority (HTA), a further 35 freezer spaces will be built and available for use from September 2016. Concern had been raised regarding the number of bodies being kept in the body store for longer than 30 days without being placed in the freezer.
- The viewing area waiting room within the mortuary had a leak from the heating system and the carpet required replacing. There was warning tape around an area in the middle of the carpet because of a trip hazard. A request for new carpet had been made but had not yet been actioned. However, we were told that this was the responsibility of St George's University London (SGUL) rather than the Trust.
- 13 neighbouring hospitals in London used the mortuary for post-mortems, it also stored bodies for the Westminster coroner.
- We observed satisfactory systems to ensure the right person was in the correct body store and prevent the wrong person being taken by undertakers or presentation for viewings at the hospital.

End of life care

Medicines

- There were arrangements in place to keep people safe and manage medicines for patients.
- Anticipatory medicines had been prescribed in all of the 17 drug charts we reviewed. Anticipatory medicines were prescribed for patients, including those discharged to their own home or a hospice, to manage pain and common symptoms, if required. This prevented delays in symptom and pain relief. The palliative care team were usually involved when these medicines were prescribed, as indicated by three nurses we spoke with.
- Medicine administration records were completed accurately in the patient records we looked at.
- Where syringe drivers were being used, we found them to be locked as per guidelines to prevent other people altering or increasing doses.
- Some patients had syringe drivers, which delivered measured doses of drugs over the course of 24 hours. We saw examples of appropriately prescribed syringe drivers, which nurses checked to make sure they were functioning correctly and that the patient was receiving the correct doses of medicines.

Records

- We reviewed 22 sets of patient records. We found the vast majority to be legibly written, however on 11 of the patient records, the nurse or doctor reviewing the notes had not documented their name or grade and in six records 'ceilings of care' had not been documented.
- In the nursing evaluation last days and hours of life prompt sheet which was nursing led, we a patient had had nutrition and hydration stopped, without discussion with the family. a family member raised their concern after some time that the patient had not been given anything to drink. Hydration was commenced again.
- Patient notes were kept in unlocked trolleys around the nurse's station which could be accessed by any passer-by.
- Recording of patients who had been identified as entering their last days or hours of life was done by the 'nursing daily evaluation last hours and days of life' prompt sheet.

Safeguarding

- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff had access to the trust safeguarding policy on the intranet.
- Safeguarding was part of the trust annual mandatory training. All nursing staff had access to safeguarding adults levels two and three.
- Staff at all levels knew how to contact the safeguarding lead if they wanted further advice.

Mandatory training

- All staff took part in mandatory and statutory training to ensure they were trained in safety systems, process and practices such as moving and handling, safeguarding, health, safety and welfare, infection control and dementia awareness.
- Portering staff completed mandatory training on their induction and yearly thereafter. Areas covered included privacy and dignity, moving and handling, infection control and prevention, mortuary procedures and safety processes.
- In the 18 months prior to inspection, the palliative care team had undertaken a programme of training which included ward visits which was delivered to over 1000 staff. The team advised palliative care training was not mandatory training but they were piloting a new form of training provision which would be rolled out on a monthly basis if successful.
- In the 18 months prior to inspection, the palliative care team had undertaken a programme of training which included ward visits which was delivered to over 1000 staff. The team advised palliative care training was not mandatory training but they were piloting a new form of training provision which would be rolled out on a monthly basis if successful.
- Dementia awareness formed part of the mandatory training programme.

Assessing and responding to patient risk

- Patients that were recognised as deteriorating or dying were started on the end of life plan. We were told by staff this was commenced following discussions with the palliative care team.

End of life care

- The trust used the early warning score (EWS) system for monitoring acutely unwell patients, to alert staff of a deterioration in their condition. Staff on the wards were aware they could access advice and request support from the palliative care team if their patient had been identified as requiring palliative support.
- Where the progression of a patient's illness was clear, the level of interventions was reduced to a minimum. Care was based on ensuring the patient remained as comfortable as possible. When it was identified a patient was nearing the end of their life, monitoring was reviewed to ensure the emphasis was on comfort. We saw the palliative care team had discussed with patients and their families to ensure they understood the plan for keeping the patient as comfortable as possible.

Nursing staffing

- The palliative care team had 10.2 whole time equivalent (WTE) clinical nurse specialists covering the inpatient wards. The nursing staff worked 9am -5pm on weekdays, with one clinical nurse specialist working 9am to 5pm at weekends and public holidays.
- At the time of the inspection, the palliative care team was at staffing establishment.

Medical staffing

- The specialist medical team comprised 2.4 WTE consultants and one WTE specialist training registrars (StRs). Out-of-hours cover was provided by way of a tripartite agreement between three providers. Consultants from St Georges, a local hospice and another NHS Provider provided 2nd oncall support to a StR who was based at the local hospice. on call telephone advice available from a palliative care StR via Trinity Hospice. There were no reported medical staffing vacancies in the palliative care team.
- There was a 0.6 WTE counsellor on the palliative care team.

Major incident awareness and training

- We viewed the mortuary's storage contingency plans and we felt assured that measures were in place to respond to major incidents. The mortuary had a total capacity for 163 bodies with five freezer spaces. In response to a recent report from the Human Tissue Authority (HTA), a further 35 freezer spaces will be built

and available for use from September 2016. Concern had been raised regarding the number of bodies being kept in the body store for longer than 30 day without been placed in the freezer.

- During 2015/16 the palliative care service created or updated a total of 235 'Coordinated my Care' (CmC) records. CmC is a shared clinical service which allows healthcare professionals to record patient's wishes and ensures their personalised care plan is available for all those who care for them, including ambulance and community services.

Are end of life care services effective?

Requires improvement



We rated effective as requires improvement because:

- The Nursing Daily Evaluation Last Hour and Days of life document was a prompt sheet that was not backed up by either assessment or evaluation tools.
- Patient records did not always meet NICE guidelines 2015 for end of life care in various areas.
- We saw no evidence that pain assessment scales were used.
- Staff attendance at training courses was sometimes hindered by workloads.
- The out of hours service which was provided by Trinity Hospice did not have a formal service level agreement.

However

- The trust performed above the England average in four out of the five clinical key performance indicators in the national care of the dying audit - hospitals 2016
- A seven day face to face service was provided by the palliative care team.

Evidence-based care and treatment

- The palliative care team had responded to the report of the independent review of the Liverpool Care Pathway and introduced in April 2016 a replacement document which the trust feels to be in line with the five priorities of care of the dying person (One Chance To Get It Right, 2014), Ambitions for Palliative Care and the NICE Guidelines on Care for the Dying Adult in the Last Days

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of Life documents. The document was the 'Nursing Daily Evaluation Last Hours and Days of Life' which is a prompt sheet for staff to consider in the daily review of the patient. This document was reviewed during our visit and it was felt it was a list of prompts which were not backed up with either assessment tools or any evaluation tool to show whether the prompt has been addressed. For example, there was no evidence of any pain assessments or pain evaluations used in conjunction with it.

- The records we reviewed did not always meet the NICE guidelines 2015 for end of life care for review of symptoms, pain control, discussion and communication with the patient and the people important to them. Of the 22 records we reviewed, evidence of established ceilings of care were not documented in six patient records. Evidence of discussions with family member was not documented on three occasions.
- The trust undertook an audit of the rapid discharge (fast track) service 1 April 2015 – 31 March 2016. The conclusion being the service increased in demand during 2015/16, but 60% of patients were discharged within five working days.

Pain relief

- In the patient files we reviewed we did not see any evidence of the use of either the numeric rating scale (NRS) and/or verbal rating scale (VRS) to assess pain in patients with verbal and non-verbal skills. Behavioural pain scales were not being used and any pain assessments that were undertaken were very generic.
- We found that anticipatory prescribing followed the NICE guidelines for symptom control. Some pain control was managed by PRN (pro re nata or as required) analgesia.

Nutrition and hydration

- Nutrition and hydration needs were identified in the patient notes and we saw evidence of the use of fluid balance and food charts.
- We did however see that the use of the 'nursing daily evaluation last hours and days of life' prompt had caused confusion regarding a patient's hydration and nutritional needs. In that patient's case it was the family who had highlighted to the ward staff they were concerned as to the lack of fluids been given to the patient.

- "Encourage and support oral food/ hydrations as patient is able" is a prompt on the nursing daily evaluation last hours and days of life prompt sheet. We saw evidence patients were supported to eat and to drink.
- Patients told us the food was good and drinks were available frequently.

Patient outcomes

- We found that the palliative care team were not providing a specialist palliative care service. they were providing a generalist end of life service to all dying patients within the hospital rather than focusing on complex patients who required a specialist palliative care service. The palliative care team was an advisory team who offered guidance, education and training to the medical specialities. The team reported that their remit was not to 'take over the care' of dying patients but to support the generalist medical teams in their delivery of good end of life care.
- The trust participated in the National Care of the Dying Audit – Hospitals (NCDH). The audit was made up of an organisational assessment and a clinical audit. St George's Hospital performed above the England average in four out of the five clinical key performance indicators (KPI) and achieved four out of eight organisational KPIs in the 2015 audit. Clinical audit revealed gaps in the following KPI:
- There is documented evidence in the last 24 hours of life of a holistic assessment of the patient's needs regarding an individual plan of care.

Organisational KPIs where gaps were identified were as follows:

- KPI6 Lay member on the trust board with a responsibility/role for end of life care.
- KPI 8c Did formal in-house training include specifically communication skills training for care in the last hours or days of life for nursing (non-registered) staff and KPQ 8d allied health professional staff.
- KPI10 end of life care facilitators within the trust as of 1 May 2015

End of life care

- The palliative care team had analysed the main findings of the audit and had proposed a number of recommendations to improve the service and they plan to undertake an end of life care audit later in 2016.

Competent staff

- The palliative care team was made up of competent and highly trained individuals.
- Attending additional educational courses was sometimes hindered due to the workload.
- The palliative care team provided support at the bedside to generalist staff. The clinical nurse specialists visited the same wards every day and were available by bleep to identify any help the staff and patients may need.
- The trust had successfully bid for funding from Health Education South London (HESL) for two cohorts to undertake the Quality End Of Life Care For All (QELCA) programme. The QELCA programme supports generalist staff to deliver end of life care for all patients with a focus on compassionate, individualised care. The QELCA was designed by St Christopher's Hospice to enable and empower teams to lead change in culture. Two cohorts from acute medicine and oncology had successfully completed the training programme.

Multidisciplinary working

- The palliative care team did not hold multidisciplinary team (MDT) meetings. There was a morning meeting where the team discussed all the patients that had died overnight, any new referrals overnight, those who were identified as in the dying stage and who they would visit that day..
- Each of the clinical nurse specialists had their own caseload of patients, however the team held a briefing each morning to have formal discussions about each patient.
- The clinical nurse specialists attended ward MDT meetings, especially on wards where end of life care patients were identified.
- There were clear pathways between the hospital and the community organisations to enable rapid discharge of patients who were fit for discharge to their preferred place of care.

- An out of hours telephone advice service was provided by an on call palliative care specialist registrar from Trinity Hospice. We were told there was no service level agreement for this arrangement.

Seven-day services

- The palliative care service operated a face to face visiting service seven days per week 365 days per year from 9am to 5pm. The service on Monday to Fridays consisted of palliative care clinical nurse specialists, palliative medicine consultants, a specialist registrar and a counsellor. On weekends and public holidays, one clinical nurse specialist was on site from 9am to 5pm. Outside of these hours, an on call telephone advice services was provided by Trinity Hospice.
- The mortuary provided a seven day service with viewings arranged by appointment on Saturday and Sunday.

Access to information

- Each ward had a palliative care resource folder for staff to refer to when required. It contained practical information such as the DNACPR forms, bereavement booklet given to families when a patient died and mortuary forms. Ward staff were aware of these files and found them to be helpful.
- The palliative care team used both paper and electronic patient records. We did not find that this caused any confusion within the service.
- The palliative care team had access to 'Coordinate my Care' (CmC), an electronic system developed to give patients an opportunity to create a personalised urgent care plan to express their wishes and preferences in relation to how and where they were treated and cared for.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence of consent being asked for and given by patients during ward rounds, we also saw evidence of consent in the majority of the patient records we reviewed.
- In the 19 DNACPR records we reviewed we saw assessment of patient capacity in 17 records. Evidence

End of life care

that a discussion had taken place with the family or next of kin of the patient was not present in six of the records and in four of the records we reviewed, the DNACPR had not been reviewed and endorsed by a senior clinician.

- Staff undertook Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training as part of their mandatory equality and diversity and human rights training. Staff we spoke with were able to describe accurately the process they would follow should someone be found to be not able to make a decision in relation to their care or give consent to agree to treatment

Are end of life care services caring?

Good



We rated this service as good for caring because:

- Patients were treated with dignity and respect. Staff were caring and supportive
- Patients and families of patients were happy with the care they were receiving.
- The local registrar attended the hospital two afternoons per week to register deaths.

Compassionate care

- Staff consistently treated patients with dignity and respect. Nurses and doctors from the palliative care team introduced themselves to patients and sought permission to enter their bed space. Ward staff drew curtains around bed bays when privacy was needed. Patients who remained on the ward in their final stages of life were moved to side rooms where possible.
- Interactions between staff and patients were positive across the service. Staff were warm and caring, with a compassionate and sensitive manner.
- We observed staff providing care and support. We noted how they took care to explain what they were going to do and how they were going to do it.
- We accompanied nurses and doctors from the palliative care team when they visited patients on the wards and observed how they spoke to each patient empathetically about their worries and fears. Symptoms

were discussed and treatment options were explained to each patient, before a final decision was reached. Agreed changes were then made to patient records and these were shared with the wider team.

- Patients and families told us they were happy with the care they had received. They told us call bells were answered promptly and staff were kind.
- Porter and mortuary staff said the bodies of deceased patients were handled with dignity and respect. The porters who collected the bodies from the wards performed their role with caring and concern for the deceased and their family members.
- We were told the area around the bed spaces in some wards was very cramped and it was difficult at times to position the containment trolley at the bedside without moving lots of furniture.
- The bereaved family members made an appointment at the bereavement office to collect the forms needed to register the death. The local registrar attended the hospital two days per week so register deaths on sites, which assisted family members who did not then have to travel to the local town hall to register the death.
- The trust undertook their first bereavement survey from April 2016 – June 2016. There were 31 respondents and the feedback was good. Approximately 90% of the respondents felt communication, comfort and overall care was either excellent or good. 90% of respondents also felt their deceased family member/friend had been treated with dignity and respect.
- The palliative care team counsellor was in attendance on one of the wards we visited, he was meeting with a family member of a patient who was in the last days of their life and he was there to talk through the family members concerns.

Understanding and involvement of patients and those close to them

- The patients we observed had a named nurse, which allowed patients and family members to know who was caring for them on that day.
- We found the nurses and doctors from the palliative care team had a good understanding of their patients. They spoke about them in a personable and caring way. Care was planned and delivered in a way which involved the patient and their family.

End of life care

- Most records showed some discussion between clinicians and patients and family members. A relative we spoke to said “the care was very good, they have explained what they are doing to (my relative) to me and I am in agreement”.
- Family members were able to stay overnight. If the patient was in a side room, family members could stay in the room with them, but if the patient was in the ward, the family member could stay in the relative’s room. Concessionary parking fees were offered to family members staying overnight.

Emotional support

- The palliative care team had a counsellor who provided emotional support to patients and family members.
- The bereavement and Macmillan offices provided information and contact details for local support groups and bereavement counselling services for family members to contact.
- The hospitals multi-faith chaplaincy service was available to support patients and we saw evidence of this service being offered to patients.
- The bereavement officers supported bereaved families and friends after a patient’s death by explaining all the legal process and what to expect when someone had died. An information pack which included contact details for support and counselling groups was provided.
- The chaplaincy services told us they visited the wards to support patients and relatives when requested. The chaplaincy service also held a number of services which family and friends could attend during the year in order to remember their relative or friend who had died at the hospital.

Are end of life care services responsive?

Good



We rated this service as good for responsive because:

- The Macmillan Cancer Centre offered advice and support to patients who had cancer.

- The spiritual centre provided for people of faith or those of no faith, remembrance services were held annually and services of many faiths were held on a regular basis in the centre.
- 89.5% of patients on the fast track discharge pathway were able to go to their preferred place of care.
- The palliative care team counsellor provided emotional support for patients and their family member

However

- Only 60% of patients were being discharged within 5 working days which is not very rapid.
- A stair lift previously used to support visitors with reduced mobility easy access to the mortuary viewing room was faulty. The trust reported that the stair lift had been decommissioned however this had not been communicated to mortuary staff. As such, mortuary staff reported difficulties for those with reduced mobility having easy access to the mortuary viewing room.

Service planning and delivery to meet the needs of local people

- The trust’s end of life care strategy was out for consultation and phase one of a five year plan. The first phase was focused on improving care of patients in the last days and hours of life at St George’s Hospital during 2016-17. The aim of the strategy was to ensure that all people reaching the end of their life received the most appropriate care and support for their own circumstances.
- The hospital did not have dedicated end of life care beds. Patients identified as being in the last day or hours of life were mostly cared for on general medical or surgical wards. Staff told us where possible patients were moved to a side room to offer more privacy when they were nearing the end of life.

Meeting people’s individual needs

- For patients and family members of patients affected by cancer, the Macmillan information centre, which was open Monday to Friday 10am – 4pm (except bank holidays), offered practical, emotional and financial support and information. The centre was able to direct patients and relatives to local and national support services and signpost them to self help and support groups. The centre provided support in a quiet and calm

End of life care

environment with a full range of patient support documentation in paper format. Staff told us feedback about the service was good; however we were unable to talk to any services users during our inspection.

- Patients described how the nursing staff answered call bells very promptly and made sure they were comfortable and cared for.
- The bereavement office carried out the administration of a deceased patient's documents including the Medical Certificate of Cause of Death (MCCD) and their belongings, as well as signposting relatives to registering the death and planning a funeral. The bereavement office had a quiet room, where interviews of the bereaved relatives could take place in privacy.
- We visited the mortuary and saw the viewing suite where families came to spend time with their relatives after their death. The viewing suite was neutral in colour and devoid of any religious insignia. However, we were shown religious insignia by the staff which was available upon request. Appointments could be organised Monday to Friday.
- The mortuary manager told us an effective procedure was in place to log the deceased into the mortuary. We were walked through the process and we were shown the ledger which contained the required information. We observed the book was completed appropriately and neatly and was completed in a respectful way. Confidentiality was maintained at all times.
- Mortuary staff told us they were unable to provide an area for religious washing of bodies.
- The spiritual care centre had both a female and male prayer room, a quiet multi-faith room and multi-denominational Christian chapel. The rooms were available for use by those of faith or no faith.
- A Muslim prayer room was available, with two carpeted prayer rooms. There were no washing facilities.
- Sacred texts were available through the chaplaincy. There was no Shabbat room but the multi-faith quiet room was used to celebrate Hanukkah.
- Separate annual remembrance services were held for the following groups neonatal, pregnancy and miscarriage, organ donations service, children and adults. They were very well attended. The services were for those of faith or no faith.
- A range of services took place in the chapel weekly, including Roman Catholic mass (Sunday), rosary (Friday), holy hour (Thursday) and prayers (Friday).
- The chaplain told us she attended both the end of life operational and programme boards. The chaplain had also been involved in the developing of the end of life strategy draft. The chaplains were involved in delivering training to staff at inductions. The chaplaincy provided services tailored to patients' individual needs, for example, they conducted contract funerals of deceased patients who had no known relatives.
- Translation services were available and the bereavement officer showed us how they accessed the 'on the phone' service and how to arrange for a face to face translator.
- - The lift used to access the mortuary for people with mobility problems was broken and had not been working for over two years. This meant the mortuary was difficult to access for family members if they had mobility problems. They had to navigate a service road to gain entry into the mortuary. Mortuary staff told us they had repeatedly raised the issue with the estates department, but had not been able to remedy the situation. The trust subsequently reported that the lift had been de-commissioned circa two years previously due to significant concerns relating to the health and safety of users. The trust reported that contingency plans existed so as to address the issue however it was apparent from our discussions with mortuary staff that these arrangements had not been effectively communicated.

Access and flow

- The palliative care team had 1615 referrals in from April 2015 to March 2016. This was an increase of 442 patients from the previous year. Of those referrals, 1430 were new patients to the service and the remainder had been

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seen by the palliative care team on a previous admission. All urgent referrals made from April 2015 – March 2016 were seen within 24 hours and non-urgent referrals were seen within 48 hours.

- We were told systems were in place to facilitate the fast-track discharge of patients to their preferred place of care or preferred place of death. A clinical nurse specialist had taken on the role of palliative care fast track discharge co-ordinator.
- The rapid discharge service (fast track) report detailed 285 patients who were eligible for 'fast track' under the national framework during the period April 2015 and March 2016, which was an increase of 17.28% from the same period in 2014-15. Of the 285 patients, 59.3% had a cancer diagnosis and 40.7% had a non-cancer diagnosis. 89.5% of patient achieved their preferred place of care. 60.9% of patients referred into the fast track service were discharged within five working days of the referral to the service.
- The increase in numbers of non-cancer diagnosis patients being eligible for fast track funding had been anticipated by the trust and had been increasing steadily since the changes to the national continuing care framework.

Learning from complaints and concerns

- We visited the patient advice and liaison service (PALS) during our inspection and we were informed there had not been any complaints regarding end of life care in the last six months.
- Staff on the wards told us any concerns raised with them were discussed and rectified as soon as possible. Learning from complaints was disseminated to staff at team/ward meetings.
- The bereavement office staff told us during their meetings with family members after the death of a patient, if any issue arose around the care of the patient, they contacted the ward to resolve the matter for the family.

Are end of life care services well-led?

Requires improvement



We rated this service as requires improvement for well led because:

- The end of life care strategy was more of an action plan than a strategy, ;there were no clear pathways to achieve the results detailed within the document.
- The palliative care team were not supporting staff on the wards to care for non-complex patients. The palliative care team saw all dying patients. The referrals into the service had increased year on year and it was felt this was unsustainable . unless funding was sourced to support the continued expansion of the team.
- There was a lack of strategic direction for the service from the top of the organisation.

However

- The trust had appointed an end of life care non-executive director one month prior to our visit.
- The chaplain attended both the end of life programme board and operational groups, which demonstrated the trust recognised the importance of religious and spiritual input to the delivery of the end of life care service.

Vision and strategy for this service

- The trust was consulting on their five year end of life care strategy during our inspection. The first phase of the strategy to get underway in 2016-17 was to focus on improving care of patients in the last hours and days of life at St George's Hospital. The strategy had drawn from a number of national publications and guidance, but focused on the 'Ambitions of Palliative and end of life care' as a framework for their organisational change. They aim to achieve the strategy through identification, fair access to care, advance care planning, co-ordination of care, education and training and by involving carers, families and the community. However the strategy appears to be more of an action plan without clear pathways to achieve the results described within.

End of life care

- We felt it would be very difficult to provide the required level of service if the number of patients being referred continued to increase at the level it had year on year during the preceding years.
- Some of the ward staff had been proactive in seeking skills and competencies outside of the palliative care team through training from Trinity Hospice.
- The members of the palliative care team we spoke with had a clear understanding of the strategy, however at ward level we were not assured all staff understood the aims and objectives of the strategy and how it was being implemented.
- An end of life care non-executive director has been appointed one month prior to our inspection.

Governance, risk management and quality measurement

- The end of life programme board took place monthly, with attendees from palliative care, deputy nursing director, mortuary, chaplaincy, patient experience manager and patient representative. The agenda discussed included the end of life strategy and policy, training and education and raising awareness.
- The end of life operational group met monthly and attendees included deputy director of nursing, patient experience lead, palliative care team, practice educator and a physiotherapist. The agenda items discussed included national guidance, current service provision, care plans and education and training.
- The director of nursing had been appointed as the nominated board lead for the development of the end of life strategy. A non-executive director had been appointed to report to the board on end of life services.
- The palliative care team had been on the trust's risk register for over a year due to staff vacancies within the team, however they had now been removed from the risk register because they were at full establishment.
- The mortuary risk register identified the areas of concern about the broken lift and carpet that needed replacing in the viewing waiting room due to it being a trip hazard.

Leadership of service

- There appeared to be good leadership within the palliative care team, led by the consultants and nurses. We observed the palliative care team were visible and responsive.
- The chaplaincy service was led well by the lead chaplain. We observed the chaplaincy team were visible and responsive. The lead chaplain was a member of the end of life care programme board and operational groups. This highlighted the trust recognised religious/spiritual input was important in the delivery of end of life care.
- Whilst we were told end of life care was 'everyone's responsibility', we observed that whilst the palliative team worked well, there was a lack of strategic direction for end of life care from the top of the organisation. The appointment of the new end of life care non-executive director may address this issue but they had only been in post one month at the time of our visit and had not attended the end of life programme board yet.

Culture within the service

- We saw members of the palliative care team were dedicated and passionate about providing end of life care to patients and their families. The ward staff told us the palliative care team were "excellent" and "always available to support".
- All staff we spoke with demonstrated a positive and proactive attitude towards caring for people who were dying. Staff felt they could speak out and were listened to. This was demonstrated when we spoke to a nurse on Amyand Ward who told us she felt she could speak out if she had a concern and felt she would be listened to.
- The chaplaincy team told us that they felt the palliative care team were "dedicated and supportive".
- The mortuary manager told us he contributed to the development of the end of life care strategy. The porters and undertakers were frequent visitors to the mortuary and were able to see where the mortuary staffs' work fitted into the end of life care services.
- On the wards we visited, we saw the palliative care team were well respected and integrated well with the nursing and medical staff.

End of life care

Public and Staff engagement


- There was patient representation on the end of life care programme board and operational group, to give the patients and families their “voice” in discussions about the service.
- The chaplaincy service organised annual remembrance services throughout the year to which bereaved relatives were invited.
- The bereavement office conducted a survey of bereaved family members. Thirty-one families responded to the survey. It was intended the survey will be repeated at regular intervals though out the year.

- The palliative care team engaged with staff on the wards on a regular basis.

Innovation, improvement and sustainability

- The staff within the palliative care team demonstrated a strong focus on improving the quality of end of life care though the national audit results in 2016.
- With the palliative care team now being at full establishment, plans were in place to audit all deaths in the service in 2016 and audit the use of all syringe drivers.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at St. George's Hospital (SGH) were located across the hospital in various locations. The outpatient services were organised into specialties which sat across the four trust divisions. The outpatient and diagnostic imaging services were part of the children and women diagnostics, therapeutics and critical care division. There were a total of 762,490 outpatient appointments at this site between September 2014 and August 2015 for first and follow up appointments.

The trust ran a wide range of outpatient clinics including cardiology, neurology, gastroenterology, diabetes, renal, respiratory and rheumatology. There were surgical clinics for ear, nose and throat, colorectal, vascular, orthopaedics and trauma, including pre-operative assessment clinics. During our inspection, a team of inspectors, specialist advisors and experts by experience visited the main outpatients department, the dermatology and rheumatology clinic, the ear, nose and throat (ENT) clinic, trauma and orthopaedics, diabetes, cardiology, breast care outpatients and therapy services. Phlebotomy, pharmacy and therapy services were provided within the outpatient department areas.

SGH also provided a full range of diagnostic imaging, including general radiography, computed tomography (CT), ultrasound, magnetic resonance imaging (MRI), nuclear medicine and interventional radiology. The service performed approximately 20,000 examinations each month and the radiology department supported the outpatient clinics as well as inpatients, emergency and GP referrals. Inspectors visited both the main and ED X-ray departments

in St James' Wing, the scanning and MRI departments in Lanesborough Wing, breast imaging in the Rose Centre and interventional imaging in the Atkinson Morley Wing. We spoke to a wide range of people, including radiologists, radiographers and patients.

We spoke with 20 patients, carers and relatives. We also spoke with 64 members of staff including managers, reception and booking staff, nurses of all grades, radiographers, healthcare assistants, doctors, consultants and domestic staff. We observed care in outpatient clinics and three radiology procedures. We received comments from our listening and staff focus group events and from patients and the public directly.

We also reviewed the systems and management of the departments including the quality and performance information.

Outpatients and diagnostic imaging

Summary of findings

We rated this service as inadequate because:

- There were several examinations where radiographers gave contrast to patients despite PGDs not being in place.
- The systems in place for the prevention of healthcare associated infections with specific regard to hand hygiene, were not being consistently followed throughout the outpatient department. Monthly clinic hygiene and cleaning audits were completed by the contracted cleaning provider, however, the results did not reflect the cleanliness of the areas we inspected, which were worse than the results indicated.
- The design, maintenance and use of facilities and premises did not keep people safe at all times. Some of the areas were cramped and very busy.
- Staff were not able to observe the patients waiting in their departments.
- Staff struggled to maintain patient privacy and confidentiality, mainly due to the lack of space and overcrowding of certain clinics.
- There was limited audit of patient waiting times for clinics and all the clinics we attended over-ran.
- Staffing levels had been critically low and the outpatients had been running at approximately 50% vacancy rates. However, the staffing structure had been reviewed and vacancy rates were much improved in outpatient administration areas.
- Availability of records for outpatient clinics had improved since the last inspection although we found the records were easily accessible by the public during clinic sessions, often left in unsupervised areas.
- The introduction of the Electronic Data Management System had ongoing issues and extra capacity was needed to ensure further roll-out.

However:

- Most staff had completed mandatory training.
- Staff were aware of their responsibilities within adult and children safeguarding practices and good support was available within the hospital.

- Staff followed consent procedures and had a good understanding of the Mental Capacity Act 2005.
- Staff were committed to delivering good care, but morale was low and they felt under pressure.
- Staff were caring and involved patients, their carers and family members in decisions about their care.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated safe requires improvement because:

- There were several examinations where radiographers gave contrast to patients despite PGDs not being in place.
- Cleaning and routine checks on equipment were in place and complete, however, staff told us they felt the cleaning audits were inaccurate and did not reflect the actual condition of the clinic areas.
- We did not see staff fully adhering to infection control procedures as hand gels was not routinely used by staff or patients.
- There had been insufficient staff in outpatients to manage the service but a recent recruitment drive meant most vacancies had been filled. Staff were yet to start in these posts and bank and agency staff were still in place. The paediatric ultrasound service in particular was under strain to manage the workload.
- Staff and patients were unsafe in ED X-ray should a patient become acutely unwell, because there was no way for staff to raise the alarm in the department.

However:

- The corporate risk register highlighted that the diagnostic imaging department was not complying with all the policies and procedures based on the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The IR(ME)R regulations are to protect patients, staff and the public. However, we found measures put in place appeared to be appropriate to address the problem whilst minimising the impact on patient care and referral pathways.
- The majority of records were available for outpatient appointments and a new tracking system was in place to reconcile clinic need with the available notes during the transition from paper to electronic records. This process, however, was not consistently used in all clinics.
- There was evidence of the WHO checklist being completed and audited in interventional radiography. Patient protocols were in place in radiology.

- There was an Outpatients Transformation Plan in place to improve the systems and process, invest in IT and review the estates.

Incidents

- There was a trust-wide incident reporting policy in place. There were no 'never events' reported for outpatients and diagnostic imaging between May 2015 and April 2016. (never events are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented).
- The trust provided the datix incident log covering outpatients and diagnostic imaging from April 2015 to March 2016. The majority of the 798 incidents reported during this time were of low or no harm to patients/staff/visitors. However, the outpatients and diagnostic imaging services reported a total of eight serious incidents during this time. We saw that incidents had been investigated and root cause analysis had been completed to identify the causes of the incidents. Patients and their families had been involved and informed. Incidents were reported using the trust's electronic incident reporting system (Datix.) Actions and learning were disseminated to staff in various formats including the departmental meetings and the daily outpatient huddle. Some staff we spoke to could not describe the incident reporting system and said they were often too busy to find out and use it anyway. They were not aware of the serious incidents that had been reported during the past year.
- We looked at the minutes for the meeting of the clinical diagnostic clinical directorate group covering March, April and May 2016. High level reports on incidents were discussed but there was no evidence of discussion on trends and any lessons learnt. Senior staff in outpatients gave an example of how practice was changed in the process for managing outpatient outcome forms following a reported incident. No follow up appointment had been given to a patient in February 2016. An audit was done on outcome forms from January – March 2016. Results showed 63 patients had not been followed up. Outcome forms were now scanned to ensure an electronic record.

Outpatients and diagnostic imaging

- Standard Operating Procedures were put in place to support inexperienced staff in the area to understand the process. Administrative staff were asked about this process in one clinic and they were not clear of the process.
- We saw the trust's Duty of Candour policy and templates for duty of candour letters. Staff we spoke to told us about their understanding of the duty of candour and their obligations. They were less sure of the systems in place to ensure patients were fully informed of the circumstances which led to any incident resulting in severe/moderate harm. The hospital had processes in place to report any radiation incidents to the Care Quality Commission (CQC) under Ionising Radiation (Medical Exposure) Regulations (IR (ME) R). At the time of the inspection, there were no open cases with the CQC.

Diagnostic Imaging

- NHS trusts are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R. Diagnostic imaging services had procedures to report incidents to the correct organisations, including CQC. At the time of the inspection, there were no open cases with the CQC.
- Every radiographer we spoke to knew how to report incidents that occurred within the department. They also knew what 'duty of candour' was and all said that they would be open and honest with a patient if something had gone wrong.
- Staff told us that they felt confident to raise concerns because of the close-knit nature of the department.
- Staff told us that feedback and learning from incident investigations was shared during monthly staff meetings. They also told us that any changes to practice implemented following an incident were communicated to staff by email in addition to being discussed at staff meetings.
- Incidents were presented at monthly radiology clinical governance meetings. Actions from these meetings feed into the radiation protection committee, which meets twice a year.
- Local rules were evidenced as required under Ionising Radiations Regulations 1999 (IRR99) and were within review dates. IRR99 are a statutory instrument, which form the main legal requirements for the use and control of ionising radiation in the United Kingdom.
- The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) procedures were in place and all documentation was available on a shared drive. This ensured only the most recent versions were available for staff to reference.

Cleanliness, infection control and hygiene

- On visual inspection, all areas we visited in outpatients and diagnostics appeared clean and tidy, including the toilets and changing rooms. Monthly audit records for cleaning and hygiene were displayed in most areas, but the staff were not happy with the results. The results showed overall 98-100% compliance, but did appear to be the same results each month. One audit was repeated in March by the charge nurse and infection control nurse. This audit showed actual compliance rate of 52% as opposed to 98%, which had been recorded by the cleaning company. Feedback was given but staff had not received adequate feedback.
- Posters prompting hand hygiene were clearly displayed and hand gel pumps were available across the areas. We did not observe any staff or patients using them during an extended observation in the main outpatient area. On one occasion, twelve medical students walked into the audiology clinic and none of them used the hand sanitising gel. This was brought to the immediate attention of the infection control nurse and consultant microbiologist.
- We observed the majority of staff adhered to the 'bare below the elbow' guidance and staff wore personal protective equipment (PPE) where necessary. This reduced the risk of infections to staff and patients and was in line with good practice.
- Infection prevention and control policies were available for staff to access on the intranet. The infection control link nurse details were clearly displayed in the clinic areas.
- All sinks were hand wash stations and fully compliant with HBN 0009 Infection Control in the Built Environment (March 2013), which is department of health best practice guidance.
- All soft furnishings were wipe able and in good condition except for a couch in the ENT clinic which had a large tear in the fabric. This was an infection risk and although staff told us it had been escalated via the

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incident process, it had not been removed from service. The chair displayed an 'I Am Clean' sticker which was contradictory in nature as the chair could not be fully cleaned due to its poor condition.

- The vinyl floor in the departments was in good condition.
- Mandatory training records showed that 76.32% of nursing staff in outpatients had attended infection control training against a target of 85%.
- The outpatient department was given prior notice of infectious patients by the infection control team. There was not a dedicated room but once the clinic room had been used, the rapid response cleaning team would be contacted and the room deep cleaned before making it available for further use.
- The ENT clinic decontaminated nasoendoscopes locally within the department which is no longer compliant with new decontamination guidance. This was highlighted on the corporate risk register. Senior staff were unaware that it was on the register. The risks related to the environment, process and tracking of equipment, which currently placed staff and patients at potential risk of chemical toxicity and cross contamination. Further risks arose from the decontamination process on the wards due to a lack of separate clean and dirty space to undertake the correct procedure.
- The outpatients department had infection prevention and control link nurses in place that attended infection control meetings and then reported back to the rest of the team.
- We observed good waste streaming with the use of hazardous waste bins and recycling bins. We found the temporary closure on sharps bins was not used. This contravenes the Health and Safety legislation on waste regulation.
- Hand hygiene audits were carried out across all outpatient areas. We saw action plans were put in place where improvements needed to be made.

Diagnostic Imaging

- All areas within the radiology department appeared clean.
- Staff of all specialties and professions were 'bare below the elbow' however, none were seen washing their hands or using sanitising gel between patients, with the exception of staff in the neuroradiology department in the Atkinson Morley Wing.

- We saw results of a hand hygiene audit in radiology that showed that 100% of staff observed were compliant with trust policy.
- We saw a departmental cleaning schedule in MRI that was completed and up to date. We also saw the use of 'I am clean' stickers on equipment throughout radiology.
- We saw up to date daily disposal and contamination monitoring records in nuclear medicine. All radiation waste within nuclear medicine was disposed of appropriately and the process fully documented. Reports were sent weekly to the Radiation Protection Advisor and monthly to the Environment Agency.
- We saw an infection control audit from May 2016 displayed in the breast-imaging department that showed compliance ranging from 91.3 – 100% compliant.

Environment and equipment

- There was resuscitation equipment available across outpatients and diagnostics. We looked at resuscitation trolley checklists and found them to be checked and signed on a daily basis. The outpatient teams took responsibility for checking on a rotational basis.
- Medical physics kept a log of all outpatient equipment including dates due for maintenance and electrical safety testing. All testing and maintenance was in date. Outpatient couches and chairs were not routinely checked by the department.
- Bariatric chairs were available in most outpatient areas and staff knew the policies and protocols around their use.
- There was a dedicated phototherapy treatment room and radiation warning signs were in place.

Diagnostic Imaging

- X-ray equipment had regular servicing carried out by manufacturer engineers. We saw evidence of the manufacturers completed service reports. We also saw evidence of routine surveys of all X-ray equipment.
- The diagnostic imaging department's risk register included replacing ageing imaging. Staff told us there was no capital replacement programme in place and a business plan had to be written each time equipment needed replacing which was a time consuming process.
- There was a resuscitation trolley in the interventional room in the main radiology department. The equipment check was correct and up to date. This was also found to be the case with the resuscitation trolley located in the breast-imaging department.

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- Records on the resuscitation trolley located in the ultrasound department showed that both daily and monthly checks had been made however, the monthly stock check showed that some items were missing from the trolley. There was no evidence that the missing items had been replaced. We raised this with the sonographer working in the area and they addressed it at the time of the inspection.
- The resuscitation trolley in the ED CT department had been taken away to be restocked following an arrest the previous day. Despite the fact that the resuscitation trolley had not been returned more than 12 hours after the cardiac arrest, the radiographers had continued to perform cardiac CT scans. This type of scan often requires the patient to be given drugs to alter the heart rate and there is a potential risk that the patient may suddenly deteriorate after being given these drugs. Staff assured us that if a patient arrested they would go and get the resuscitation trolley from ED which is a short distance from CT.
- We saw up to date Quality Assurance (QA) records for the equipment in the breast-imaging department.
- We saw a recent report from an inspection of the nuclear medicine department by the Environment Agency, which had no actions for the trust to address.
- We observed radiology staff wearing specialised personal protective aprons. These were available for use within all radiation areas and on mobile equipment. Staff were also seen wearing personal radiation dose monitors which were monitored in accordance with the relevant legislation.

Medicines

- The medicines cupboards we inspected were generally locked and secure, all stock was within expiry date and there was evidence of stock rotation. There were some drug cupboards containing lignocaine that were open. Also a cupboard containing substances hazardous to health was not locked during a busy outpatient clinic.
- Fridge temperatures were checked and recorded daily and were within the required range to store medicines safely.
- Prescription pads were stored securely in locked cupboards and drawers. There was no system in place to record and log the usage of the prescription pads by clinicians. This meant there was no information

available to identify the serial numbers of the prescription sheet used, the patient prescribed to or the doctor prescribing. This did not meet best practice guidelines for the use of controlled drug stationary.

- Staff were aware of the policies involving medicines management and knew where they were located in the department and on the staff intranet.

Diagnostic Imaging

- We checked the contrast warmers throughout the department and all bottles of contrast were found to be in date.
- We were told that Patient Group Directives (PGDs) had been written but were still awaiting approval from the pharmacy. These documents allow radiographers to give patients contrast agents and a very limited number of drugs without an individual prescription from a doctor. We observed several examinations where radiographers gave contrast to patients despite these PGDs not being in place.
- The fridge temperature logs were accurate and up to date.
- We checked the controlled drugs cupboard in interventional radiology and found that records were accurate and up to date.

Records

- The main records store was in a secure area that could only be accessed by authorised staff.
- However, we observed that medical records were often left in unsupervised areas within the outpatient clinics. Some clinics used a large cage on the reception desk to store the notes. This not only looked unprofessional, it also allowed very easy access to the notes from the public.
- The records were in the process of being transferred to a full electronic system. The process had not been fully completed and there were still issues to resolve in the transfer. Some staff told us that neither the paper notes nor the scanned copies were available for the clinics. Senior staff outlined the process in place to mitigate the risk of missing notes. Clinic staff were to look at the clinic list 24 hours in advance and escalate to medical records any missing notes. This process was not consistently used across the clinics. The trauma and orthopaedic clinic recorded missing notes on the day

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and during the week of the inspection, over two clinics, there were three patients with no imaging reports, one patient with no referral letter, four patients with no notes and two patients booked into the wrong clinics.

- We looked at the audit of notes being available in clinic from April 2015 to April 2016. The target was greater than 98% to be available. Results ranged from 95.42% to 97.2%, therefore not reaching the target in any of the months audited.
- To support the tracking of patient files the trust has moved towards an electronic tagging system. We were told this was an efficient and effective system and notes could be more easily located across the hospital. Audit results demonstrated an improvement.

Diagnostic Imaging

- The trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records were stored securely and access was password protected.
- The RIS and PACS systems interfaced well with one another and there was rapid access to stored data.
- We looked at 10 patient safety checklists in both MRI and CT, all of which had been accurately completed.
- We reviewed five patient records on RIS and saw that the radiographers had completed them accurately, including the documentation of who checked patient identification and the recording of patient dose information. We also saw evidence that the radiographers had checked and documented patient pregnancy status in line with departmental protocol
- We reviewed the daybook for one of the scan rooms in the nuclear medicine department. We found that it had been only partially completed, with frequent failures to record whether images had been checked on PACS. The daybook was used for departmental audit purposes, and the trust had alternative failsafe mechanisms to ensure that films were archived before deletion.

Safeguarding

- Safeguarding has three levels of training; level one for non-clinical staff, level two for all clinical staff and level three for staff working directly with children and young people. Level 2 training at SGH was on-line and staff were responsible for accessing this. The outpatients department reported a compliance level of 94.74% for

outpatient nursing staff attendance at adult safeguarding training against a target of 95%.

Compliance for children's level 2 safeguarding training was 93.33% against the trust target of 95%.

- We saw policies in place and in date for both safeguarding children and adults.
- The majority of staff we spoke with demonstrated they understood safeguarding processes and how to raise an alert. They could access support from senior staff if needed and were able to show us the electronic policies and procedures. Some staff were unable to tell us the correct procedure and said they would deal with the patient directly.
- We saw the trust had a current whistleblowing policy.

Diagnostic Imaging

- All staff we spoke to had completed the correct level of safeguarding training.
- All radiographers that we spoke to knew who the adult safeguarding lead was, however, they were unsure who the paediatric safeguarding lead was as this post changed recently. All radiographers that we spoke to knew how to contact the safeguarding leads and flowcharts describing the process were displayed throughout the department.
- One of the radiographers told us they had raised a safeguarding concern and because of this had created a flowchart for use in the department to assist other colleagues needing to raise a similar concern.
- Staff in the nuclear medicine department described a robust procedure for highlighting when paediatric patients did not attend for their appointments on a number of occasions. They described a system of emails and contacts with consultants to ensure that safeguarding concerns were raised and those paediatric patients did not "slip through the net".

Mandatory training

- Mandatory training included infection control, health and safety, fire safety, conflict resolution and safeguarding.
- We saw records that showed 94.74% of outpatient nursing staff had completed conflict resolution training, 86.84% had completed fire training and 94.74% had completed health, safety and welfare training.
- Mandatory training included e-learning and face to face meetings. Staff told us the quality of the training was good.

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- The trust target for all mandatory training was 95%. Targets were not being met in outpatients for some of the subjects. For example, manual handling was at 72% and fire training at 76%.

Diagnostic Imaging

- Radiology management told us that all radiographers were up to date with their mandatory training and all staff we spoke to confirmed this.

Assessing and responding to patient risk

- The trust was not meeting the urgent two week referral target for patients with suspected cancer. The overall trust position was 87.8% against a national target of 93%. The target had only been achieved in three out of the twelve months from April 2015 to March 2016.
- These referrals were received into the central booking service via a dedicated fax machine. Staff told us that some patients received an appointment within the two week period and others did not. This information is supported by the current data reflecting variances across the specialties. For example, lung referrals were running at 95.7% seen within two weeks.
- The trust commissioned an external report published in June 2016 because of concerns with the quality of data being recorded. The report stated that the current RTT patient tracking lists are totally unfit for the purpose of managing patients through their pathways. Patients were being excluded and those included were highly likely to have inaccurate waiting times. The resulting potential impact on patient care had yet to be established and was beyond the scope of this inspection.
- A backlog of 1,000 patients in dermatology had recently had appointments booked. There were now 154 patients waiting over 18 weeks with a further 2014 patients with unknown waits. No patient risk assessment was provided to demonstrate that patients had been prioritised on clinical need.
- A nurse told us clinical observations such as temperature and blood pressure were monitored and recorded prior to, during and after any interventional procedure. This meant the patient was monitored to detect any deterioration in their condition. Systems were in place to contact an emergency response team.

Diagnostic Imaging

- SGH was supported by an 'in-house' radiation protection service. They provided the radiation

protection advisor (RPA), radiation waste advisor (RWA), medical physics expert (MPE), for diagnostic imaging, nuclear medicine, and provided support for lasers and magnet use within diagnostics throughout the trust. However, we were told that there is only one part-time RPA to cover the whole trust, which is unusual for a trust of this size.

- There were radiation protection supervisors (RPS) for each controlled radiation area. Their role met the Ionising Radiation Regulations 1999.
- Dose reference levels were evident for X-ray rooms.
- An adapted version of the World Health Organisation (WHO) checklist was used for all interventional procedures. We saw copies of these scanned into the patient electronic record.
- A radiation safety policy was in place which included the Ionising Radiation Medical Exposure Regulations (IRMER) procedures. There was also a protocol for the management of contamination, monitoring and spillage of radioactive material and a procedure for the disposal of radioactive waste.
- We saw local rules were in place and available for all staff to follow in the imaging areas we visited. They were also clearly visible on the mobile imaging equipment.
- We reviewed the divisional risk register and saw two risks for radiology, both of which were rated as 'extreme'. One of these risks related to the high vacancy rate within radiology and the other was regarding non-medical referrers. We were assured, following discussions with radiology management that work is being undertaken to address both matters and that suitable interim measures have been put in place to reduce the risk to patients.
- Radiology management told us of an issue detected following an upgrade to the electronic referral system. This issue related to the non-medical referrers requesting imaging examinations for patients without having been trained, in line with trust procedure. Radiology management showed us the measures they had put in place to ensure that all non-medical referrers had received training and had scopes of practice in place, outlining the examinations for which they could refer. These measures appeared to be appropriate to address the problem whilst minimising the impact on patient care and referral pathways.
- Staff in ED X-ray told us that there was no way for them to raise the alarm should a patient become acutely unwell. Staff told us that out of hours there might only

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be one radiographer working on their own in ED X-ray as colleagues may be required elsewhere in the hospital and that if they needed help they would have to leave the patient to either call the crash team or go to ED to get assistance.

Nursing and administrative staff staffing

- There were dedicated nursing and healthcare assistant staff across the outpatients department.
- The staff were supported by a Head of Outpatient Nursing, three matrons and three service managers. Senior staff felt the staffing levels were adequate, although there was a demand for extra clinics to meet waiting time targets. Clinics were open from Monday to Friday with extra clinics scheduled in the evening and on planned weekends.
- Bank staff were used to fill gaps in staffing in the outpatients department. Induction was thorough and limited agency staff were used.
- Staff told us there had been significant vacancies over the past year which were slowly being recruited to. Many of the staff we spoke to were new in post during the last six months.
- The central booking centre had a full time establishment of 52 whole time equivalents (wte). They had been 18 wte staff short until recently. They had recruited 10 staff in the last few weeks which were due to start from July 2016 onwards. The service manager left in April 2016 and a new interim post was due to start at the end of June 2016.
- The medical records department reported a recent large number of vacancies that had now been filled. There was currently one wte vacancy which was covered by an agency member of staff.

Medical staffing

- Two new consultant posts were being recruited in dermatology and other specialties such as gastroenterology and gynaecology will review their staffing to meet the increased need.
- Medical cover for clinics was arranged within the specialities.

Diagnostic Imaging staffing

- We saw evidence from February 2016 that the radiology department had an overall vacancy rate of almost 24%. Radiology management told us that the vacancy rate

had recently been as high as 30%. They said that there were currently about 28 whole time equivalent (WTE) radiographer vacancies and four WTE radiologist vacancies.

- Because of the high radiographer vacancy rate, the department was heavily reliant on agency staff. However, the agency radiographer that we spoke to described a very thorough induction programme for all agency staff that included an assessment of competence.
- We saw a comprehensive training programme for radiographers learning how to undertake MRI examinations. We also saw an equipment training programme for both the main and ED X-ray departments. There were also up to date training records for staff in nuclear medicine.

Major incident awareness and training

- The trust had a major incident plan in place and there was evidence of business continuity plans for both outpatients and diagnostic imaging.
- Staff understood what actions to take in response to a major incident. Staff described a recent flood to a clinic area and how they had been able to continue the clinic using a different space and accessing the notes electronically.
- We saw a major incident folder located in the ED X-ray department. This had been updated in 2015. We also saw the major incident plan displayed in CT.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate the effectiveness of outpatient and diagnostic imaging services though we found:

- Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.
- Staff obtained written and verbal consent to care and treatment which was in line with legislation and guidance.
- Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard.

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- The majority of staff had received appraisals although access to suitable training was restricted.

Evidence-based care and treatment

- Staff had access to evidence based protocols and pathways based on National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines.
- NICE guidelines and minimum standards from the British Association of Dermatologists were followed for phototherapy services.
- National Royal College of Nursing guidelines were used regarding the self-administration of anti-rheumatic drugs.
- The outpatients and diagnostics department were currently involved with the national margins audit for breast cancer surgery.
- The therapies department worked to the NICE guidelines for the management of low back pain, the management of pelvic girdle pain and perineal tears.

Diagnostic Imaging

- We were told that the radiologists provided a two-tier on-call system, with both registrar and consultant grade radiologists available.
- Referrers could access i-refer (a guidance tool written by the Royal College of Radiologists) via the SGH intranet.
- The interventional radiology checklist adopted from the World Health Organization (WHO) surgical checklist was used within interventional radiography. We observed the correct use of this checklist during two procedures. We also saw evidence from four quarterly audits, which demonstrated 100% compliance with the use of the checklist.
- We observed one interventional procedure where the request form included the incorrect side to be treated. However, this error was spotted as staff were going through the WHO checklist, allowing them to identify the correct limb to be treated. The procedure was carried out successfully on the correct limb.
- The trust had established a combination of local and national diagnostic reference levels (DRLs) within radiology. We saw DRLs displayed in all areas visited. DRLs are typical doses for examinations commonly performed in radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL. They are not designed to be directly compared to individual doses however, they can be used as a signpost to indicate to staff when equipment is not operating correctly.

- SGH had adopted UK scaling factors to ensure that paediatric nuclear medicine scans were optimised appropriately. Scaling factors are used to calculate the activity that each child should be given based on their weight.
- Policies and guidelines were available through the trust's intranet and staff told us they had opportunities to access computers to view these. However, on a couple of occasions when staff tried to show us documents on the intranet they could not locate them.
- We saw a paper copy of the imaging protocols for fluoroscopy examinations available to staff in the fluoroscopy room. We also saw a folder in the paediatric room that contained the paediatric protocols.
- The paediatric lead radiographer had updated the non-accidental imaging protocol to ensure that it was in line with national guidance.
- We saw 'Pause and Check' posters displayed in all imaging areas visited (The Society and College of Radiographers produced 'Pause and Check' resources to reduce the number of radiation incidents occurring within radiology departments)
- We heard that two new CT scanners had recently been installed. We were told that an applications specialist from the manufacturer had been regularly visiting the department to review protocols and ensure that examinations were well optimised.
- SGH provided a thrombectomy service from 8am – 8pm Monday to Saturday. This service is used for patients suspected of having a stroke and these patients must have a CT prior to treatment being started. We were told that the average 'door to scan' time was less than 30 minutes, which was in line with NICE recommendations. We were told that an audit of this service was currently underway as the trust wanted to extend the service to 24 hours.

Patient outcomes

- The DNA rate was consistently higher than the national average from September 2014 to August 2015 with records showing between 9-11% DNA rates. We looked at the minutes for the diabetes care group for three months from March – May 2016. These showed an 18% DNA for clinics.
- Patients attending for outpatient therapies completed outcome measure forms at their first and final appointment. Results were recorded in the discharge

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summary. Staff told us there was room to improve this process and a recent change to practice had helped support this. The outcome forms were now printed in yellow paper to stand out in the notes.

- There was a lack of local audits and initiatives within the outpatient department generally to monitor and report on patient outcomes.
- Patients not on RTT pathways such as post treatment patients were not being monitored within the trust. The external data report outlined this as a serious concern.

Diagnostic Imaging

- We saw evidence of a departmental protocol and flowchart for highlighting urgent and unexpected findings with referrers to ensure timely treatment for patients.
- Staff told us that there were monthly 'morbidity and mortality' meetings to discuss patient cases however, these meetings did not include all patients who experienced a poor outcome.

Competent staff

- Staff told us they were able to identify specific learning through the appraisal process but access to training to support the identified need was limited.
- Some nursing staff were not well supported for ongoing professional training but mandatory training levels were meeting trust compliance levels overall.
- Specialist nurses worked within the outpatients department providing nurse-led clinics alongside medical colleagues.
- Extended scope physiotherapists worked at the trust. They held injection clinics for shoulders and knees. The staff had completed a university competency module.
- A weekly teaching session was held in cardiology outpatients which staff told us they appreciated.

Diagnostic Imaging

- Registrars told us the consultants held daily teaching sessions from 8-9am.
- We saw evidence of some role development for radiographers. A small number of radiographers had been trained to perform CT colonography examinations. There were two consultant radiographers in breast imaging who ran their own clinics and undertook procedures such as biopsies.

- We heard radiologists held regular discrepancy meetings to discuss radiology cases. We saw feedback forms for highlighting any discrepancies as well as a letter to a radiologist providing feedback on a report.
- We were told that all staff in the nuclear medicine department had received an appraisal.
- The appraisal rate for radiologists was 100% and all of their job plans had been reviewed recently. We saw evidence from February 2016 that showed that only 61.5% of non-radiologist staff had had an appraisal, which was below the trust target of 85%.
- Staff told us that access to continual professional development (CPD) opportunities within imaging was difficult due to the high vacancy rate within the department.

Multidisciplinary working

- The outpatient department held daily pre-clinic briefings to update all staff working on that day.
- Breast one stop clinics were held in the Rose Centre. We spoke to some patients attending the clinic and they told us it had been a good experience and they felt well looked after by the team.
- All specialty areas were part of a care group. This allowed multi-disciplinary input from nursing, medical, therapy and diagnostic staff.
- The skin cancer screening clinic involved the melanoma nurse specialist and the plastics team to offer an integrated service to the patients.
- The diabetic foot clinic held a multi-disciplinary meeting every week involving several specialist areas. One staff member told us this was a pivotal approach to saving limbs for the patients.
- Several staff in the diagnostic department felt there could be a closer working relationship, especially when dealing with increasing capacity within the outpatient's clinics as this had a knock-on effect to their service.

Diagnostic Imaging

- Radiologists supported all multidisciplinary team meetings (MDTs) that required their input with the exception of vascular surgery. However, we were told that work was underway to address this.
- Radiographers told us and we observed that there is always at least one radiologist based in both the CT and ultrasound departments. This ensured that radiographers could discuss queries relating to patient scans and seek advice from a radiologist.

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- We saw good communication between the interventional team during a procedure.
- Several radiographers told us that they are not able to attend MDTs, mainly due to radiographers not being invited to attend, work pressures and not being informed of when the MDTs were held.

Seven-day services

- The outpatients department was open Monday to Friday 8am to 5.30pm, with occasional 'waiting list reduction' clinics being held on planned weekends and in the evenings.

Diagnostic Imaging

- The radiology service provided emergency cover 24/7 across CT, ultrasound, interventional radiology and cardiology, as well as plain film imaging.
- Both CT and MRI ran extended days 8am – 8pm Monday to Friday. MRI appointments were also offered 8am – 4pm on Saturdays and 9am – 5pm on Sundays for the MRI scanner in the Lanesborough Wing.
- Additional weekend lists for routine patients were also offered most weekends for the MRI scanner located in the Atkinson Morley Wing from 8am – 8pm when not in use by the neurology team. These lists were staffed on a voluntary basis.

Access to information

- Staff told us and we saw that they had access to trust policies and procedures on the intranet, although the IT system was very slow and some attempts to look at information had to be abandoned due to time constraints.
- The trust did not have one integrated Patient Tracking List. In February 2014, the trust upgraded their IT system to use additional RTT functionality. However, these electronic functions were not being used appropriately and many manual solutions have been put in place. The external data report stated these manual systems have a significant level of risk and all waiting lists were unreliable.

Diagnostic Imaging

- The trust used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patient's radiological images and records were stored securely and access was password protected.

- We saw patient information leaflets in both the main X-ray department and MRI. These leaflets were in a 'reader-friendly' format.
- We were told that all examinations performed within radiology received a report by a radiologist and that the local target was that 90% of non-urgent examinations received a report within one week. We saw evidence from February 2016 that radiologists reported 97.5% of GP patients, 95.2% of in-patients and 90.1% of ED non-urgent images within one week. However, only 71.5% of outpatient images were reported within one week and we were told that this had recently fallen further as a result of radiologist vacancies.
- Staff in the breast-imaging department told us that they always tried to obtain previous images for women attending for mammograms with suspicious findings, as the previous images may assist with making a more accurate diagnosis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated confidence and competence in seeking verbal and written consent from patients. Verbal consent was observed in the X-ray room and the gynaecology outpatient clinic. The consent process included a discussion of the risks to the patient and an opportunity for the patient to ask questions.
- Four patients we spoke with told us they had been asked for their consent before they received treatment.
- Staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity; they demonstrated a knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good for because:

- Throughout the inspection we witnessed good care being given. Patients clearly appreciated the staff and the care they were given.
- We observed and patients told us the staff were friendly and approachable. The majority of patients we spoke with were positive about their experience of care.

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- We observed the staff supporting patients that required any assistance although on many occasions the staff were very busy.
- There were quiet rooms available for patients who were to be given bad news.
- We observed staff being respectful at all times.

However:

- There was a lack of privacy and dignity for patients in the phlebotomy department and in the busy dermatology clinic.
- Staff did not always update patients on clinic waiting times.

Compassionate care

- We observed good interactions between nurses, radiographers, medical staff, healthcare assistants and administration staff and the patients, although it was clear in some clinics that staff were extremely busy. One staff member said they barely had 'time to breathe' and could not always update the patient information board regarding length of clinic waiting time.
- We spoke with 20 patients and carers across the departments. There were some negative aspects of care highlighted to us such as clinic waiting times, but overall we were told the staff were very compassionate.
- One patient told us they attended regularly and always received good care. They felt the continuity of care was 'excellent.'
- We observed patients being greeted in a friendly manner by staff but they were not often told of the wait time for the clinic. The trust's 'Friends and Family test' taken across the outpatient departments from October 2015 to March 2016 showed that only 57% of patients were informed of any delays.
- Curtains were not used around the phlebotomy bays and during one observation, six patients were having their bloods taken in a communal space. We did not observe patients being asked whether they wanted the curtains drawn around their bay.

Diagnostic Imaging

- We witnessed a porter offer to stay in the department while a child was X-rayed to avoid the patient having a long wait to be taken back to the ward.
- We saw a radiology department assistant monitoring patients in the CT waiting area to ensure they were comfortable.

- We saw a patient being reassured throughout an interventional procedure. The staff also explained to the patient what was happening throughout the case.
- We saw radiographers in the ED CT scanner use a window blind in the scan room to maintain privacy and dignity when preparing a patient for a scan.

Understanding and involvement of patients and those close to them

- Most patients we spoke with felt well informed about their care including any investigations that were planned. One patient showed us their information leaflet about attending for a CT scan and said they found it helpful. Patients we spoke to in the breast imaging department told us that staff were good at explaining procedures and providing opportunities for them to ask questions.
- We spent time in the main reception area and observed patients being greeted and booked into the clinics. They were not always given clear instructions as to where to sit and the inspectors were asked directions on several occasions by patients unsure of where to go.

Emotional support

- There was a weekly bereavement clinic. Outpatient staff we spoke with said they would refer patients to this service if required.
- Staff told us they would direct appropriate patients to the Macmillan information centre to access support and further information.
- Staff told us a quiet room would be made available for breaking bad news. One counselling room we inspected was also used as a store room and contained many boxes on the floor. This did not make it a conducive space for receiving emotional support.

Diagnostic Imaging

- Staff in the nuclear medicine department told us that they arranged familiarisation visits for paediatric patients. They also involved play therapists to improve the patient experience.
- We were told of a patient who had attended for a procedure the week before our visit who was known to have a history of severe psychological trauma. The neuroradiology team had coordinated with a wide range of staff, including psychiatry and PALS, to ensure that the patient experience was positive and appropriate to their needs.

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Are outpatient and diagnostic imaging services responsive?

Inadequate



We rated responsive as inadequate because:

- Inaccuracy in the RTT data meant patients were waiting a long time to receive a first appointment.
- An external review of Referral To Treatment (RTT) data quality at St George's University Hospitals NHS Trust was published in June 2016. This found that patients were not being treated in chronological order. The prioritisation process for ensuring patients in need of an appointment quickly was in its initial stages.
- Following the inspection, the trust wrote to NHS Improvement and NHS England, to confirm their intention to temporarily cease national reporting of our RTT data. This was because, they could not guarantee the data they were reporting was robust and accurate.
- People were not able to access services for assessment, diagnosis or treatment when they needed to. The trust was not meeting national waiting times for diagnostic imaging within six weeks and outpatient appointments within 18 weeks for the incomplete pathways.
- The trust was not meeting the urgent two week referral target for patients with suspected cancer and cancer waiting times on the whole were variable across the targets.
- Follow up appointments were not always made in a timely manner.
- 'Did Not Attend' rates were higher than the England average. The 5% clinic cancellation rate in March 2016 was below the national average of 7%. However, staff reported clinic cancellations as an ongoing issue. The primary reasons given for clinic cancellations were staff annual leave, study leave or sickness.
- Telephone calls to the call centre, answered within the service level agreement targets were low, with only 8% being answered within thirty seconds and 13% within one minute. On one day of the inspection, a high percentage of calls to the call centre were abandoned by the caller (24.2%). We were told following the inspection that the trust had a plan a place to fix the issues.
- Clinics often ran late and communication given to the patients about this varied.

However:

- Staff were aware of patients with dementia. There was access to interpreters for patients whose first language might not be English.
- Self-service touch screen units for booking in were available in some of the outpatient clinics.
- The service closely monitored any complaints and staff were confident in dealing with them locally where possible.
- Patients had good access to refreshment areas in the main outpatient department but some other clinics were situated some distance away.
- Extra clinics and imaging sessions were being provided in the evenings and weekends to meet demand.

Service planning and delivery to meet the needs of local people

- Patients were able to use the 'choose and book' system to enable them to choose an appointment in a location closer to their home.
- A text reminder service had just been re-introduced to help lower the DNA rate. The service had been removed previously to save costs. The largest DNA rate was for the diabetes clinic at 18%.
- Some areas in the outpatient and diagnostic imaging departments did not have the adequate space or capacity to deal with the demand on the service.
- Some patient waiting areas in outpatients were small and cramped. Patients and relatives had to queue along the corridor and had very limited places to sit within the dermatology clinic. During one clinic, we found sixteen patients were left standing. Extra chairs were used which blocked the fire exits. This had been raised as a risk and the fire warden for the trust had recommended immediate removal. On the date of the inspection, this had not been actioned. Other outpatient areas such as The Rose Centre and the Atkinson Morley were bright, well decorated and welcoming to patients.

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- Radiology had extended working hours, to include weekends for some examinations to meet the demand for imaging services.
- Radiology had adapted one of the fluoroscopy rooms so that it could be used for ultrasound examinations in order to increase capacity, as demand for fluoroscopy examinations had decreased.

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- Radiology management told us that they were looking to out-source some of their CT and MRI reporting to an external company until they have a full complement of radiologists.
- Radiology offered additional paediatric ultrasound lists at weekends when waiting times for these examinations started to increase.
- We were told that a new breast-imaging unit had been established in South London, but staff were not able to use the unit as there were no computers available and there was confusion around who was responsible for purchasing the IT equipment.
- We saw audits of the cancellation rate for vascular procedures in neuroradiology. The first audit showed that in 2014 the cancellation rate was about 25%. However, staff reviewed their local processes and altered practice with the result that a further audit demonstrated that cancellation rates had been significantly reduced to 3% in 2016.

Access and flow

- An external review of Referral To Treatment (RTT) data quality at St George's University Hospitals NHS Trust was published in June 2016. This found that due to a high number of unknown start times of a patient's referral journey, patients were prevented from being treated in chronological order. The trust was also inconsistent in achieving their two week targets for patients with suspected cancer.
- Following the inspection, the trust wrote to NHS Improvement and NHS England, to confirm their intention to temporarily cease national reporting of our RTT data. This was because, they could not guarantee the data they were reporting was robust and accurate.
- Hospital Episode Statistics for September 2014 – August 2015 showed that 789,389 outpatient appointments were made at the hospital.
- 'Did Not Attend' rates were higher than the England average.
- The 5% clinic cancellation rate in March 2016 was below the national average of 7%. However, staff reported clinic cancellations as an ongoing issue. The primary reasons given for clinic cancellations were staff annual leave, study leave or sickness.
- Referral to treatment rates for incomplete pathways was below the standard and the England average of 92% from July 2015 to February 2016. We reviewed three specialties and found there were 359 patients waiting more than 18 weeks in June 2016 and a further 539 patients with an unknown waiting time.
- The percentage of people seen by a specialist within two weeks for all suspected cancers was below the England average from quarter one 2015/16 to quarter three 2015/16. The overall trust position was 87.8% against a national target of 93%. The target had only been achieved in three out of the twelve months from April 2015 to March 2016. These referrals were received into the central booking service via a dedicated fax machine. Staff told us that some patients received an appointment within the two week period and others did not. This information was supported by the current data reflecting variances across the specialties. For example, lung referrals were running at 95.7% seen within two weeks.
- A backlog of 1,000 patients in dermatology had recently had appointments booked. There were now 154 patients waiting over 18 weeks with a further 2014 patients with unknown waits. No patient risk assessment was provided to demonstrate that patients had been prioritised on clinical need.
- The percentage of people waiting less than 31 days from diagnosis to first definitive cancer treatment was above the England average from quarter four of 2013/14 to the present reporting date.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive cancer treatment was below the England average from quarter three of 2014/15 to quarter two 2015/16. Improvements had been made in quarter three of 2015/16.
- The trust requested an external review of their data quality for patients accessing services at St. George's in February 2016. The report published in June 2016 stated there were significant concerns around:
 - significant numbers of unknown clock starts
 - pathways excluded inappropriately across both admitted and non-admitted pathways
 - planned patients that do not appear to be actively managed
 - lack of a standardised process to book follow up appointments.

Outpatients and diagnostic imaging

- The average clinic overrun time during our inspection was one hour. No audit was undertaken of clinic wait times although all staff acknowledged this was an ongoing problem.
- Staff at the call centre told us their workload had increased significantly. Their biggest challenge was answering the phones in a timely manner. On one day of the inspection, the call centre received 1,585 calls. 1,200 of these calls were answered with 385 (24.2%) abandoned by the caller. The longest wait time was 18 minutes and 12 seconds.
- Waiting times for diagnostic imaging were monitored and recorded. The percentage of patients waiting more than six weeks for a diagnostic test ranged from 4.5% in January 2015 to 1.4% in January 2016. This was overall higher than the England average.
- Many staff told us that the clinics were overbooked. They felt the e-triage system was now working well with the main issue being patients booked into the wrong clinics.
- We looked at clinic cancellation data from January 2016 to March 2016. We noted that out of 3356 requests for cancellations, 245 were at short notice and under the six week trust policy. This equated to 7.3% of the total. 1,237 patients were affected and needed to have clinic appointment re-booked.
- The booking system did not historically allow any patients to be booked after 11 weeks post referral. This had caused blockages in the system and the IT team had been consulted to remove this block. Staff told us the change was imminent and would help assist with the booking of long waiting lists.
- Waiting times were not routinely displayed on white boards in the waiting areas for patients. An electronic message board was connected in the main outpatient area but only displayed the wording, 'empty message.' One staff member told us it had been like that for a long time.

Diagnostic Imaging

- The MRI department had a separate area where staff could cannulate patients to avoid delays in the scan room and improve patient throughput.
- A radiographer showed us the electronic system used to request porters to bring patients from the wards to radiology. This system allows staff to book appointments for patients to attend radiology as well as track whether a porter has been assigned to each task,

whether the patient had left the ward. However, numerous staff in radiology told us there were often long delays in both patients arriving from and being returned to the wards. One radiographer told us it was common for patients to wait an hour before they were taken back to the ward.

- Patient waiting times, once they had arrived in the department, varied. One woman in the breast-imaging unit told us she had only waited about 5 minutes before being seen whereas a patient in ultrasound had been waiting 30-40 minutes beyond their appointment time without having been informed of how long the delay was. Another patient told us that they had been waiting for over an hour beyond their appointment time.

Meeting people's individual needs

- We noted that water dispensers were available throughout the outpatients department and a small café was located inside the main outpatient's area.
- A café was also located in the Rose Centre. Staff told us this was often appreciated by patients who attended the one stop breast service as they could be in the unit for several hours.
- Staff told us interpreting services could be booked for patients attending outpatient appointments, if the original referral letter stated an interpreter would be required. We saw posters clearly displaying information about accessing translation services.
- The staff we spoke with demonstrated a good understanding of the needs of patients living with dementia and learning disabilities. We were assured the patient who may be distressed or confused would be treated appropriately.
- Overall patients we spoke with were very positive about the outpatient and diagnostic imaging services and told us they received good treatment and were happy to attend these departments. Some patients were very unhappy about the length of clinic waits. One patient said, "it is chaos."
- We saw the outpatient department kept a wide choice of patient information leaflets which meant that patients were supported to make informed choices about their care.
- There were some facilities available for children in the clinics, for example in ENT.
- During our inspection, we visited the phlebotomy clinic. This was a walk-in clinic meaning patients did not need

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to make an appointment. We noted there was a 45 minute wait for blood tests at the time we inspected. We spoke with one patient who said, "The wait is usually quite quick, but today seems quite busy."

- One patient told us they really needed a drink but were afraid they would miss their appointment. They felt they could not ask the reception staff as they were too busy.

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- While patients were not given a choice as to when their appointment would be, we overheard several instances where staff were changing appointment times to accommodate patient requests.
- We saw a separate waiting area for in-patients in the main CT department. In the main radiology department, we saw a section of the main waiting area dedicated to in-patients with curtains to provide privacy, however on several occasions we saw patients in this area without the curtains having been drawn. There were separate male and female in-patient waiting areas in the ultrasound department.
- We saw a dedicated paediatric waiting area within the main radiology department. There was also a 'distraction box' in the paediatric X-ray room for patients to use.
- Staff in MRI told us that when scanning patients with dementia they prioritised the most important sequences to do first as these patients often find it difficult to tolerate a complete MRI scan.
- All staff we spoke to were aware that there was a list of staff members who were able to translate for patients. We also saw a poster on a noticeboard in the ultrasound department informing staff how to access more formal translation services via the 'Language Line'. Staff in CT told us that they could select different languages on the CT scanner to ensure that the patient could understand the specific breathing instructions required for some scans.
- Staff told us that there was no formal chaperone policy however, if a patient requested a chaperone, then staff would provide one. We saw posters in the ultrasound rooms informing patients that they could ask for a chaperone to be present during their scan.
- We saw vending machines available for patient use in the main radiology waiting area. We also saw a water cooler

for service users in the breast imaging department, although one lady mentioned to staff that there were no cups available and staff immediately addressed this matter.

- Staff in the nuclear medicine department told us that all paediatric patients were cannulated on the paediatric ward to decrease patient anxiety and to reduce the length of time young patients were waiting in the nuclear medicine department.

Learning from complaints and concerns

- The outpatients department at St. George's Hospital received 36 complaints from April 2015 to March 2016.
- The outpatient's senior staff told us the main reason for complaints in the department was waiting times and being able to access the booking service.
- Complaints were handled in line with the trust policy.
- Staff told us learning from complaints was shared via various forums such as the daily huddle. One member of staff told us they had recently resolved a complaint relating to the text messaging service and had put measures in place to prevent any further complaints on this issue.
- There was limited use of the Friends and Family test in some outpatient areas due to staff being too busy to administer the survey. This meant valuable patient feedback was not being captured during the outpatient process.
- We saw PALs signs were situated throughout outpatients and imaging department, which explained how to raise any concerns or complaints.

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- Radiology management told us that when they were informed of any potential or actual complaints, they tried to speak directly to the patient in order to address the issue straight away.
- Radiology management told us that complaints were included on the care group and directorate scorecards monthly. They also told us that the governance group reviewed complaints on a quarterly basis.

Are outpatient and diagnostic imaging services well-led?

Inadequate



We rated well-led as inadequate because:

Outpatients and diagnostic imaging

- Governance arrangements were not robust, as specialties were governed by their respective divisions. This led to incohesion as well as limited audits and performance monitoring.
- Although a new governance structure had been put in place and the management team strengthened, we felt this was not yet fully embedded across the service.
- Patients were not receiving appointments in a timely manner and in accordance with national targets.
- Data quality was not robust and further work needed to be done to validate the data and put systems and processes in place to deal with prioritisation of workload and any potential breaches.
- Reduced staffing had a negative impact on the quality of the service delivered to patients.
- There was a difference in attitudes from staff across the departments. Many were demoralised and could see no changes happening, whereas others were hopeful for the future and the new changes in place.
- There was little evidence of staff role development to meet service need.

However:

- Monthly meetings were in place for all levels of staff.
- Risk registers locally and corporately reflected the service risks.
- Teamwork within radiology was good.

Vision and strategy for this service

- Most of the staff we spoke with were fully aware of the trusts vision and values. However, several staff told us there had been too many changes of leadership and they were unsure of the future direction.
- Generally across the departments, there was no shortage of vision but the implementation didn't happen.
- We looked at the improvement plan for the outpatients department. This included a full scale review of the processes and systems in place. Staff were aware of the strategy and were overall supportive although some staff told us they met improvement plans with a degree of scepticism. We spoke with the senior team about this and they told us they felt the process was being 'well-managed', with staff central to the discussions.

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- We were told by one radiographer that they had identified two areas where they could improve the service they provided to patients by appointing some advanced practice radiographers.
- Two radiographers told us that while some radiologists were supportive of radiographer role development, others were not. The radiographers felt that this had created some barriers for improving some services provided to patients.
- Radiology management told us they believed that the lack of opportunities for role development might be contributing to the high radiographer vacancy rate as staff were leaving to find these opportunities elsewhere.
- Radiology management told us that a member of the trust's executive team chief operating officer had asked radiology to achieve a one week referral to scan target. However, they said that with the current level of staff vacancies, radiology was finding it difficult to meet the current two week wait.
- We saw evidence that radiology management had established five workstreams within the department to look at areas such as increasing capacity, liaising with referrers to review demand for services and managing staffing issues.

Governance, risk management and quality measurement

- Governance arrangements were not robust, as specialties were governed by their respective divisions. This led to incohesion as well as limited audits and performance monitoring.
- The newly appointed interim divisional director of operations had very recently been appointed the RTT lead for the trust. A meeting was to be held with the chief operating officer during the inspection to clarify the governance and responsibilities of the role. The data quality review stated the trust needed to accept that the current PAS system implementation had failed and preparations needed to be made to implement it properly. They concluded the report saying, "robust governance and leadership will be required in order to deliver the cultural and operational changes required."
- During the changeover of paper to electronic notes, we were not assured the hospital had a robust process in place to ensure there was a complete set of contemporaneous patient notes on site during clinic appointments.

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- Audit systems were very limited and as result, little information was available to analyse and improve the quality of the service.
- Monthly care group meetings were held in different specialties. We reviewed the minutes for the divisional board and the outpatient senior management team meetings across a three month period, January 2016-March 2016. These demonstrated there was an oversight of the outpatient departments' performance, risk, quality and key milestones.
- The performance data for the outpatients department was presented as a monthly dashboard. The latest information we could review was from September 2015.
- We saw the departments had updated risk registers in place and the ones that had been identified in our discussions were reflected on these registers.

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- Radiology management told us of an issue detected following an upgrade to the electronic referral system. This issue related to the non-medical referrers requesting imaging examinations for patients without having been trained, in line with trust policy. Radiology management showed us the measures they had put in place to ensure that all non-medical referrers had received training and had scopes of practice in place, outlining the examinations for which they could refer. These measures appeared to be appropriate to address the problem whilst minimising the impact on patient care and referral pathways.
- Radiology management had recently had to raise a concern relating to patient safety in vascular surgery. They told us that, once aware of the concern, senior management within the trust reacted quickly to deal with the matter.
- Radiology management told us that they had a spreadsheet, updated on a daily basis, which listed all patients waiting for imaging examinations. This spreadsheet allowed them to pre-empt problems and arrange additional weekend lists to ensure that waiting time targets were met as much as possible.

Leadership of service

- The outpatient senior team told us they were more confident for the future of the service. They felt a focus on outpatients with the improvement plan was in progress. We saw the board report dated December

2015 and the progress being made to implement the recommendations. Work had commenced on recruitment and reviewing the clinic templates to allow more flexibility in the service.

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- Staff members told us they felt vulnerable and did not know where they stood following all of the changes within the senior management team at trust level.
- We saw the band 8 radiographers within the department were a strong and cohesive team. Lead radiographers we spoke to knew exactly what was happening in their area of responsibility. They all had clear ideas about how they would like to develop their areas to improve the service they provide.
- Staff described the local leadership within the neuroradiology team as excellent and staff liked that they were visible within the department.

Culture within the service

- There were many vacancies for administrative staff, which were all advertised. However, the reduced staffing negatively impacted on the quality of the service delivered, for example increased waiting times in outpatients and delays in answering calls to the booking centre.
- Some staff felt they were not listened to and felt this was due to a complicated reporting structure. One member of staff said that the only way to make things happen and get things done at the trust was to circumnavigate the middle management and raise issues at the highest level.
- Other staff spoke with pride about their services, and many staff were proud of working for the trust. However, some were 'very tired and ready to leave'. Where it was obvious that changes needed to be made to the existing environment, staff worked around the issues as best as possible but felt changes were long overdue.
- Several staff told us they felt overworked and undervalued.
- We heard of a friendly culture within the outpatient department. However, many staff reported the service was very stretched and had been under-resourced for a long time. This was particularly evident within the dermatology clinic.
- The majority of staff described a positive working environment and good team work amongst colleagues.
- There was evidence of a good education and research culture within the cardiac investigation unit.

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- All staff we spoke to told us that teamwork within radiology was good and that it was a close-knit department. Because of the close knit nature of the department, staff told us that they felt confident to raise concerns.
- Student radiographers told us they enjoyed placements at SGH and had requested to come back next year. They told us that the radiographers were always willing to help.

Public engagement

- The departments sought feedback from patients using the Friends and Family survey. The response rate was low.
- Patients and relatives took part in the friends and family test across the various units. We saw the results were variable such as 49% of patients would recommend the service to friends and family in the fracture clinic to 95% in the gynaecological clinic. The average score was 76.5%.

Staff engagement

- Staff told us they had a daily huddle meeting before the outpatient clinics commenced.
- Although several staff told us they were proud to work for the trust, they did not feel involved or listened to as regards service improvement.

Innovation, improvement and sustainability

- The therapies service offered a health and wellbeing clinic to all staff at the trust to have fast access to physiotherapy treatment for conditions such as lower back pain. This meant staff could be treated sooner and hopefully avoid long periods of sickness.
- The hospital offered a newly re-instated appointment reminder service where patients were reminded of their outpatient appointment by a free text message.
- We visited the cardiology investigations unit. The department was well-led and staff told us there was a strong drive to improve and exceed standards. There were short waiting times for tests and some home visits had been offered for immobile patients.

Outstanding practice and areas for improvement

Outstanding practice

- Outcomes for renal patients in relation to survival rates and transplantation were excellent and some of the best in the country.
- The outcomes achieved by the specialist medical and surgical services provided by the hospital.
- The effectiveness of maternity care delivered by the hospital.
- The responsiveness of the neonatal unit to parents whilst their baby was on the unit and the support provided by the outreach nurse.
- The involvement of children of varying ages on the interview panel as part of the recruitment process for ED paediatric nurses.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

- Ensure all premises and facilities are safe, well-maintained and fit for purpose.
- Ensure all care is delivered in accordance with the Mental Capacity Act, 2005, when appropriate.
- Review all governance processes, so that patients receive safe and effective care.
- Ensure the RTT data is robust and accurate so that patients are given appointments and treatment based on their needs and within national targets.
- Ensure serial numbers of prescriptions (FP10s) for prescribers are always monitored for use.
- Ensure staff only administer medication where appropriately authorised Patient Group Directions (PGDs) or valid prescriptions are in place.
- Ensure the fit and proper persons' requirement regulations for directors is always complied with.
- Ensure the paediatric ward environment, staffing and training requirements are suitable for treating and caring for children and young people with mental health conditions.
- Ensure medicines are stored in an appropriate manner, by keeping cupboards locked when not in use.
- Ensure the process for decontamination of nasoendoscopes is always compliant with guidance.
- Review the fluid storage within the ED major incident cupboard to ensure that training equipment is not stored with 'live' equipment.
- Ensure staff consistently follow guidance related to the prevention of healthcare associated infections with specific regard to hand hygiene.
- Ensure the equipment stored on Pinckney Ward is cleaned and there are systems in place for monitoring the cleanliness of equipment returned to the ward.
- Ensure all staff caring for children receive level 3 safeguarding training.
- Ensure the process for investigating serious incidents is timely and undertaken by people trained in investigation so they understand the root causes of an incident and identify measurable action.
- Minimise the cancellation of operations and when this cannot be avoided, they are rescheduled within 28 days.
- Reduce the moves of patients to wards that are not appropriate.
- Ensure there are robust arrangements in place, which staff are conversant with, in relation to the recognition and escalation of deteriorating patients.
- Ensure divisional and trust priorities are shared by personnel of all grades and professions who work together to promote the quality and safety of patient care.
- Address the low morale among theatre staff and consultant surgeons.
- Replace damaged furniture in patient/clinical areas so that they can be thoroughly cleaned.
- Ensure that all patients within the ED 'streaming' area are assessed within a private area.

Action the hospital SHOULD take to improve

In addition, the trust should:

- Maintain patient privacy, dignity and confidentiality at all times.

Outstanding practice and areas for improvement

- Ensure staff can observe the patients whilst they are waiting in their outpatient departments.
- Ensure patient electronic records are not easily visible or their paper records are not easily accessible by the public.
- Improve the percentage of telephone calls answered by staff in the outpatient department are within the service level agreement targets.
- Communicate effectively with patients when outpatient clinics overrun.
- Ensure there is sufficient diagnostic equipment (including cystoscopes) to supply day surgery, main theatres and endoscopy.
- Ensure staff are appropriately inducted to the clinical areas to which they are employed to work.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>Some premises and equipment were not properly maintained or suitable for the purpose for which they were being used because:</p> <ol style="list-style-type: none">1. There were two ceiling leaks in a corridor in the emergency department, during rain fall.2. The viewing area waiting room within the mortuary had a leak from the heating system and the carpet required replacing.3. There was not an uninterrupted power supply on Richmond Ward and some patients were ventilated on this ward.4. There were not enough cystoscopes to supply day surgery, main theatres and endoscopy.5. St James' theatre suite, day surgery unit and Gray Ward were cluttered because of lack of storage space and there was not enough space around the beds on Gray Ward.6. Paul Calvert theatres had no cleaning cupboard and no storage space for the large pieces of orthopaedic surgery equipment used.7. The paediatric ward environment was not suitable for treating and caring for children and young people with mental health conditions.8. There were no bedside night lights on Dalby Ward.

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements

- **Premises**
- **Mental capacity assessments and best interest decisions**
- **Governance**
- **Fit and proper persons requirement**

Where these improvements need to happen

- Lanesborough Wing, St James' Wing, Paul Calvert theatre, Buckland Ward, Maternity staff room
- Allingham, Dalby and Rodney Smith medical wards
- Trust wide
- Trust wide