

Queen Victoria Hospital NHS Foundation Trust

The Queen Victoria Hospital (East Grinstead)







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	Good	
Minor injuries unit	Good	
Specialist burns and plastic services	Good	
Critical care	Requires improvement	
Services for children and young people	Good	
Outpatients and diagnostic imaging	Good	

Summary of findings

Letter from the Chief Inspector of Hospitals

The Queen Victoria Hospital (QVH) provides a specialist burns and plastic surgery service to both adults and children. The trust provides emergency, trauma and elective reconstructive surgery and rehabilitation for people who have been damaged or disfigured through accident or disease. Patients are admitted from the south east of England including south east London. The trust also provides 'hub and spoke' specialist services at other hospitals in the south east of England, bringing QVH staff with specialist skills to remote hospital locations.

Additionally the hospital provides a minor injuries unit and services for the treatment of common conditions of the hands, eyes, skin and teeth for people living in and around East Grinstead, as well as outpatient and therapy services'

There are two surgical wards with 47 beds where trauma and plastics patients are cared for together with a dedicated burns unit with 12 beds. The hospital has 10 operating theatres with associated areas for anaesthetics and recovery within the main theatre suite. Two further theatres are used for plastic surgery (Rowntree; day care 1 and 2). There is also one theatre attached to the burns unit where patients who arrived by ambulance are assessed and treated before being transferred either to the burns unit or to critical care.

There are 9 beds on Peanut Ward for the care of Children and Young people.

The Hospital was inspected as part of our Comprehensive Inspection programme for the NHS Trusts in England. It was inspected on the 11th and 12th November 2015, with unannounced visit on 23rd November 2015.

Our key findings were as follows:

Safe

There were effective and robust systems and protocols in place to protect patients from harm, and staff contributed to an incident-reporting culture. There were opportunities for learning from results of investigations.

A culture of openness was found in the Hospital. We found examples where the organisation had carried out its Duty of Candour and generally staff we talked to were aware of the requirements.

The Hospital was clean, and the environment was found to be conducive to safe care although some areas required some redecoration and minor maintenance.

Medicines management was good. Regular medicines audits took place. Controlled drugs were regularly checked with entries double signed. The pharmacy staff worked closely with colleagues in the trust to ensure best practice in prescribing was undertaken.

We found nurse staff levels to be appropriate and safe to provide the care given.

Effective

Throughout our inspection we observed patient care carried out in accordance with national guidelines and best practice recommendations.

However the trust did not meet national guidance on managing burns patients as the hospital did not have the on-site facilities that a large district general hospital would provide; such as specialist renal, haematology and intensive care facilities. Substantial work had been undertaken to ensure that the hospital was able to care safely for the patients that were admitted.

Consultants and nursing staff from a range of specialties were engaged in the development of national and international treatment guidelines for burns and plastics, as well as engaging in international research programmes.

Summary of findings

We found that food was available to patients as required and people were able to access drinking water in all areas. There were 3 refreshment areas where visitors could get food and hot drinks.

Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure safe and effective patient outcomes. Staff received an annual performance review and had opportunities to discuss and identify learning and development needs through this.

Caring

Throughout the hospital and in all specialties we saw examples of compassionate and considerate care being delivered.

In children and young peoples services and Burns and plastics we saw outstanding examples of care toward patients.

Patients were treated with respect and dignity and all the patients and their families who we spoke with, both before and during the inspection told us that they were treated with dignity and respect and had their care needs met by caring and compassionate staff. This positive feedback was reflected in the Family and Friends feedback and patient survey results, where the hospital consistently achieved scores of over 95%.

Parents felt involved in the care of their child and participated in the decisions regarding their child's treatment, and that staff were aware of the need for emotional support to help children and families cope with their care and treatment.

Responsive

Services for local people were responsive to their needs and offered a minor injuries unit, outpatient services as well as access to therapies.

The specialist services undertaken by the trust were responsive because the needs of patients throughout the south east of England, the local people, commissioners and stakeholders were taken into consideration when planning services. The trust operated a 'Hub and spoke' system so that patients who lived a great distance from the trust could benefit from the QVH staffs skills and experience.

Interpreting services were available for people whose first language was not English and we saw patients with a learning disability or living with dementia were well supported.

Complaints were acknowledged, investigated and responded to. Information was shared to promote learning and prevent reoccurrence

Well led

At the inspection we spoke with positive and loyal teams, many of whom at worked at QVH for a considerable time. Staff told us that they felt valued and felt able to deliver individual and compassionate care to people using their services. Staff described an open culture, where they were encouraged to report incidents, concerns and complaints to their manager. Staff we spoke with told us they felt able to raise concerns and felt that the organisation was transparent with a "non-judgemental, no blame" culture.

Most staff we spoke to could describe the Hospitals vision and strategies, and had been consulted on the future of services at the QVH.

The Trust is currently developing a strategy for the future of the services provided by the QVH, particularly the sustainability of providing acute burns care.

Additionally there is consideration being given to developing more services for local people, including more primary and community care.

Summary of findings

Clinical governance structures were stronger in some areas than others. For example in burns and plastics there was a robust structure, records of meetings and risk register which was current and regularly reviewed. In MIU the structure appeared less clear and risk issues were discussed in routine team meetings and the risk register did not capture known risks.

Leaders in the organisation were available to staff and had a high profile across the hospital and staff gave examples of senior staff attending, wards and departments and taking part meetings.

We saw several areas of outstanding practice including:

- Staff were taking exceptional steps to improve the hospital experience for patients living with dementia. Allowing extra time during assessment, facilitation families in supporting the patient, awareness of the environment and equipment in relation to vulnerable patients and the use of distraction accessories such as ‘twiddle muffs’ demonstrated that the needs of vulnerable patients were taken into consideration and steps taken to personalise their care and treatment.
- The burns outreach nurse post was an innovative solution to the problems of dealing with burns in the community. Patients were able to be discharged quicker with continuity of care and treatment.
- The hospital’s audit office undertook the task of monitoring and auditing the quality of care and treatment across the trust. The staff demonstrated passion and enthusiasm for improving patient experience through the use of data and audit.
- The trust developed and actively uses a Telemedicine Referral Image Portal System which has been developed in collaboration with the London and South East of England Burns Network. Telemedicine is the use of telecommunication and information technologies in order to provide clinical health care at a distance. Telemedicine was chosen as the SE Coast Regional Winner in the 2008 Health & Social Care Awards in the category of “Innovative Information & Communications Technology” and went on to be a runner up at the National awards. This Innovative use of telemedicine allows trained staff to view a burn injury at a distance either in another hospital or via ambulance staff photos and give appropriate advice, assessment and advise transfer to most appropriate location.
- Staff within the paediatric service had been instrumental in developing unique aftercare opportunities for patients. One such initiative was called the CREW camp. This stands for challenging, recreational, educational weekend for burns patients which is funded by local businesses and provides educational activity weekends for up to 30 ex patients. A committee of eight staff have been established to run the event which selects nominated children who they consider would get the most benefit from the activities.
- The prosthetics department was cutting edge and provided a patient focussed individualised service. Clinicians worked with patients to ensure the best outcomes were achieved. Staff were enthusiastic, dedicated and were committed to continual professional development publishing regularly in professional journals. This meant that patients received the most up to date advancements in prosthetic development.
- The patient pathway for head and neck patients was comprehensive. Patients attended a pre-assessment appointment, were allocated a named nurse and visited other departments in the hospital that would be part of the treatment intervention. There was a separate waiting area in outpatients so that patients had privacy whilst waiting to be and seen and a psychology service was available to support the emotional needs of patients coming to terms with life changing body image issues.

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

Importantly, the trust must:

- The provider must ensure that all medication in theatre is stored appropriately.

Summary of findings

- The provider must ensure adequate and safe out of hours medical care.
- The provider must ensure all clinical staff have training in the Mental Capacity Act.

In addition the trust should:

- Ensure that all COSHH (Control of substances hazardous to health) products should be stored appropriately.
- Continue to review how it benchmarks itself against national quality standards.
- Review how patients pain is managed specifically when carrying out dressing changes.
- Continue its review of governance arrangements so that critical care has its own individual agenda.
- `Ensure that departmental risks are identified, recorded and regularly reviewed.
- Ensure there are mechanisms in place for staff and patients to raise an alert in an emergency situation in the therapies department.
- Ensure all incidents are reported in a timely manner in outpatients.
- The trust should ensure the décor is refreshed and updated in outpatient department 1.
- Ensure there are adequate facilities for patients attending the hand therapy clinic and that privacy is maintained.
- Ensure that staff in MIU have attended all mandatory training.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Minor injuries unit

Rating

Good



Why have we given this rating?

This a small MIU with c11,000 attendances each year and we found that Cleanliness, infection control and hygiene were meeting the standards expected. And that staff were reporting incidents in a timely manner. There had been no never events or serious incidents reported in the last year.

Mandatory training rates were variable with only 46% of staff having had mental capacity act training, which is not acceptable.

Staffing levels were adequate to cover the unit and staff were suitably qualified. There was a system in place to monitor staff competencies and ensure they had the right skills to treat patients who attended the unit.

All patients we spoke to were positive about the treatment they received and reported that staff were professional, caring and courteous. All patients were triaged by an emergency nurse practitioner within 15 minutes of arrival at the department and a priority allocated.

The department was well-led and there was regular contact with senior managers. However environment compromised confidentiality in the reception area and patients' privacy and dignity in treatment cubicles.

Specialist burns and plastic services

Good



Patients who used the service experienced safe, effective and appropriate care and treatment and support that met their individual needs and protected their rights. The care delivered was planned and delivered in a way that promoted safety and ensured that peoples individual care needs were met. Patients had their individual risks identified, monitored and managed and the quality of service provided was regularly reviewed. We found that patients were protected from avoidable harm because there were systems to report, monitor, investigate and take action on any incident that occurred. There were robust systems in place to monitor clinical safety throughout the service such as infection control, slips, trips and falls and manual handling. This included the five steps to

Summary of findings

safer surgery and the World Health Organization's (WHO) procedures for safely managing each stage of a patient's journey from ward through to anaesthetic, operating room and recovery. The hospital had systems to identify when patients' condition deteriorated and were becoming increasingly unwell. This enabled staff to provide increased support. Recognised tools were used for assessing and responding to patient risks. Outcomes for patients were good and the departments followed national guidelines. Departments undertook frequent audits such as the theatre checklist and hand hygiene. Audits were analysed and the results cascaded to staff. Staff were competent and knowledgeable about their specialties on both the wards, the burns unit and in the theatres. However mandatory training was not always up to date for all staff groups. The general environment was visibly clean and a safe place to care for surgical patients. However there was little monitoring or routine assessment of environmental safety, such as security, COSHH flammable liquids and facilities, however the hospital undertook annual Health and Safety assessments. There was sufficient emergency resuscitation equipment available. This was usually checked appropriately and ready for use in suitable locations throughout the surgical services. The trust provided evidenced based and adhered to national and best practice guidance where possible. However the trust did not meet national guidance on managing burns patients as the hospital did not have the on-site facilities that a large district general hospital would provide; such as specialist renal, haematology and intensive care facilities. Substantial work had been undertaken to ensure that the hospital was able to care safely for the patients that were admitted. The care delivered was measured on a continuous basis to ensure quality and adherence to national guidance and to improve quality and patient outcomes. The trust was able to demonstrate that it continuously met national quality indicators with patient outcomes monitored and reviewed through

Summary of findings

national and local audits. Medicines management was generally good however remained practice in theatre that did not meet current best practice or comply with national guidelines.

The care was very much multidisciplinary where every healthcare professional's input was valued and respected. Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through sharing consultant knowledge and experience, multidisciplinary teamwork and specialists. The hospital had a dedicated pain team that provided specialist pain services to patients. Nursing staff assessed the nutritional needs of patients and supported patients to eat and drink with the assistance of a red tray system and protected mealtimes. Special medical or cultural diets could be catered for.

Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure safe and effective patient outcomes. Staff received an annual performance review and had opportunities to discuss and identify learning and development needs through this.

We found that the hospital was not yet offering a full seven-day service. Staffing constraints and availability had yet to be addressed. There was limited routine availability of other support services such as therapies over the weekend and out of hours. Although staff reported few problems with being on call staff into the hospital, not having on site staff available at all times limited the responsiveness and effectiveness of the service the hospital was able to offer.

Patients and their families were treated with compassion, dignity and respect. They had their care needs met by caring and dedicated staff. This positive feedback was reflected in the Family and Friends feedback and patient survey results.

Both patient and stakeholder needs were taken into consideration when planning services. Patients who lived far from the hospital were able to access the specialist services of QVH through the 'Hub and Spoke' outreach system. There was innovative use of telemedicine to aid the urgent assessment of injuries, improve patient experience and prevent unnecessary hospital admissions. There were clear admission criteria for burns patients in order to

Summary of findings

manage the hospital's relative clinical isolation and noncompliance with the national burns standards in relation to providing essential support services. Service level agreements with other hospitals within the burns network ensured that patients were triaged to the most effective location for their particular physical needs. The effective management of elective and trauma cases meant that operations were rarely cancelled. Complaints were acknowledged, investigated and responded to with information was shared to promote learning and prevent reoccurrence.

The specialist services undertaken by the trust were well-led with clear strategic objectives were in place that were known and understood by the staff. Senior leaders were visible, available and supportive to all staff. There was an effective governance and risk management structure in place with robust clinical governance and reporting arrangements in place. There was clear leadership with staff taking ownership and responsibility for their areas of influence. All staff spoke with passion and pride about working at QVH. The trust promoted and encouraged both local and national innovations to improve patient care and treatment.

Critical care

Requires improvement



The unit was clean and staff adhered to infection control policies and protocols. Consultants in CC all have CCT in anaesthesia have received training in intensive care but do not have CCT in intensive care medicine".

A drug error had been reported at the time of the inspection. This was due to the wrong dose of medication being given and resulted in no harm to the patient. There was no evidence of the incident being reported straight away on the electronic system and nothing documented in the nursing notes. This was brought to the attention of staff whilst on the unit. We asked the trust to report on the outcome of their investigation following this incident.

Nursing staff had the relevant qualifications and worked flexibly to cover the peaks and troughs of occupancy rates.

Staff worked in a flexible manner in order to ensure all patients were looked after when demand increased.

Summary of findings

The unit had no individual clear vision and strategy although it was part of the burns unit governance programme and as such the unit did not have its own entity.

There was a strong culture of teamwork and staff spoke of being proud of their unit.

Services for children and young people

Good



We found that services for children and young people at the Queen Victoria Hospital caring and compassionate and were well led. We received positive feedback from patients and their parents about the care, facilities and staff on Peanut Ward, and other areas of the hospital used by children.

We saw that emergency equipment and medicines were appropriately stored and checked in line with protocols. Additional patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.

The hospital responds well to patients needs and supports children with complex needs in an innovative and caring manner.

Staff work hard to ensure that children who have had body changing surgery are supported through a network of mentors. These mentors are children who have similar life changing surgery.

Outpatients and diagnostic imaging

Good



There was a positive culture of reporting incidents and staff were aware of and used the incident reporting process. Clinical areas were visibly clean with cleaning rotas and check lists in place. Not all equipment had not been regularly checked and tested. Medicines were well managed with good support provided by the pharmacy team. Patient records were safely stored and their availability at clinic appointments was on the whole, good. There were safeguarding policies and procedures in place and staff were aware of safeguarding leads. Staff were up to date with their mandatory training. Patient dignity and privacy was respected and maintained by staff where possible. Staff were kind, considerate and caring. We saw positive interactions between patients and staff.

Summary of findings

Outreach outpatient clinics were available for patients across Kent and Sussex so that patients could receive a service close to their home, however there was no specific strategy for outpatients, diagnostic and imaging and therapy services. Sustainability of services within the prosthetics department was well managed.

The Queen Victoria Hospital (East Grinstead)

Detailed findings

Services we looked at

Minor Injuries Unit; Specialist burns and plastic services; Critical care; Services for children and young people; Outpatients and diagnostic imaging

Detailed findings

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Background to The Queen Victoria Hospital (East Grinstead)

The Queen Victoria Hospital (East Grinstead) is managed by The Queen Victoria NHS Foundation Trust.

The Queen Victoria Hospital (QVH) provides a specialist burns and plastic surgery service to both adults and children. The trust provides emergency, trauma and elective reconstructive surgery and rehabilitation for people who have been damaged or disfigured through accident or disease. Patients are admitted from the south east of England including south east London. The trust also provides 'hub and spoke' specialist services at other hospitals in the south east of England, bringing QVH staff with specialist skills to remote hospital locations.

Additionally the hospital provides a minor injuries unit and services for the treatment of common conditions of the hands, eyes, skin and teeth for people living in and around East Grinstead, as well as outpatient and therapy services.

There are two surgical wards with 47 beds where trauma and plastics patients are cared for together with a dedicated burns unit with 12 beds. The hospital has 10 operating theatres with associated areas for anaesthetics and recovery within the main theatre suite. Two further theatres are used for plastic surgery (Rowntree; day care 1 and 2). There is also one theatre attached to the burns unit where patients who arrived by ambulance are assessed and treated before being transferred either to the burns unit or to critical care.

There are 9 beds on Peanut Ward for the care of Children and Young people.

The Hospital employs approximately 835 whole time equivalent staff.

The Hospital was inspected as part of our Comprehensive Inspection programme for the NHS Trusts in England. It was inspected on the 11th and 12th November 2015, with unannounced visit on 23rd November 2015.

Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop Doctor (retired)

Head of Hospital Inspections: Alan Thorne Care Quality Commission

The team included CQC inspectors and a variety of specialists including Consultants in anaesthetics, critical

care, paediatrics, radiology, plastic surgery and senior specialist nurses from theatres, paediatrics and emergency care, therapists and a pharmacist. NHS managers included governance experts, estates and facilities management, safeguarding, therapies and nursing. Additionally the inspection team included a junior doctor and two experts by experience.

Detailed findings

How we carried out this inspection

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

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

The inspection team inspected the following 5 services at the Queen Victoria Hospital (East Grinstead):

- Minor Injuries Unit
- Burns and Plastic Surgery
- Critical care
- Services for Children and Young People
- Out patients, therapies and diagnostics

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included clinical commissioning groups (CCG), Monitor, NHS

England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges, national commissioners of specialist burns services and the local Healthwatch team.

We held a listening event for local people to share their experiences of care on the 3rd November 2015.

We also held focus groups for staff and the QVH on the 3rd and 4th November 2015, these groups included nurses, junior doctors, consultants, staff side representatives, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested. We talked with patients and staff from the all the ward areas, MIU, outpatient services and therapy services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We also carried out an unannounced inspection on 23rd November where we revisited Peanut ward and MIU.

Facts and data about The Queen Victoria Hospital (East Grinstead)

Demographics

The hospital provides a minor injuries unit and services for the treatment of common conditions of the hands, eyes, skin and teeth for people living in and around East Grinstead. It provides specialist services of reconstructive surgery, burns care and rehabilitation services for people across the South of England.

Activity

Between 2014 and 2015 the trust facilitated:

- 20,211 inpatient admissions
- 189,625 outpatient attendances
- 11,870 MIU attendances

Context

- Serves the population of the South East of England for burns and plastics

Serves the population of East Grinstead and surrounds for MIU, Out patients and therapies

Intelligent monitoring – Safe

- There was one never events recorded between Aug/14 and Jul/15.
- 10 serious incidents reported five of which were confidential information/IG breach.
- 734 NRLS incidents reported 84% of which were no harm to patients.
- The NRLS has not been compared the England average due to this being a specialist trust.
- There were no MRSA cases and one C.Difficile case reported during the reporting period.
- There were three MSSA cases reported during the reporting period, all of which occurred in March 2015.
- During the safety thermometer audit periods there were no falls and one catheter UTI reported.

Detailed findings

- There were nine pressure ulcers reported during the audit periods with no real change in numbers reported overtime.

Intelligent monitoring – Effective

- Mortality indicators show no evidence of risk
- Risk identified for 'Composite risk rating of ESR items relating to staff registration.

Intelligent monitoring – Caring

- The trust is in the top 20% of trusts for 25 of the 33 indicators in the Cancer Patient Experience Survey.
- In the CQC inpatient survey the trust scored 'better performing trusts' for 10 of the 12 questions.
- Consistently performed above the England average in the Friends and Family Test percentage recommended
- Scored similar to the England average for PLACE indicators.

- The numbers of written complaints has remained similar over the time period.

Intelligent monitoring – Responsive

- Over 50% of delayed transfers of care in the trust are due to awaiting care package in own home' or 'waiting further NHS non-acute care' - this is higher than the England average.
- Bed occupancy varies above and below the England average over time.

Intelligent monitoring – Well Led

- Staff sickness absence rate is lower than the England average from Jan/11 to Jan/15.
- Performed better than the England average for 15 out of 21 indicators in the NHS Staff Survey.
- Performed similar to the England average for 9 out of 12 indicators in the GMC National Training Scheme Survey.

Our ratings for this hospital







Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries unit	Good	Good	Good	Good	Good	Good
Specialist burns and plastic services	Good	Good	Outstanding	Good	Good	Good
Critical care	Requires improvement	Requires improvement	Not rated	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Outstanding	Good	Good	Good

Notes

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

Minor injuries unit

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

Information about the service

The minor injuries unit at Queen Victoria Hospital, East Grinstead was responsible for treating 11870 people with minor injuries from April 2014 to March 2015. The unit is nurse led. The MIU serves a population of East Grinstead and the surrounding areas.

The main function of the unit is to treat patients who had sustained a minor injury. It is also the main receiving unit for trauma referrals relating to patients requiring assessment for plastic surgery, and these patients are expected and managed by the site trauma and plastics team, and not MIU staff. Patients with more serious health problems were required to access other services such as a GP, or for more serious illness or injury, the Accident and Emergency department at Brighton or Redhill.

The unit accepts both adults and children with approximately 30% of all attendances from children under 16. It was open from 08:00 – 22:00 seven days a week. X-ray is available Monday–Friday 9:00–17:00 and Saturday mornings 09:00–13:00. There is limited availability on Sundays and bank holidays (10:00–13:00) for adults and children over the age of four. There is an on call service outside these hours.

We spoke to four patients, and five staff, including the matron, student and qualified nurses and a health care assistant. We observed care and treatment and reviewed some of the trust's quality monitoring information and data.

Summary of findings

We rated this service as good.

There had been no never events or serious incidents reported in the last year. Cleanliness, infection control and hygiene were meeting the standards expected. There were separate waiting areas and facilities for adults and children. All waiting areas were monitored by reception staff.

Medication was stored safely and dispensed in line with trust policies. Processes were in place to safeguard patients. Staff were knowledgeable about safeguarding protocols and knew how to raise safeguarding alerts.

Mandatory training rates were variable with only 46% of staff having had mental capacity act training, which is not acceptable.

Staffing levels were adequate to cover the unit. Staff were suitably qualified to assess patient risks and access to training and development was good. Staff were well supported to carry out their duties. Annual appraisal was completed for all staff. There was a system in place to monitor staff competencies and ensure they had the right skills to treat patients who attended the unit.

The unit used best practice guidelines from the College of Emergency Medicine and there was evidence of local audits being undertaken to monitor quality and patient outcomes. Staff understood the principles of the Mental Capacity Act 2005 and their responsibilities in obtaining consent from patients.

Minor injuries unit

All patients we spoke to were positive about the treatment they received and reported that staff were professional, caring and courteous. All patients were triaged by an emergency nurse practitioner within 15 minutes of arrival at the department and a priority allocated.

The department was well-led and there was regular contact with senior managers. There were regular meetings where a range of clinical governance and organisational issues were discussed.

The environment compromised confidentiality in the reception area and patients' privacy and dignity in treatment cubicles which were partitioned by curtains only. Space within the unit was also limited due to the presence of the trauma clinic. There were insufficient clinical areas for the number of clinics and patients that needed to be seen.

Are minor injuries unit services safe?

Good



There had been no never events or serious incidents reported in the last year. Staff were aware of the incident reporting process and were confident to use the system. Cleanliness, infection control and hygiene were meeting the standards expected. There were separate waiting areas and facilities for adults and children. All waiting areas were monitored by reception staff.

Medication was stored safely and dispensed in line with trust policies. Processes were in place to safeguard patients. Staff were knowledgeable about safeguarding protocols and knew how to raise safeguarding alerts.

Mandatory training rates were adequate and staffing levels were sufficient to cover the unit. Staff were suitably qualified to assess patient risks. Access to training and development was good and staff were well supported to carry out their duties. Annual appraisal was completed for all staff. There was a system in place to monitor staff competencies and ensure they had the right skills to treat patients who attended the unit.

Incidents

- There had been no never events or serious incidents requiring investigation in the last 12 months. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Trust policy stated that incidents should be reported through a commercial software system enabling incident reports to be submitted from the department. All staff we spoke to were aware of the incident reporting process and were confident in using it. One member of staff said it was really easy to use.
- There were 25 incidents reported from May 2015 to August 2015 which identified a wide range of incidents that had been appropriately reported, investigated and actions had been taken.
- We saw that a root cause analysis (RCA) was completed as part of the investigation of incidents. RCAs identified learning from incidents and lessons learned from incidents were shared across the team.

Minor injuries unit

- Analysis of these incidents does not show any themes or trends; however an example of learning from incidents involved the miss-recording of a controlled drug. Appropriate action was taken and staff involved in the incident were required to take an oral drug assessment to review their competency. All staff were reminded of the requirement to ensure that controlled drugs are safely and accurately recorded.
- One member of staff said that there was a good culture of reporting medicine incidents in the department and that change had been implemented as a consequence. For example the competencies were updated so that the incident would not be repeated, as described above. The learning from this was shared at the Emergency Nurse Practitioner meeting.
- Risks, incidents and the environment were a regular discussion point at monthly departmental meetings.
- Senior staff were aware of duty of candour (DoC) and could explain how the process worked. Other staff were aware of the principles but did not know how it should be implemented. 84% of staff had had training in DoC
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other relevant person within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has or may have occurred. No such incidents had occurred in the last six months.
- Auditing had been undertaken for hand hygiene in February 2015 and showed staff in MIU were 100% compliant, with 41 observations taking place. Additionally infection prevention and control training for staff was 77% of all staff.
- We saw that gloves, aprons, and other personal protective equipment (PPE) were readily available and used by staff. There were sufficient hand gel dispensers within the unit although these were not clearly visible or signposted. We observed staff adhering to the bare below the elbows policy.
- The importance of visitors cleaning their hands was publicised and we saw people coming into the MIU using the hand gel dispenser next to the entrance door.
- All equipment had been labelled with 'clean' stickers with dates and these had been checked, where appropriate and we saw there were effective arrangements in place for the storage, handling, and disposal of clinical waste.
- We saw that sharps management generally complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw that sharps containers were used and that they were dated and signed when brought into use.

Environment and equipment

Cleanliness, infection control and hygiene

- All areas within MIU were found to be compliant with the Department of Health's 'Code of Practice on the prevention and control of infections and related guidance'. There was a trust approved infection prevention and control policy in use within the unit and staff could direct us to the policy.
- We found that MIU was clean and well maintained, with dedicated in-house cleaning staff. Cleaning rotas were available for scrutiny and regular audits of cleaning undertaken to monitor the effectiveness of cleaning regimes.
- The MIU was located in an old building but the entrance was welcoming. However the doors were temperamental, opening and closing while staff and patients were standing on the entrance mat, which when the weather was inclement, could potentially cause cold air or wind to come into the department. This was not on the risk register.
- There were separate waiting areas for adults and children which were both separate from reception. The children's waiting area had a play area for younger patients.
- All areas were centrally monitored at reception through Close Circuit Television (CCTV).
- Space around the reception area was limited and this compromised patients' privacy, when they were booking in additionally it hampered the ability of staff to freely move around reception and the adjoining cubicle area.

Minor injuries unit

- The MIU has plaster room.
- There were small clinical treatment areas for the number of clinics being undertaken. There were three clinical areas divided by curtains; one small paediatric clinical cubicle which was also curtained; two consulting rooms and one procedure room. However this did not impact on waiting times to the extent that targets were breached. The consulting rooms and the procedure room were primarily used by the trauma clinic. Plans were in place to relocate this service which will improve patient confidentiality for those attending the minor injuries unit.
- There was awareness of environmental risk within the department. An environmental risk audit had been completed in May 2015 including a dementia friendly environment assessment. These audits identified that confidentiality was not always maintained and that the relocation of the trauma clinic would help mitigate this.
- We observed the resuscitation trolley was appropriately secured and the contents had been regularly checked and records completed.
- Staff told us that Electrical Medical Equipment (EME) was well maintained centrally by the EME department, and that Portable Appliance Testing (PAT) labels were attached to electrical systems showing that it had been inspected and was safe to use.
- COSHH assessments had been completed appropriately for flammable and potentially harmful substances.
- There were 60 patient group directives (PGDs) authorised for use in the MIU. Nurses completed the generic medicines competency assessment and the Trust PGD training before being signed off as competent to use PGDs. Staff authorisation lists were seen attached to PGDs. All PGDs seen had been authorised were in date and a review date noted. PGDs provide a legal framework that allows some registered health professionals to supply and or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. PGDs were all correctly completed, authorised and in date.

Records

- Patient records were paper records, and patient personal data was pre-populated on them, via the electronic patient administration system which reception staff completed when patients arrived in the department.
- Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.
- Leaflets explaining patients' rights to access their medical records were available and the trust's website carried information on people's rights under the Freedom of Information Act 2000.
- We were not aware of any case note audits being undertaken.
- 100% of staff had had training in information governance.

Safeguarding

- Processes were in place for the identification and management of adults and children at risk from abuse. Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- There was a different coloured sheet used for children who were identified as being at risk of abuse. One member of staff described the process of identification and escalation that would be taken.
- 100% of all staff working in MIU had received level 1 adult safeguarding training.

Medicines

- Medication was stored safely and supplied in line with trust policies and controlled drugs (CD) were securely stored and administered according to current guidance and legislation.
- In treatment rooms medication was kept in locked cupboards. Fridges were clean and tidy and appropriate checks had been undertaken to ensure correct temperature controls.
- Good support was provided by the pharmacy department including a stock top up service and using 'do not use after' stickers when dispensing liquid medicines. These processes ensured that medicines were available to be used and safe to administer to patients.

Minor injuries unit

- 92% of all staff had received level 1 safeguarding children training, 85% level 2 and 62% level 3.

Mandatory training

- Staff we spoke to told us they were up to date with mandatory training, however data provided by the trust showed compliance with mandatory training for the department was between 100% for information governance training and 46% for mental capacity act training.
- Resuscitation training for both adults and children's reported 70% of all staff.
- Training relating to staff safety showed that 92% of staff had had NHS Conflict Resolution (England), 85% for Health, Safety and Risk and 83% having had moving and handling - Level 1 training.
- Other training data showed us that 92% of staff had had Equality, Diversity and Human Rights training.
- Emergency planning training showed that planning for non-clinical emergency was 93% and clinical emergency 72%.

Assessing and responding to patient risk

- All patients attending the unit were triaged and given a category of 1-4 (1 the most urgent and 4 being non-urgent). The Emergency Nurse/ care Practitioner (ENP) saw all patients within 15 minutes to determine the category of urgency risk and applied a category to individuals. The trust did not audit or monitor the treatment times for each category.
- Children were assessed by the ENP, however staff from Peanut Ward (The Children's Ward) were available to come to the department if a children's nurse was required. Nursing staff from Peanut Ward also rotated to the department, to ensure some paediatric cover. The paediatric early warning scores (PEWS) were used for children attending the unit. This meant that children attending the unit were being assessed using a national warning score tool so that any deterioration in their condition could be picked up.
- The MIU had a least 1 ENP on duty at all times with advanced Paediatric life support training.

- A policy was in place for the management of children requiring care which could not be managed at Queen Victoria hospital, with transfer arrangements in place.
- One patient we spoke to had not been seen within 15 minutes for initial assessment but had attended the unit several times with the same presenting clinical condition and so staff were able to treat without assessment.
- The Emergency Nurse/ care Practitioner (ENP), treated and reviewed care of the patients, in the department, and oversaw the treatments given by other trained staff.
- Patients with acute respiratory distress and chest pain were also seen immediately by the ENP, and escalation procedures were in place to transfer patients immediately to designated emergency departments if medical intervention was required. There were guidelines and protocols in place to ensure referrals were appropriate and emergency ambulance services were used if the patient's condition was critical. Of the 11,931 patients seen in the department during the 12 month period 303 were transferred to other providers, this included GPs and dentists as well as emergency departments in nearby hospitals. We were unable to determine the breakdown of this data.
- During the inspection a patient walked into the unit with chest pain and was found to be having a severe cardiac episode. Immediate action was taken, and an ambulance arrived within 10 minutes and he was transferred from the MIU to the emergency department in Brighton.
- Patients are not transferred to the QVH MIU by ambulance for emergency treatment other than for minor injuries. The ambulance trust have clear protocols to ensure patients requiring emergency department treatment are not taken to the MIU.

Nursing staffing

- The unit was nurse led. It was staffed by Emergency Nurse Practitioners (ENPs) who had completed a qualification in emergency care practice.
- The department had an establishment of 1 Manager, 6.28 whole time equivalent (WTE) emergency nurse practitioners, 2.08 WTE staff nurses, 1.8 WTE healthcare assistants (HCA) and 2.43 WTE reception staff. There were two ENP vacancies one of which was for children.

Minor injuries unit

- During the period 1st April 2015 and 31st July 2015 the number of registered nurses required to cover the unit was planned at 506 shifts and the actual number was 608, HCA planned was 143 and actual cover was 145. This shows that the department is able to exceed the requirement to ensure adequate staffing levels.
- There was minimal use of bank and agency staff and this only happened where there were shortfalls of staff due to annual leave or sickness.

Major incident Awareness

- There was a major incident plan in place which staff were aware of. This had been discussed at a team meeting and an action card was available on the staff room door for staff to follow in the event it was needed.
- All staff we spoke to were aware of the major incident plan and action cards were stuck to the staff room door outlining staff responsibilities. One member of staff told us this had been discussed at a staff meeting.
- 82% of staff in the department had received major incident training. There had been no major incident exercise in the last 12 months other than a table top in October 2015.

Are minor injuries unit services effective? (for example, treatment is effective)

Good



There was evidence of local audits being undertaken to monitor quality and patient outcomes. Best practice guidelines as set by the College of Emergency Medicine were followed.

Staff had access to training and development and were supported to carry out their role. Staff understood the principles of the Mental Capacity Act 2005. They understood their responsibilities in ensuring consent was obtained from patients.

Evidence-based care and treatment

- Staff told us they followed best practice guidelines in line with those set by the Royal College of Emergency Medicine, and we saw these were available to staff.

- Clinical guidelines were available in line with National Institute for Health and Care Excellence (NICE) guidance. We were able to see these were available to staff within the unit, on the trust intranet and used in patient records.
- A range of local clinical audits were undertaken within the department. We saw the clinical audit plans and were told by two members of the team that a wound care audit was currently taking place.
- A Retrospective analysis and audit of all the plastic surgery trauma referral sheets for the month of February 2015 was undertaken which showed that 37% of records were not completed regarding the likelihood of alcohol involvement causing the injury. The outcome was that staff now have been asked to ensure all referral sheets are complete with a target of 90% compliance set.
- Results of the hand hygiene audit carried out in February 2015 showed had 100% of staff in MIU were compliant with 41 observations taking place. The bare below the elbows audit done at the same time showed 100% compliance.
- A quarterly controlled drugs audit was undertaken by the pharmacy department and the MIU was compliant.

Pain relief

- Patient group directives (PGDs) covered a wide range of analgesic preparations.
- We observed patients being given analgesia in a timely manner, there were no available pain audits.
- Distraction methods were used with children, and we observed this with a child who had dislocated her finger. The play therapist from Peanut Ward was available if required to help with distraction and bubbles for blowing were available in the MIU.
- We observed one situation where a patient was in severe pain from a toothache and was quite difficult to manage. Staff were compassionate and caring and provided the telephone number of an emergency dentist. The patient left the department satisfied.

Nutrition and hydration

- There was a restaurant close to the unit where patients and staff could purchase food and drinks.
- Water was available from staff for patients if required.

Minor injuries unit

- There were no hot drinks available in the unit and one patient told us this would have been appreciated when waiting for treatment.

Patient outcomes

- Unplanned re-attendance rates to MIU within seven days was 1.1% which is better than the English average of 7% and the target of 5% during the period from April 2013 to date. Which shows the MIU is performing well.
- Where patients attended MIU but did not meet the referral criteria they were signposted to the appropriate service.
- Of the 11,931 patients seen in the department during the year (September 2014 – September 2015) 303 were transferred to other providers, for more appropriate care to meet their needs such as GPs, dentists or other healthcare providers.
- We did not see any other data relating to patient outcomes.

Competent staff

- Newly appointed ENPs were given a competency booklet and worked with the matron to ensure all competencies were completed within acceptable timeframes. All other new staff and students received an induction to the unit and were supported to complete competencies relevant to their role.
- Nurses completed the generic medicines competency assessment and the trust patient group directives (PGDs) training before being signed off as competent to use PGDs. Records of this were seen.
- Staff told us about the Trust teaching sessions that happened every month for example ECG updates and wound care. Staff were encouraged to attend these and keep up to date with latest clinical practice.
- The trust supported staff in their professional development for example one member of staff had received training as a plaster technician and was supported to keep up to date with developments in the field.
- Staff appraisal rates were at 92%
- All nursing staff within the unit had received competency training in treating children and there was cross cover available from the paediatric ward. Staff

skills were also kept up to date by utilising training and senior staff from the paediatric ward. This was in line with the Royal College of Paediatrics and Child Health Standards for Children and Young People in Emergency Care Settings, 2012.

Multidisciplinary working

- There was good multidisciplinary working particularly across the hospital. Consultants, anaesthetists, the resident dentist and radiologist were all available should their specialist advice be required in MIU.
- There was agreement with a local acute Trust to provide paediatrician support for children requiring specialist intervention when they are on site, Monday, Wednesday and Friday.
- There were two multidisciplinary handovers each day at 08:00 and 20:00.
- Staff told us they worked well together and we observed good interactions between all staff within the unit.

Seven-day services

- The unit was open seven days a week from 8am to 10pm. X-Ray services were available Monday – Friday 9am to 5pm, Saturday 9am to 1pm and Sunday and bank holidays 10am to 1pm.

Access to information

- We saw that clinical guidelines, policies procedures were held in the staff office and were available on the trust intranet, which enabled staff to give effective care in line with policies.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to describe the concept of Gillick competencies and the arrangements for seeking consent from children and young people where they had been assessed as being competent to make decisions regarding their care and treatment.
- Staff were aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were able to describe the arrangements that were in place should the legislation need to be applied. This is a way of assessing whether a patient is able to make a specific decision for themselves at a moment in time.

Minor injuries unit

- There was a Mental Capacity Act flow chart incorporated into a brightly coloured best interest decisions form and staff were able to explain when this would be used.

Are minor injuries unit services caring?

Good



We saw good communication with patients and staff were caring and compassionate whilst maintaining their professionalism.

We spoke with four patients who told us they were very happy with their care.

Compassionate care

- We saw good communication with patients from all staff working in the unit and staff were caring and compassionate and dealt efficiently and effectively with the range of patients attending.
- Patients were made aware of the waiting times to be seen as soon as they arrived at reception.
- Staff were seen to regularly attend to patients to ensure their comfort and safety.
- Although patient confidentiality was compromised due to the lack of privacy at reception and the curtained cubicles staff spoke quietly to avoid private and personal information being overheard. Patients dignity was maintained by ensuring curtains were closed at all times.
- The department used the Friends and Family Test to capture patients' feedback and comments cards were available in the waiting area. Scores were positive and between October 2014 and July 2015 the minor injury unit scored consistently above 95%.

Understanding and involvement of patients and those close to them

- We saw involvement of a parent and child in the decisions about the treatment options available.
- Staff explained care and treatment options to patients and patients told us they knew about the plans for their care.

- Interpreters were available to patients whose first language not to English to ensure they understood their care and treatment.

Emotional support

- Staff were sensitive to the needs of the patients attending the MIU.
- We saw staff talking with patients and their relatives and responding to questions in an appropriate way. All staff gave responses and reassurance to patients and relatives who were anxious or concerned.

Are minor injuries unit services responsive to people's needs? (for example, to feedback?)

Good



The responsiveness of the service was good

Information was available about waiting times when patients visited the unit. There was good access to X-ray services and patients thought this was a fast and efficient service.

The unit performed better than the standard and England average in treating patients within four hours.

There was a good understanding of the complaints process and action was taken from lessons learned.

Service planning and delivery to meet the needs of local people

- The MIU provides a nurse led unit to meet the needs of local people with minor injuries and it is highly thought of by local people and used appropriately.
- There were clear admissions criteria to the unit that had been agreed with South East Coast Ambulance NHS Foundation Trust. For example the unit could take patients with minor head injuries with no loss of consciousness, minor burns and scalds, limb injuries, simple eye infections, cuts and grazes, bites and stings, ear and throat infections and skin infections. Ambulance attendance was rare.

Minor injuries unit

- Diagnostic services are available on site, such as blood testing and radiology and patients receive results promptly.
- The department works with GPs and local CCGs in planning services for local people, and are working with them to consider future plans to improve the types of care provided.
- There were plans to relocate the trauma clinic and staff were aware of this imminent change. This will improve the capacity within the department.

Meeting people's individual needs

- Staff told us they were aware of the need to recognise more vulnerable patient groups such as people with a learning disability. There was a matrix and flow chart displayed on the noticeboard to help recognise this patient group, so that appropriate action and care could be given.
- Staff were aware and had training to ensure the needs of patients with dementia were met including the use of the butterfly system.
- Patients were informed of the initial waiting time when they first attended the reception and some verbal updates were given. Not all patients we spoke to felt informed of what was happening and what the next stage of the process was.
- There were separate paediatric and adult waiting areas, however the children's area whilst appropriate did not appear to be a secure area.
- There was access to interpreter services although this was rarely used and a range of information leaflets were available in the waiting room. None of these were in any language other than English.
- Access for people with a disability met the disability access legislation.

Access and flow

- The percentage of patients seen within four hours was consistently better than the standard and the England average for all A&E department types. This was between 96 and 100%, during the year ending June 2015.

- The unit performed better than the England average for the percentage of patients who left the department before being seen, 11849 people attended of which 206 left.
- The median time for patients in the department did not exceed 4 hours between March 2014 and June 2015.
- There was good access to X-ray services and patients told us this was efficient with minimal waiting times.

Learning from complaints and concerns

- There was information about how to raise concerns about the unit or the trust as a whole on display in the department.
- Staff understood their role in supporting patients to make formal complaints.
- Six complaints had been received in the last 12 months. Two had been discussed at staff meetings and changes in practice had occurred. For example patients who attended the MIU with sunburn were now referred to the burns unit for immediate advice.

Are minor injuries unit services well-led?

Good



The hospital currently provides therapy services and a nurse led Minor Injuries Unit for local people. The trust see the opportunity to extend their community service offering, with the potential for a fully integrated primary and community care service on the hospital site, delivered in partnership with local GPs – providing local GPs and patients with rapid access to excellent diagnostic care and assessment.

Staff we spoke with felt they were well-led at departmental level and that the matron was highly visible and very approachable. Departmental meetings were held regularly and staff had opportunities to raise concerns.

There was evidence of good team work and opportunities to learn and develop. Staff felt confident that any concerns raised would be listened to.

Vision and strategy for this service

- The trust see the opportunity to extend their community service offering to local people building on existing MIU

Minor injuries unit

provision, with the potential for a fully integrated primary and community care service on the hospital site, delivered in partnership with local General Practitioners (GPs) – providing local GPs and patients with rapid access to the diagnostic care and assessments at the hospital.

- Discussions are underway with local GP providers and local commissioners to further explore the benefits.
- It was unclear how staff were involved in these discussions; however they were aware of the overall vision.
- There were plans to relocate the trauma clinic and staff were aware of this imminent change. The matron recognised there would need to be an increase in staffing and the establishment was being reviewed to facilitate the change.
- The unit had a clear identity within the hospital and community. There were clear protocols in place to ensure that only minor injuries were treated.

Governance, risk management and quality measurement

- Monthly departmental meetings were held where risks, incidents the environment, clinical audit and performance were discussed. Minutes of these meetings were seen on inspection.
- There was a risk register for the unit where risks were managed for example, the potential for unauthorised access to ointments and lotions kept in the MIU theatre, action had been taken to change practice and we did not find medicines in unlocked cupboards.
- Staff were clearly aware of other risks and told us that good discussions took place about these at meetings but they were not formally recorded on the register. For example in the staff meetings it is recorded that the plaster room was cluttered and this caused issues when people were being treated. The action taken was to remove obsolete equipment and also free up more storage space in a disused area, where staff lockers were.

Leadership of service

- There is a clear structure in place to manage MIU and was led by a Matron supported by ENPs. Staff told us they felt supported by their managers, and this was

apparent at the inspection, we saw senior staff working alongside more junior staff. Staff told us and we observed that the matron was highly visible and approachable.

- Staff told us that senior members of the Trust Board were visible and approachable, particularly the Director of Nursing and the Chief Executive.

Culture within the service

- Staff told us that there was an open and supportive culture within the department. Morale was good and staff worked together as a team.
- Staff felt confident to raise concerns and that these would be listened to.
- Staff felt supported and were supportive of each other. We saw and were told that staff had very good professional relationships.
- Many staff had worked at the hospital for several years and we were told by them that they loved the hospital and the work they did.

Public engagement

- The department used the Friends and Family Test to capture patients' feedback and comments cards were available in the waiting area. Scores were positive and between October 2014 and July 2015 the minor injury unit scored consistently above 95%.
- Patients spoke highly of the MIU at a listening event that was held prior to the inspection.

Staff engagement

- Staff were aware of the imminent changes within the department and were planning how the additional space could be utilised. They were also aware of the long term plans for their department and the hospital.
- 56% of all staff completed the NHS Staff survey above the England average of 42%.







Innovation, improvement and sustainability

- The trust is working with partners to consider the sustainability of services at the Queen Victoria Hospital, and one of the key themes is to look at what the organisation can offer to local people to include the provision the MIU and other primary and community care provision.

Minor injuries unit

- Plans were in place to relocate the trauma clinic which will improve the clinical space available within the unit and there was plans to improve the décor within the unit.

Specialist burns and plastic services

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

Information about the service

The Queen Victoria Hospital (QVH) provides a specialist burns and plastic surgery service. The trust provides emergency, trauma and elective reconstructive surgery and rehabilitation for people who have been damaged or disfigured through accident or disease. Patients are admitted from the south east of England including south east London. The trust also provides ‘hub and spoke’ specialist services at other hospitals in the south east of England, bringing QVH staff with specialist skills to remote hospital locations. The hospital operates strict admission criteria for the admission of burns as it is unable to provide inpatient support for patients with severe burns or comorbidities. The plastic surgery service includes complex, microvascular breast reconstruction, hand, head and neck surgery. The Melanoma and Skin Cancer Unit (MASCUC) is the tertiary referral centre for all skin cancers across the South East Coast catchment area.

There are two surgical wards with 47 beds where trauma and plastic surgery patients are cared for together with a dedicated burns unit with 12 beds. The hospital has 10 operating theatres with associated areas for anaesthetics and recovery within the main theatre suite. Two further theatres are used for plastic surgery (Rowntree; day care 1 and 2). There is also one theatre attached to the burns unit where patients who arrived by ambulance are assessed and treated before being transferred either to the burns unit or to critical care. During our inspection, we reviewed information from a wide range of sources to get a balanced and proportionate view of the service. We reviewed data supplied by the trust, visited the inpatient wards, operating

theatre department, pre-assessment and the day surgery unit. We also observed care being delivered by staff. The CQC held a number of focus groups and drop-in sessions where staff could talk to inspectors and share their experiences of working at the hospital. We spoke with over 40 members of staff working in a wide variety of roles including divisional directors, the chief nurse, matrons, ward managers, nurses, health care assistants, ward clerks, and housekeeping and domestic staff. We spoke with nine patients and their relatives. We reviewed 12 sets of patients’ records as well as other documentation. We also received information from members of the public who contacted us to tell us about their experiences both prior to and during the inspection.

Specialist burns and plastic services

Summary of findings

Patients who used the service experienced safe, effective and appropriate care and treatment and support that met their individual needs and protected their rights. The care delivered was planned and delivered in a way that promoted safety and ensured that people's individual care needs were met. Patients had their individual risks identified, monitored and managed and the quality of service provided was regularly reviewed. We found that patients were protected from avoidable harm because there were systems to report, monitor, investigate and take action on any incident that occurred. There were robust systems in place to monitor clinical safety throughout the service such as infection control, slips, trips and falls and manual handling. This included the five steps to safer surgery and the World Health Organization's (WHO) procedures for safely managing each stage of a patient's journey from ward through to anaesthetic, operating room and recovery. The hospital had systems to identify when patients' condition deteriorated and were becoming increasingly unwell. This enabled staff to provide increased support. Recognised tools were used for assessing and responding to patient risks.

Outcomes for patients were good and the departments followed national guidelines. Departments undertook frequent audits such as the theatre checklist and hand hygiene. Audits were analysed and the results cascaded to staff. Staff were competent and knowledgeable about their specialties on both the wards, the burns unit and in the theatres. However mandatory training was not always up to date for all staff groups. The general environment was visibly clean and a safe place to care for surgical patients. However there was little monitoring or routine assessment of environmental safety, such as security, COSHH flammable liquids and facilities. There was sufficient emergency resuscitation equipment available. This was usually checked appropriately and ready for use in suitable locations throughout the surgical services. The trust provided evidenced based and adhered to national and best practice guidance where possible. However the trust did not meet national guidance on managing burns patients as the hospital did not have the on-site facilities that a large district general hospital would provide; such

as specialist renal, haematology and intensive care facilities. Substantial work had been undertaken to ensure that the hospital was able to care safely for the patients that were admitted. This involved very effective admission assessment of each referral with strict criteria. The care delivered was measured on a continuous basis to ensure quality and adherence to national guidance and to improve quality and patient outcomes. The trust was able to demonstrate that it continuously met national quality indicators with patient outcomes monitored and reviewed through national and local audits. Medicines management was generally good however remained practice in theatre that did not meet current best practice or comply with national guidelines. The care was very much multidisciplinary where every healthcare professional's input was valued and respected. Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through sharing consultant knowledge and experience, multidisciplinary teamwork and specialists. The hospital had a dedicated pain team that provided specialist pain services to patients. Nursing staff assessed the nutritional needs of patients and supported patients to eat and drink with the assistance of a red tray system and protected mealtimes. Special medical or cultural diets could be catered for. Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure safe and effective patient outcomes. Staff received an annual performance review and had opportunities to discuss and identify learning and development needs through this. We found that the hospital was not yet offering a full seven-day service. Staffing constraints and availability had yet to be addressed. There was limited routine availability of other support services such as therapies over the weekend and out of hours. Although staff reported few problems with bring on call staff into the hospital, not having on site staff available at all times limited the responsiveness and effectiveness of the service the hospital was able to offer. Patients and their families were treated with compassion, dignity and respect. They had their care needs met by caring and dedicated staff. This positive feedback was reflected in the Family and Friends feedback and patient survey results. Both patient and stakeholder needs were taken into consideration when planning services. Patients who

Specialist burns and plastic services

lived far from the hospital were able to access the specialist services of QVH through the 'Hub and Spoke' outreach system. There was innovative use of telemedicine to aid the urgent assessment of injuries, improve patient experience and prevent unnecessary hospital admissions. There were clear admission criteria for burns patients in order to manage the hospital's relative clinical isolation and noncompliance with the national burns standards in relation to providing essential support services. Service level agreements with other hospitals within the burns network ensured that patients were triaged to the most effective location for their particular physical needs. The effective management of elective and trauma cases meant that operations were rarely cancelled. Complaints were acknowledged, investigated and responded to with information was shared to promote learning and prevent reoccurrence. The specialist services undertaken by the trust were well-led with clear strategic objectives were in place that were known and understood by the staff. Senior leaders were visible, available and supportive to all staff. There was an effective governance and risk management structure in place with robust clinical governance and reporting arrangements in place. There was clear leadership with staff taking ownership and responsibility for their areas of influence. All staff spoke with passion and pride about working at QVH. The trust promoted and encouraged both local and national innovations to improve patient care and treatment.

Are specialist burns and plastic services safe?

Good



We rated the specialist burns and surgical services at QVH as 'Good' for 'Safety' because: The specialist services undertaken by the trust were safe because patients were protected from avoidable harm. There were systems to report, monitor, investigate and take action on any incident that occurred. Clinical safety was monitored throughout the service such as infection control, slips, trips and falls and manual handling. This included the five steps to safer surgery and the World Health Organization's (WHO) procedures for safely managing each stage of a patient's journey from ward through to anaesthetic, operating room and recovery. Patients care needs were assessed planned and delivered in a way that maintained their safety. The hospital had systems to identify when patients' condition deteriorated and were becoming increasingly unwell. This enabled staff to provide increased support. Recognised tools were used for assessing and responding to patient risks. The surgical wards used the safety thermometer to monitor and assess the quality of care being delivered. There was sufficient emergency resuscitation equipment available. This was usually checked appropriately and ready for use in suitable locations throughout the surgical services. Staff were competent and knowledgeable about their specialties on both the wards, the burns unit and in the theatres. However mandatory training was not always up to date for all staff groups. The general environment was visibly clean and a safe place to care for surgical patients. However: There was little monitoring or routine assessment of environmental safety, such as security, COSHH flammable liquids and the facilities, although there was annual health and safety assessment undertaken. Medicines management in theatre did not always meet current best practice or comply with national guidelines.

Incidents

- At QVH all incidents were reported through the trust's electronic reporting system. There was an incident

Specialist burns and plastic services

reporting policy and procedure in place. This was readily available to all staff on the trust's intranet. Staff we spoke with were aware of the policy, knew how to report incidents and were encouraged to report incidents.

- Any learning from incidents was fed back to staff and had led to changes in practice to ensure patient safety. Staff gave us examples where changes in practice had occurred following learning from incidents. This included the decontamination process and the drug administration process. This was confirmed in the minutes from staff meetings where we saw that feedback and learning from incidents was cascaded to staff both in theatres and on the wards.
- There was one never event reported between August 2014 and July 2015 relating to wrong site orthodontic surgery, where the wrong tooth was removed. The hospital conducted a thorough investigation and the surgeon underwent a period of supervision and a new pre admission criterion was implemented. (Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures are implemented).
- The trust undertook a review and investigation which identified several areas of learning for the orthodontic and maxillofacial teams. The findings the never event and from other incidents were discussed at the regular clinical directorate meetings. Any learning was shared at the bimonthly joint hospital clinical audit meetings.
- Serious Incidents are serious matters requiring investigation and reporting to the National Reporting and Learning Service (NRLS). The trust reported 10 serious incidents of which five were confidential information breaches.
- Additionally a further 734 incidents were reported to the NRLS from September 2014 to August 2015; of which 84% led to no harm to the patient. We did not compare this hospital to the England average due to this being a specialist trust.
- The operating theatres reported 350 incidents between October 2014 and October 2015. One was rated as major, two moderate, 81 minor with the remaining 266 rated as causing no harm. This indicated that there was a good reporting culture where staff readily reported any incident that occurred.
- The highest reported theatre incidents were related to drug errors (22), the loss of a swab, instrument or needle (22), issues relating to consent (21), a delay with the operation (21) and poor communication (19). The breakdown on clinical incidents was displayed around the theatre suite.
- Ward managers told us that most of their incidents related to falls or medication errors. However non clinical incidents were also well reported. Staff gave examples where drug charts weren't available or an exceptionally long wait for ambulance transport had been reported.
- One example related to the decontamination of surgical instruments in theatre. Although the incident originated with the external contractor, it had been reported appropriately and there had been significant changes to practice with action plans put in place to ensure this type of incident did not occur again.
- The pharmacy team and admissions team lead spoke about a series of reported incidents involving the loss of patients own drugs between admission and the ward. Following investigation, a new system had been introduced which documented the movement of the patients own drugs with a designated medicine bag introduced to store them We observed this in action. This demonstrated that there were systems in place to learn from any incident and actions were taken to prevent reoccurrence.
- The trust monitored and analysed incident reporting in order to identify any areas which under reported and to target improvement. We were told that incident recording was improved by all staff having computer access to allow them to record incidents electronically.
- Monthly mortality and morbidity meetings had recently started and we saw minutes of meetings where difficult cases were discussed and any learning identified. All patient deaths were discussed at the burns multi-disciplinary governance meetings and any learning disseminated. If further review and discussion was required, the patient's case was then presented at a joint hospital governance meeting.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of

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health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

- Staff we spoke with knew about the duty of candour and how to report an incident. For example the infection control team described how 28 patients were contacted when the decontamination incident occurred, and that patients were kept informed through the investigation process. This demonstrated that staff at QVH understood their Duty of Candour responsibilities and took appropriate action when required.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism.
- During the safety thermometer audit periods there were no falls and one catheter UTI reported. There were nine pressure ulcers reported during the audit periods with no real change in numbers reported overtime. Patients are admitted to the QVH for treatment to pressure ulcers.
- The surgical wards we visited were able to demonstrate routine data collection for the national safety thermometer and this was displayed on all of the surgical wards we inspected.
- The safety thermometer information displayed on the surgical wards documented there had been no recent falls or pressure ulcers developing in the past month. Hand hygiene was recorded as 100%.
- The NHS safety thermometer was displayed around the theatre suite which showed that for The year to October 2015 staff were 100% compliant with the WHO checklist, the departments uniform standards, the hand hygiene standards and venous thromboembolism (VTE) assessments.

Cleanliness, infection control and hygiene

- The trust had infection prevention and control policies available that were based on national best practice

guidelines. Staff had ready access to these policies and procedures that were stored on the trust's intranet. We found that staff were generally aware of the principles of the prevention and control of infection (IPC).

- There were no particular issues noted with infection in the surgical wards or theatres.
- There were no MRSA cases, one C.Difficile case and three MSSA cases reported during the reporting period of year(2014/15), all of which occurred in March 2015. There were a low number of reported urinary tract infections related to indwelling catheters.
- Surgical site infections were monitored and reported to Public Health England.
- The pre-admission nursing team showed us the MRSA (Methicillin Resistant Staphylococcus Aureus) screening that took place for elective patients before they were admitted for surgery. The clinical notes we reviewed demonstrated patients were MRSA screened prior to admission if possible and on admission if they did not go through the pre-assessment pathway.
- However there had been an infection outbreak the previous year in the Burns Unit. The bacteraemia root cause analysis into the infection showed the infection originated from an infected patient transferred from another hospital. Critical care has three beds which can be used flexibly . The Burns Unit and major elective patients access these beds. This is less than ideal as burns are not sterile wounds and may carry infection which could pass onto the elective surgical patients.
- Infection prevention and control was included in the trust's mandatory training programme. The trust provided training data which confirmed that 93% had attended infection prevention and control training. Those staff we spoke with all confirmed they had completed this training.
- We observed staff working on the surgical wards and in the theatre department adhering to the policies. For example operating theatres were cleaned every night after use and high wall washes were carried out every six months. We observed staff regularly used hand gel on entering clinical areas and between patients. The 'bare below the elbows' policy was adhered to and personal protective equipment (PPE) such as disposable gloves and aprons were readily available in all areas.

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- However we noted staff wearing blue surgical scrubs outside of the clinical environment. We were told that the hospital policy was that staff wearing green scrubs would change before leaving the burns unit; that hats or masks should never be seen outside of the clinical environment and that blue scrubs should always be covered when leaving the wards or theatre. We raised this issue at the time of the inspection and this was addressed. We noted that the staff used a flimsy plastic coats to cover the scrubs when outside of a clinical environment, which did not fully cover the uniform or reduce the risk of cross infection when staff were crossing the hospital grounds or in the canteen.
- All patients we spoke with said the hospital was always kept clean and tidy. They told us they noticed the nurses were always washing their hands.
- The hospital had a dedicated infection control team, which provided support to staff. The infection control team's responsibilities included attending policy review, auditing and promoting good infection control practice through attending relevant meetings and advising and training staff. They had also conducted infection control site audits in remote locations at the spoke sites to ensure safe infection control practice at the other hospitals where QVH staff treated patients.
- The infection control team were involved in all aspects of infection prevention and control in the hospital including the procurement of medical devices and refurbishment projects.
- There were infection prevention and control (IPC) link nurses who were responsible for cascading training and information and for ensuring staff were compliant with infection control best practices.
- The link nurses undertook regular infection prevention and control audits in order to make sure all staff were compliant with the trust's policies such as hand hygiene and the use of personal protective equipment (PPE).
- All the surgical inpatient areas we inspected, where patients were seen and treated were visibly clean and tidy. Staff and visitors had ready access to hand washing sinks with sanitising hand gel available throughout all the locations we inspected. However we noted that the location of the hand gel sites were not always obvious with the signs for their use being absent or inconspicuous. On the wards we noted that dressing trolleys obstructed the wash hand basins making hand hygiene difficult for staff.
- We noted the link corridors between wards and departments were not kept to the same standard as the wards with floors and walls with damaged plaster and paintwork. There were multiple posters stuck to the walls, which was a potential infection risk. Surfaces that are damaged or have posters stuck to them are difficult to maintain and keep clean.
- The main theatre suite had separate clean preparation areas and facilities for removing used instruments from the operating room ready for collection for re-processing by an external decontamination service.
- We observed theatre staff followed the National Institute for Health and Care Excellence (NICE) guideline CG74, surgical site infection: prevention and treatment of surgical site infections (2008). This included skin preparation and management of the post-operative wound.
- The trust contracted out the decontamination and sterilisation of instruments. The contractor cleaned and sterilised all re-usable instruments and equipment that were used in the operating theatres, wards, clinics and departments under a service level agreement.
- There had been a decontamination incident that originated with the contracted service. The supplier had taken action and amended their systems to ensure that the incident could not be repeated. The hospital now had systems in place to check that the instruments were appropriately decontaminated and sterilized.
- Theatres had a well organised flexible endoscopic decontamination unit. The department had completed a mock Joint Advisory Group (JAG) accreditation scheme inspection, which demonstrated they were compliant with best practice guidelines. And were awaiting a full inspection for accreditation. This unit processed all endoscopes used throughout the hospital not just the main theatre suite and the trust undertakes an annual review of flexible endoscope decontamination.
- The trust had a waste management policy, which was monitored through regular environmental audits. We

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saw that clinical and domestic waste bins were available and clearly marked for appropriate disposal. Disposable sharps were managed and disposed of safely.

- Disinfection wipes were available for cleaning hard surfaces in between patients. Equipment was marked with a sticker when it had been cleaned and was ready for use.
- Linen cupboards were clean and tidy with bed linen managed in accordance with best practices.
- The hospital employed its own cleaning staff. Ward staff said that the cleaning staff were part of the ward team and took pride and responsibility for maintaining the environment. The theatre department had its own dedicated house keeper and cleaner and we noted the theatre environment was exceptionally clean.
- Cleaning equipment was colour-coded and used appropriately. We saw cleaning rotas and cleaning checklists completed appropriately by the cleaners and checked by a manager. Monthly environmental audits took place and results of audits were available for inspection.
- A patient led assessment of the care environment (PLACE) visit took place in May 2015. The report highlighted how clean the site was despite the challenges the older estate presented.

Environment and equipment

- The equipment was serviced and maintained by an external provider. There were systems in place to monitor, check and maintain the equipment. We saw the equipment logs and the records of the monthly equipment checks and servicing that took place including training logs for any new equipment. All the equipment we saw had been labelled to verify it had been electrically tested within the past year.
- The staff we spoke with confirmed there was a wide range of equipment available and they had access to the necessary equipment required to meet peoples care needs. In particular the consultants stated that the hospital was very well equipped. Staff in the preoperative clinic said that new equipment always arrived in good time meaning that the patient's journey was not delayed through lack of equipment.
- Emergency resuscitation equipment, oxygen and suction equipment was available in each area. In theatre the emergency equipment included resuscitation items and emergency intubation. Checks on the resuscitation equipment had been made, routinely recorded and items were clean.
- There was emergency resuscitation equipment readily available on the wards.
- Staff we spoke to said they had received relevant training on how to use equipment and felt confident and competent to use it. We saw training records which confirmed staff were given training on the safe use of medical devices.
- There were 10 main operating theatres. The recovery area had 12 bays, including two used for the post-operative recovery of children. Standard theatre environment was provided, with anaesthetic rooms, scrub facilities, clean preparation rooms and dirty utility.
- All anaesthetic rooms were standardised which meant staff could work in any anaesthetic room and equipment and drugs could be found in a similar location.
- We saw in theatres that staff used equipment to minimise risks to patients developing pressure sores, such as using warming devices and pressure relief aids.
- Theatres were accessible to individuals living with a disability and technical equipment was available to support individuals where required. This included operating tables being appropriate for bariatric patients.
- Plant air handling, water safety and generator servicing in theatres was managed by estates in accordance with relevant Health Technical Memorandums produced by the Department of Health.
- The theatre risk register recorded in March 2014 that an inaccurate anaesthetic record print (ARC) had occurred. Incorrectly recorded data may lead to inappropriate care. However the incident was documented and controls put in place such as: raising staff awareness and the purchase of new equipment. The risks were mitigated as information on the print out from that machine was not used for clinical decision making. The risk was reviewed in September 2015 when new equipment had been purchased and was put into use.

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- We saw good practice with the storage of medical gas cylinders which were stored in a 'bomb proof' cabinet. Empty cylinders were stored in another location in line with the trusts guidance on the security and safety of medical gas cylinders.
- Although the general ward environment was safe we noted that patients, visitors and staff could gain access or leave the ward through a door in the sluice. This may pose a risk to patients who were confused leaving the ward or unauthorised people gaining access to the ward.
- There was no system in place to routinely check environmental health and safety. For example manual handling, environmental and ligature risk assessments were not available. Formal monthly health and safety checks were not undertaken. We noted that the wards did not have a general health and safety folder for staff to access. However we did see a health and safety risk assessment had been completed for a pregnant worker.
- COSHH (Control of substances hazardous to health) assessments had been recently completed. However although these assessments identified some highly flammable liquids, these were not stored in dedicated flammable liquid storage cupboards but in a wooden domestic type of cupboard. This meant that although the cleaning materials had been identified as a hazard they were not stored appropriately.

Medicines

- The trust had medicine management policies available that were based on current legislation and national best practice guidelines. Staff had ready access to these policies and procedures that were stored on the trust's intranet. We found that staff knew about the safe management of medicines policies and how to access them if needed.
- All the surgical areas inspected had a clinical pharmacy service. Ward staff confirmed that pharmacy staff visited every ward during the week between Monday to Friday.
- There were processes in place for staff to obtain medicines and pharmacy advice out of hours either through the pharmacy site lead or through an alternative London Hospital. The nursing staff we spoke with were aware of this process.
- On the surgical wards we found that medicines and intravenous fluids were stored securely in locked cupboards and locked rooms. The medicine trollies were kept locked and secured within a locked treatment room when not in use. The treatment rooms where medicines were stored were neat and tidy, temperature controlled with the cupboards kept locked.
- The pharmacy team completed the documentation of medicine reconciliation (MedRec) and managed the top up of stock to ensure that over stocking did not take place.
- The discharge co-ordinators had a supply of over-labelled medicine that were used for patient discharges when the pharmacy was shut at the weekends and during the evenings. There were clear process in place for use of stock; such as double checking by another clinician; only dispensing against an electronic discharge summary with special attention given to high risk medicines such as warfarin and insulin. The protocol included checking the patients' own medicines to avoid duplication for example drugs that included paracetamol and co-codamol.
- The discharge co-ordinators provided training for ward nurses on the discharge process to ensure that it was done safely when they were not available. The discharge co-ordinators told us that they were on duty six days a week (10.5 hours per day). FP10 prescriptions were available via the site co-ordinator.
- Liquid medicines had 'do not use after' stickers, which were attached by the pharmacy at dispensing stage.
- Medicines audit results and information was displayed on a notice board on the ward. The information included the number of missed and omitted drugs on patients charts.
- We reviewed a sample of medicine administration charts (MAR) and found they were well documented. There were very few omitted doses, allergies were documented, venous thrombosis assessments completed with the prescriber's identifier completed on front page of drug chart.
- Medicine counselling was provided by the pharmacy staff.
- Controlled drugs (CDs) were stored in appropriate cupboards. Only CDs were stored in these cupboards

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with daily stock checks taking place. These were audited each quarter by the pharmacy department and this showed good compliance. The pharmacy department now checked the liquid CD balances monthly in response to an incident. We noted that a CD error had been correctly documented with the entry struck through but still legible.

- In theatres the August 2014 risk register raised concerns relating to unlocked drug cupboards in anaesthetic rooms. This meant that patients or unauthorised staff could access drugs without the authorised staff being aware. This was being audited to see what improvements had been made since the last audit. These results were not available at the time of the inspection.
- We saw controlled drugs (CDs) in theatres were stored in locked cupboards, which were secured to the wall. All CD registers we looked at were completed appropriately. However during our inspection we found two occasions when CDs were left on the side of the anaesthetic bench. This raised concerns that there were still times when drugs were left unsecured. This was brought to the attention of the staff at the time of the inspection.
- Medicines fridges were checked and the temperatures at which items were stored were recorded.
- Patients did not self-administer any drugs as this was considered inappropriate for post-surgery patients.
- All the patients we spoke with told us they received their medication as expected, including any regular medicines they usually took at home.
- We saw that medical gases were stored according to best practice in cabinets that were 'Bomb proof'. Empty cylinders were removed and stored in separate location.

Records

- We looked at samples of five sets of nursing and medical records on each of the wards and in the burns unit. In general we found they were well completed, accurate, fit for purpose. They were stored securely. We noted that a red card inserted into the notes indicated the most current entries. This provided staff with easy access to the most recent documentation and saved time in searching through the notes for information.

- Patient records were paper based, with the exception of discharge summaries and requests for diagnostic procedures. Standardised pathways were followed with staff adding information to personalise them.
- Staff in the preoperative clinic also used a paper based system of recording information, however they were soon to be moving to an electronic preoperative system to improve communication and the speed and availability of information.
- Patient notes contained evaluation and progress updates, as well as information in respect to discharge planning and documented the patient's progress.
- The records included multidisciplinary input from other healthcare professionals. For example, the records included entries made by dieticians, physiotherapy and occupational therapists. Medical personnel also contributed directly to the records, with commentary on treatment, diagnosis and required interventions.
- We saw evidence of referral to specialist advice, such as the dietician, tissue viability nurses and other support services.
- The sample of care plans we reviewed in each area had relevant, updated and complete risk assessments in place. This included falls risk assessments and MUST (Malnutrition Universal Screening Tool). Where actions were required these were seen to have been carried out. For example, with respect to nutritional needs and where falling was a risk the use of aids and signage to indicate closer observation was noted. We found that all patients had undergone an electronic VTE assessment as part of their admission.
- We saw that patient records contained evidence of attendance at the pre-operative assessment where relevant. Information taken at the pre-assessment included previous medical and surgical history, allergies, and medicines along with baseline observations.
- The theatre risk register noted the electronic theatre records system would cease in March 2016. The service had completed the procurement process and a new system would be installed in March 2016. Staff would be trained on the new system once this was in place.

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- We observed that theatre staff fully completing the checklists based on the World Health Organization (WHO) safety procedures to safely manage each stage of a patient's journey from ward through anaesthetic, operating room and recovery.
- There was a WHO champion and patient safety lead identified on the daily allocation rota and would be responsible for checking the WHO paperwork.
- Other checks were carried out in the anaesthetic rooms prior to surgery such as: consent forms completed, allergies checked and past medical history.

Safeguarding

- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on the trust intranet.
- There were safeguarding leads in the hospital who acted resources for staff.
- We saw posters displayed around the surgical departments and in theatre directing staff to the trusts safeguarding policy and displaying the named safeguarding leads.
- Safeguarding training was included in the trust's mandatory training programme.
- We were told that all staff undertook basic safeguarding training. Those staff with additional responsibilities undertook level two and three training.
- Staff we spoke with confirmed they had received safeguarding training as part of mandatory training. They were aware of the safeguarding policy and how to access it.
- The trust provided information that confirmed 100% of anaesthetists had undertaken Level One safeguarding for adult training.
- 100% of registered nurses had undertaken safeguarding for adults training and 100% and Level 2 children's safeguarding training in theatres.
- Patients' social vulnerability was assessed when they attended the pre-admission clinic. Staff in the pre-admission clinic liaised with social services when

vulnerable patients were admitted into hospital. Information to support the patient in hospital and their discharge home was shared with the ward staff responsible for discharge planning.

Mandatory training

- All the staff we spoke with told us that the trust provided good training and development opportunities. Mandatory training was monitored and all staff expected to attend on an annual basis.
- We reviewed the training matrix on the surgical wards that documented staff mandatory training. We saw from performance dashboards provided that there were gaps in the achievement targets.
- Staff on the surgical wards stated that the overall mandatory training level was at above 90% However when we looked at the training records we identified there were gaps in mental capacity and Dols training.
- Although the majority of staff had undertaken adult basic life support (79); paediatric life support (75%); infection prevention and control (88%); health, safety and risk (90%) and emergency planning (above 90%).
- This meant that most of the staff had undertaken all mandatory training within the time limits set by the trust.
- We spoke with consultants and doctors of all grades. Mandatory training, such as safeguarding and infection control, was available. Junior doctors now said that the induction had improved and showed us the induction literature they were given when starting at the hospital.
- We looked at the mandatory training records kept for the anaesthetists and found that similar to nursing staff there were gaps. For example although over 90% had attended emergency planning and infection control and moving and handling less than 60% had attended adult basic life support, paediatric life support, conflict resolution, health and safety and equality, diversity and human rights. No anaesthetists had attended mental capacity training.
- The hospital tried to use the same agency staff that were familiar with the trust. We saw the new orientation and induction sheets available to support new temporary staff to the trust.

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- The hospital had three training coordinators who worked with the ward managers to facilitate learning and development.

Assessing and responding to patient risk

- A robust triaging system was in place to ensure that patients who were severely burnt (over 40%) or who had life threatening complications were not admitted. Any such patients were diverted through the Burns Network to the nearest hospital with suitable facilities to manage, not only the patients immediate burns, but any complication that might develop as a result.
- This was verified by the hospital's high survival rate where fewer than five adult burns patients died in 2014. This equated to a burns inpatient mortality rate of less than 5%.
- The National Patient Safety Agency (NPSA), 'Five steps to safer surgery' posters were displayed across the department to remind staff of their duties in improving anaesthetic safety practices, ensuring correct site surgery and avoiding surgical errors. Staff followed all five steps and we observed this.
- Mortality and morbidity meetings had just started for anaesthetists although they had participated in the wider trust wide mortality meetings. Anaesthetists discussed all patients who were transferred out of the hospital and those patients who died within 30 days of surgery.
- We saw that patients had individual risk assessments in place. For example a patient who wore splints had an assessment for their safe use at night in order to prevent falls when using the toilet facilities.
- The hospital used of an early warning scoring system, which was used to monitor patient condition following their surgery. The scoring system enabled staff to identify concerns before they became serious and to get support from medical staff. We saw the early warning system in use in patient notes reviewed.
- The WHO (World Health Organization) safer surgery checks was fully embedded and the hospital undertook regular audits to monitor its use and identify any shortfalls. We saw the theatre team using the check list during the inspection and saw audit results that showed a 100% compliance.

Nursing staffing

- Throughout the trust the staff and managers we spoke with told us that the low staff turnover was one of the real strengths of the hospital and it wasn't unusual for staff to have worked at QVH for 15 years or more, and this had led to good relationships being forged, trusting colleagues and excellent teamwork. Although we were told that they were finding it increasingly difficult to recruit new staff, retention was not an issue.
- We spoke with ward staff the majority of whom had worked at the hospital for several years. They told us they were usually well staffed. The ward managers reported very few vacant or unfilled shifts as ward staff worked overtime or bank staff filled posts. Staff were flexible and moved shifts to ensure the ward was covered. We reviewed the staffing rotas and the planned and actual staffing levels which were displayed on the wards. These confirmed that the majority of shifts were covered.
- Ward staff told us that they used agency staff for flexibility but there were never more than 20% of the staff agency and often none. This was confirmed by the duty rotas we reviewed. For example the use of bank staff between April 2014 and March 2015 was 6%.
- The agency staff were regular staff who were familiar with the hospital. We spoke with an agency nurse who had worked at the hospital for the past six months and they described how they had undertaken relevant training in tracheostomy care and the use of intravenous therapy.
- There was a system in place which highlighted the nursing staff whose registration required checking.
- There was also a wide range of specialist nurses available to support patients and give advice to staff. These included specialist head and neck nurses, breast care nurses, McMillian Nurses, and the trauma outreach nurses.
- There was an eye inpatient nurse on duty each shift who ensured that any ophthalmic patient received appropriate care and treatment. This included administering medicines and undertaking ophthalmic observations.
- The military fund the salary of one whole time equivalent military nursing post and the trust funds 0.5

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military consultant post. We spoke with the forces personnel currently employed who spoke highly of the training and experience they were receiving in the Burns Unit.

- Theatres used a standard theatre team for each operating list comprising: two scrub nurses, one circulating nurse, one HCA and one anaesthetic practitioner.
- According to data provided by the trust the vacancy rate for qualified theatre staff was 14 (26%) whole time equivalent (WTE), turnover rate was 12 WTE (12%) and staff sickness was 53 days (11%). However, shifts were not left unfilled, as they were covered by bank and agency staff.
- The trust used agency staff to cover the vacancies and a high number operating department practitioners could multi-task and provide support both on the scrub side and anaesthetic side of theatre. This reduced any impact the vacancies might have.

Medical staffing

- The medical staffing skill mix was similar to the England average for consultants and lower than the England average for junior doctors. There were 129 whole time equivalent (WTE) medical staff employed by the hospital as of September 2014.
- This was made up of England comparable levels of consultants at 42%, slightly higher than the England average of 39%; levels of middle grade doctors, at 9%, the same as the England average. Middle grade doctors have at least three years at senior house officer or higher grade within their chosen speciality. The registrar group made up 49% of the medical workforce, against an England average of 39%. The junior doctors in foundation years one or two contributed 1% of the medical staff, against England average of 13%.
- Medical cover after 22.00hrs was provided by two resident doctors with consultants in all specialties on call.
- We spoke with consultant anaesthetists who were concerned that registrars held the bleep out of hours whilst undertaking the evening trauma list in theatre. They shared their concerns that they would not be able to attend an emergency in the rest of the hospital

urgently if they were in the middle of an operation in theatre. There was no data available which documented how often the registrars were called away from theatres or were needed on the wards but were unavailable.

- This risk had been added to the corporate risk register at the end of October 2015.
- The anaesthetists we spoke with confirmed that they would have no problem in being called should a situation arise. This was confirmed by the nursing staff.
- We were told that there were army doctors working at the QVH, who worked with the hospital to improve the surgical outcomes for soldiers who had lost limbs in recent conflicts. We spoke to the lead army clinician at a focus groups, and they clearly articulated the army input to services, as described above.
- There was limited on site physician cover. This meant the trust was non-compliant with NCEPOD standards. To mitigate this, cover arrangements had been put in place by providing an onsite physician Monday, Wednesday and Thursdays, telephone cover and geriatric clinics provided by a locum geriatrician from a nearby hospital. This was included on the corporate risk register.
- The trust had also appointed two research Fellows who were now working on rotation.
- Consultants managed their own operating lists which meant they could ensure that the cases were always appropriately covered with the right consultant available.
- One trainee doctor said that “This is the best place I have worked.”, and that they had excellent exposure to surgical cases and that they were well supported, and there were no problems with accessing senior help when required. Another trainee doctor spoke of “The commitment to train us goes above and beyond – there’s a high pass rate for FRCS (Fellowship of the Royal College of Surgeons) Plastics.”

Major incident awareness and training

- The trust had a major incident plan dated 2013, which was due for review in 2016. The purpose of the plan was to establish an effective response in the event of a major incident involving the QVH.

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- The plan included the trusts response to any major incident that might affect occur or events that might affect business continuity such as pandemics, bomb threats, chemical incidents, cold and hot weather eventualities.
- Although QVH was not the nearest hospital to high risk locations such as Gatwick Airport and the M25, it was situated close to the M23 motorway. Any major incident there would have an impact on the day to day activities of the service. The QVH might be expected to receive burnt or injured patients from a major incident site or the Accident and Emergency department (A&E) of another hospital.
- QVH as the only Burns Centre within the South East is designated to provide emergency support to all A&E departments within the NHS England Surrey and Sussex Area Team. In the event of a major incident QVH would provide a Burns Assessment Team and following assessment advice on the on-going treatment and support of burnt patients. A major incident was defined as three or more adult patients with burns of 20% or more total body surface area or three or more paediatric patients with burns of between 10 to 15% total body surface area.
- The hospital would also support other front line' hospitals by providing continuing care to inpatients transferred from these hospitals.
- Staff were made aware of the trust's Major Incident Plan through electronic and paper means. The current policy was available on the trust's intranet. We spoke with staff who were knowledgeable about the policy and gave a good description of their role in any incident and what would be expected of the hospital. The Emergency Planning Officer was based on the ward and kept all the staff updated, aware and informed about current policy and procedures.
- The trust was required to test their emergency plans regularly through communications exercises every six months, table top exercises at least once a year and via a full multi-agency live exercise every three years. We saw evidence that this had been undertaken.

Good



The specialist services offered at QVH were rated as good in terms of delivering effective care. We found all the specialist services undertaken by the trust were evidenced based and adhered to national and best practice guidance where possible. However the trust did not meet national guidance on managing burns patients as the hospital did not have the on-site facilities that a large district general hospital would provide; such as specialist renal, haematology and intensive care facilities. However substantial work had been undertaken in ensuring that the hospital was able to care safely for the patients that were admitted. This involved very effective admission assessment of each referral with strict criteria. The trust invested in researching and developing new and improved methods of care on a national and international front. The trust's policies and guidance were readily available to staff through the trust's intranet. The care delivered was measured on a continuous basis to ensure quality and adherence to national guidance and to improve quality and patient outcomes. The trust was able to demonstrate that it continuously met national quality indicators with patient outcomes monitored and reviewed through national and local audits. The care was very much multidisciplinary where every healthcare professionals' input was valued and respected. Consultants led on patient care and there were arrangements for supporting the delivery of treatment and care through sharing consultant knowledge and experience, multidisciplinary teamwork and specialists. The hospital had a dedicated pain team that provided specialist pain services to patients. Nursing staff assessed the nutritional needs of patients and supported patients to eat and drink with the assistance of a red tray system and protected mealtimes. Special medical or cultural diets could be catered for. Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure safe and effective patient outcomes. Staff received an annual performance review and had opportunities to discuss and identify learning and development needs through this. We found that the hospital was not yet offering a full seven-day service. Staffing constraints and availability had yet to be addressed. There was limited routine availability of other support services such as therapies over the weekend and

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out of hours. Although staff reported few problems with bring on call staff into the hospital, not having on site staff available at all times limited the responsiveness and effectiveness of the service the hospital was able to offer.

We saw there was exceptional use of telemedicine within the trust. Telemedicine is the use of telecommunication and information technologies to provide clinical health care and advice remotely.

Evidence-based care and treatment

- The hospital had a wide range of policies, procedures and protocols available for staff on the hospital's intranet. The policies were based on legislative requirements and best practice guidelines.
 - Patients who attended pre-admission assessment were having pre-operative investigations and assessment carried out in accordance with NICE clinical guidelines. This included following guidance regarding medicines and anaesthetic risk scores.
 - Staff followed procedures to ensure patients receiving post-surgical care were nursed in accordance with the NICE guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. This included recognising and responding to the deteriorating condition of a patient and escalating this to medical staff following the early warning alert system.
 - Within the theatre areas we observed that staff adhered to the (NICE) guidelines CG74 relating to surgical site infection prevention. Nursing staff followed recommended practice in respect to minimising the risk of surgical site infections. There was a sepsis pathway to follow where patient's needs indicated.
 - We observed staff following local policies and procedures in respect to the management of sharps, swab and needle counts, as well as the checking of surgical instrumentation. We observed the patient journey through into the operating theatre and saw staff complied with WHO safety checks at each stage.
 - The care plans and notes we reviewed demonstrated compliance with local hospital policies. For example the care records documented that staff were following NICE guidance on falls prevention, pressure area care and venous thromboembolism. We saw that anti-coagulant therapy was prescribed for patients at risk of the latter and anti-embolic stockings were measured and fitted to relevant patients.
- The trust did not meet national guidance on managing burns patients as the hospital did not have the on-site facilities that a large district general hospital would provide; such as specialist renal, haematology and intensive care facilities.
 - The hospital had a service level agreement with a trust 30 miles away who could provide the in-patient burns service with additional in patient services if required.
 - There was a dedicated Burns Audit Team, which was proactive in identifying ways of improving burns care through monitoring of patient treatments and outcomes.
 - The trust had a programme of auditing and monitoring the quality of care provided. Staff gave us examples of recent audits that included pain, nausea and vomiting and other complications post operatively. They gave several examples from pain audits, to records and outcomes for clinical procedures. An audit of assessing the importance of requesting the correct anaesthetic for plastic surgery patients had been undertaken and it showed that over a quarter of sedation requests were later converted to local anesthetic only due to patients condition and that consenting should be more robust, to ensure patients fully understood the reasons why there had been changes made to their original anaesthetic choice..
 - The hospital maintained the only database in the country for orthognathic surgery. Orthognathic surgery is undertaken to correct conditions of the jaw and face related to structure, growth and sleep apnoea, together with orthodontic problems that cannot be easily treated.

Pain relief

- QVH had a pain management service that was nurse led with support from consultant anaesthetists with an interest in pain management.
- The Pain Team worked in collaboration with the surgical teams to help manage the patients' pain control. They received referrals directly from the surgical teams. We

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were told that the pain nurses proactively visited wards looking for patients in pain and supported staff to manage their pain better. The Pain Team quickly responded when asked.

- The Pain Team also supported staff and patients with any pain issues through information and education.
- We saw that pain was monitored throughout the patients stay in hospital with dedicated space on the care pathway to record pain perception both pre and post operatively. A pain scoring tool was used to assess adult pain levels. In the records we reviewed have were completed appropriately and pain relief was given when needed.
- We observed that consideration was given to the different methods of managing patient's pain, including using patient controlled analgesia pumps.
- Patients coming round from surgery in recovery were assessed for their pain and given pain relief as prescribed. Intravenous pain relief was given where needed.
- All the patients we spoke with told us they received their pain relief as and when needed.
- One patient told us they had requested a strong pain killer before having a drain removed as they had had a bad previous experience of drain removal. The drug was prescribed on the 'as required' medicines with a specific instruction 'for drain removal'.
- One patient requested additional pain relief during our visit to the ward. We noted that the request was written in the doctors 'to do' book and the doctor then telephoned to ask how soon they would be coming to the ward to write up the medication. The doctor attended promptly and the pain received their medication within half an hour of asking for it.
- Another patient asked for pain relief from the nurses as we arrived on the ward and was given analgesia within less than 10 minutes".
- All the patients we spoke with who had recently undergone surgery told us there were no problems in obtaining adequate pain relief.
- On the Burns Unit we were told that a duty anaesthetist was available every day to provide sedation if needed when dressings were planned to be changed.

Nutrition and hydration

- The nursing staff assessed the nutritional needs of patients as part of the initial assessment, as well as when their circumstances changed. The assessment included special diets, unexplained weight loss and any help required with feeding. Staff screened patients preoperatively for any diet related disease or concerns such as diabetes, indigestion and food allergies.
- Patients' weights were recorded on admission and monitored to identify any weight loss during their hospital admission. We saw evidence of good clinical practice on the wards with the majority of patients being weighed.
- The surgical inpatient care pathway identified the length of time patients were starved pre-operatively. We spoke with the trauma coordinators who told us that when they scheduled patients into the trauma clinics or minor injury unit they monitored the length of time the patient hadn't eaten to make sure they were not starved for an unnecessarily long time.
- Fluid balance charts were in use where appropriate and used to monitor the patients' input and output. This included intravenous fluids.
- Dieticians and speech and language therapists were available to advise staff and patients when concerns with eating and drinking were identified.
- The hospital now supplied a weekly menu as few patients stayed longer than a week. We looked at menus and found that a variety of meal choices were available including those patients with special needs including low-fat, diabetic and gluten free, alternative meals were available where patients had particular requests.
- Patients were informed about the hospital's catering service and the importance of eating well for would healing through information leaflets.

Patient outcomes

- The trust had an effective programme of auditing, monitoring and researching the quality of care and treatment provided in order to identify areas where practice could be improved. Information regarding patient outcomes was fed into national data bases and used to inform future care and treatment.

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- The national burns healing time target had been adjusted for patients over 65 years old to under 31 days due to additional issues which may impede healing. The trust had subsequently reanalysed their data for 2013-2014.
- Burns patients who were likely to exceed the wound healing targets were discussed in the multidisciplinary team meeting and reviewed by a burns consultant with a view to discussing with the patient closing the wound surgically. The care pathways of any inpatients whose stay may exceed their target length of stay were also discussed at this meeting. Shorter burn healing time may reflect better quality of care through dressings, surgery and prevention of infection. Burns that take longer to heal may be associated with poor long-term scars.
- In 2014 the percentage of adult (under 65 years) burn wounds healing within 21 days was 64%.
- The percentage of adult (over 65 years) burn wounds healing within 31 days was 59%.
- The average time for adult burn wound healing was 16 days
- The target length of inpatient stay of burns patients was related to the size of their burn, measured as a percentage of their body surface area. The aim was for adult patients between the ages of 17 and 65 years of age to have a one-day inpatient stay per 1% burn. Adult inpatients over 65 years should require a two-day inpatient stay per 1% burn as the length of stay was often complicated by the higher prevalence of co-morbidities and the requirement for complex social care packages on discharge. This a QVH aspiration and exceeds the national aims.
- The average length of adult (under 65 years of age) inpatient stay (bed days) per percentage burn for acute injury admissions for 2014 was 1.6 days. For those patients over 65 years of age it was 2.7 days.
- The QVH breast team monitored clinical outcome and the women's perception and experience throughout the reconstructive treatment. This was a patient reported outcome measure (PROM). A consultant from the trust had been closely involved with the setup, design and implementation of a national free flap registry which included PROMs.
- In 2014 the breast team performed a total of 230 flaps. This was a 22.3% increase on 2013. Breast reconstruction was performed immediately after the mastectomy in 43% of cases, representing a year-on-year increase from 39% in 2013 and 26.3% in 2012. This is in line with good practice.
- The trust reported 100% success rate in free flap survival in breast reconstruction after mastectomy using the free tissue transfer. This was below the national failure rate of 2%.
- The QVH hand surgery department undertook one quarter of all elective plastic surgical operations at the trust and accounted for 80% of the trauma surgery at the hospital. In 2014 the trust carried out 208 primary repairs of flexor tendon injuries. Skin cancer care and surgery
- The rupture rate following repair of flexor tendon injuries was less than 5%, this compares favorably with the likely rupture rate of 10% nationally.
- In 2014 the trust's Melanoma and Skin Cancer Unit (MASCUC) undertook 1,386 cases for excision of basal cell carcinoma (BCC). The complete excision rate was 96.1%. The trust noted that the high rate of complete excision was commended as 40% of their referrals were from dermatologists who referred more complex cases.
- The clinical effectiveness audit of complete excision rates of malignant melanoma (229 cases) in 2014/2015 was 96.1% against the NICE guidance target of 75%.
- The QVH saw 55 new cases of head and neck cancer where each of the pre-treatment and surgical resective pathology results were discussed at an MDT meeting. Each of these cases underwent major head and neck surgery at QVH.
- The clinical effectiveness data for the maxillofacial service was collected over a three year period with the surgery taking place one year before the end of treatment. The data indicated a high level of patient satisfaction with 85% of patients very satisfied with the outcome of their surgery. 100% of the orthodontic patients stated they were completely satisfied with their treatment in 2014/2015.

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- The percentage of patients achieving vision better than 6/12 after cataract surgery in the trust's corneoplastic unit was 100% with correction and 92% unaided. The trust performed 1,106 cases of phacoemulsification for cataracts in 2014.

Competent staff

- The trust had in place appropriate recruitment and employment policies and procedures together with job descriptions used for staff recruitment. Recruitment checks were made to ensure new staff were appropriately experienced, qualified and suitable for the post. On-going checks took place to ensure continuing registration with professional bodies.
- New employees undertook both corporate and local induction with additional support and training when a need was identified.
- There were checklists in place for agency and bank staff. We spoke with agency staff who described how they had been orientated to the ward and given relevant information on working at the hospital.
- Learning and development needs were identified during the appraisal process. According to data provided by the trust, between April 2014 and March 2015 the appraisal rate for nursing staff in theatres was 80%.
- Nurses were supported in their learning and development by their managers and practice development nurses who provided ward based training and individual support.
- We saw that in theatres there were training plans in place for each staff member.
- Posters were displayed around the theatre suite about the Monday morning teaching sessions available for all staff. This included resuscitation training.
- A simulation centre had recently opened which was stocked with old theatre equipment. This was used to offer doctors the opportunity to undertake practical training programmes.
- Junior doctors reported to us they were well supported clinically at senior level and that teaching allocated regular times and was good. They gave us examples where Monday mornings were always allocated training days for the Registrars and mandatory and induction training days were prioritised

- The physiotherapists explained how they used the 2005 Burns Therapy Standards to develop a competency framework. These were reviewed each year alongside of respiratory and plastic surgery competencies. We reviewed the competency checklists and the individual sign off by the Band 7 clinical leads.
- We saw evidence that staff who required extra support had action plans in place to ensure they met the required standard.

Multidisciplinary working

- On the Burns Ward we observed positive and proactive engagement between all members of the multidisciplinary team (MDT). For example psychiatric and psychology input was taken into account when caring for a vulnerable patient with psychiatric problem. A registered mental nurse was present to act as an advocate and support the patient. A consultant physician attended the ward round on the Burns Unit providing medical input.
- We spoke with the physiotherapists and they confirmed they attended the ward handover meetings and were fully involved part of the multidisciplinary team.
- We attended a multidisciplinary team handover and noted there was an excellent approach to MDT working. The meeting was led by the surgical consultants and attended by other grades of doctors, trainee doctors, a psychiatrist, nursing staff, a physiotherapist, physician and pharmacist. The meeting included telemedicine with supporting images. We noted that the discussions included anticipating issues in the future as well as addressing the current problems of the patient. We noted that everyone's opinion was valued and listened to, there was clear job allocation and a clear process for follow up and what happened next.
- In theatre there were weekly multi-disciplinary meetings held on a Monday to discuss operating lists and bed requirements for the week ahead.
- We visited one of the day care theatres where Mohs microsurgery was taking place. (Mohs surgery is the most effective evidence based technique improving the reoccurrence rate by 5% against other forms of surgery for removing skin cancers and has a 98% success rate).
- Patients were seen by a dermatologist and then by a plastic surgeon for surgery. They would be operated on

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as a day case procedure and would be seen post operatively by their GP. Staff worked well together in order for the patients to be seen only once and reduce the number of times they had to attend the hospital. Since 2010 there had been 383 procedures with 93 taking place since April 2015

Seven-day services

- Emergency theatres were available at all hours with scheduled lists undertaken on Saturdays and Sundays, mainly for burns and plastics surgery.
- Out of hours for trauma there was a site practitioner, trauma coordinator, plastic surgery SHO and an anaesthetic registrar on site. On call there was a Maxillo Facial registrar, a plastic surgeon and anaesthetic consultant
- The trust is working reviewing the anaesthetic on site service out of hours.
- The therapy service did not offer a seven day service as recommended by NHS England for specialised burns services. Physiotherapists provided five days a week in patient support with on call arrangements for the evenings and weekends.
- There was no out of hour's pharmacy service on the site, however cover is supplied by another NHS trust, for emergency advise and urgent supplies.

Access to information

- We saw there was exceptional use of telemedicine within the trust. Telemedicine is the use of telecommunication and information technologies to provide clinical health care and advice remotely.
- We observed telemedicine in action, where trained staff spoke with ambulance staff in the community about the care and treatment needed for an elderly patient who had sustained a leg injury. Photos of the wound were sent to the QVH team who assessed the wound remotely and prescribed an appropriate course of treatment. This was undertaken by the paramedic practitioner in the patient's home with follow up information sent to the GP and district nurse team. This meant that that attendance at hospital had been avoided and the elderly person had received appropriate care and treatment in their own home.

- We saw several examples of the use of telemedicine being used to provide quick and effective care for patients either at the scene of the accident, in other healthcare settings or in patients own homes.
- The telemedicine records were also available for reviewing the effectiveness of the treatment, training and for medico-legal purposes. Doctors and nurses could assess the progress of the wound healing through photographs reducing the need for taking down dressings. This information was available to whole team and could be shared with other health care providers.
- On the wards staff attended ward meetings when able and any urgent information was communicated at this time.
- Theatre staff received information at theatre 'briefs' and 'debriefs' as well as at departmental meetings..

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- Clinical psychologists were available to support staff with advice when considering making a DoLS referral
- Recovery staff were sent on extended courses at a neighbouring trust as part of their Deprivation of Liberty (DoLS) safeguarding training.
- Consent forms identified all possible risks and complications following the procedure. The consent forms we reviewed were fully completed and contained no abbreviations so that patients could easily understand what had been written.
- Patients that we spoke to told us that they had been given information about the benefits and risks of their surgery prior to signing the consent form in a clear manner. They had been able to ask questions if they were not clear on something.
- Staff working in theatres had a good understanding of the Mental Capacity Act.
- We observed a patients journey through the day surgery unit from the consultation with the anaesthetist and

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surgeon to transfer to the operating theatre for their operation. We observed consent being given by the patient to their procedure. This was explained in full and included some of the risks to the surgery.

- Training on consent and the Mental Capacity Act 2005 was available and staff reported there was no problem with accessing the training, however and only 32% had training in the mental capacity act.
- We were told that best interest decisions and deprivation of liberty decisions were taken where indicated and these were formally documented.

Are specialist burns and plastic services caring?

Outstanding



We rated the specialist services provided at QVH as outstanding for providing a caring service for patients.

Patients felt valued and involved in their care and their dignity and privacy was maintained at all times. On the Burns Unit we noted outstanding care with detailed attention paid to patients' individual needs. Staff took time to discuss individual fears and took into account social situations when assessing and treating patients.

All the patients and their families who we spoke with, both before and during the inspection told us that they were treated with dignity and respect and had their care needs met by caring and compassionate staff. This positive feedback was reflected in the Family and Friends feedback and patient survey results.

During our inspection we observed patients being treated in a professional and considerate manner by staff. All the staff we spoke with were enthusiastic about the service they provided. We were told several stories of staff 'going the extra mile' to ensure patients received good-quality care that they would want their own families to receive. For example on the day of the inspection staff helped an elderly patient to celebrate their birthday by staff making them a cake and decorating their bed space.

We saw evidence of behavioural assessments having been carried out, as well as the assessment of individuals psychological and emotional needs, particularly where patients had needs associated with living with dementia.

Patients reported feeling involved in planning their care and told us they received enough information about their conditions. The hospital had specialist nurses and other health care professionals who were able to provide emotional support to patients and make referrals to external services for support if necessary.

Compassionate care

- The QVH consistently performed above the England average in the Friends and Family Test and was in the top 20% of trusts for 25 of the 33 indicators in the Cancer Patient Experience Survey.
- The 2014 national inpatient survey had a response rate of 49% compared to a national average of 45%. In the survey, QVH scored significantly better than other trusts on 41 of the 58 questions, about the same on 16 and worse than average on only one.
- QVH achieved the top scores in the county for ten of the questions and achieved 9.2, the highest score in the country for overall patient experience
- In the CQC inpatient survey the trust scored 'better performing trusts' for 10 of the 12 questions.
- The preoperative clinic, friends and family results were included with the outpatients department.
- The results from the various patient experience audits and questionnaires was confirmed by the patients we spoke with during the inspection and those who contacted us before the inspection.
- On the Burns Unit we noted outstanding care with detailed attention paid to patients' individual needs. In particular the needs of vulnerable patients with mental health problems or those living with dementia were identified and addressed in a compassionate and caring manner.
- Staff took time to discuss individual fears and took into account social situations when assessing and treating patients.
- We observed a vulnerable patient being supported with specialist psychiatric help during their stay in hospital.
- We saw patients collected from the admissions lounge by theatre staff who were caring and respectful. We

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observed good staff interaction with the patients and saw that patient's privacy and dignity was protected at all times including when they were under anaesthetic and were in the care of theatre staff.

- We received positive feedback from patients on the wards about the care they received. For example patients said "You can't fault the care," and "If you press the buzzer they come straight away." "My mattress was uncomfortable and they changed it."
- All patients told us that nothing was too much trouble for the staff. One patient said "Nothing is too much trouble, they encourage you to help yourself but will help you if needs be" another told us "Everyone is courteous, they treat us as human beings and not as an object."
- We heard many examples where staff had gone above and beyond what was expected of them to improve the patient's experience. For example we heard how staff had gone out to get some fast food for a patient who expressed a wish for something other than hospital food.
- On the day of the inspection staff helped an elderly patient to celebrate their birthday with staff making them a cake and decorating their bed space while they were in surgery as a surprise when they returned. We were told that these examples were not unusual "It's just what we do."

Understanding and involvement of patients and those close to them

- We spoke with patients at all stages of their surgical journey through the hospital, and we noted they felt involved in their care and in decision making about their treatment.
 - The patients we spoke with told us they were given adequate information about their condition and the treatment options open to them. They said risks, benefits and alternatives were explained to them.
 - Patients were given time to discuss options with their families and their questions were answered in a way they could understand.
- Patients and their families gave examples such as "My family are kept well informed and updated on timings and things," "Staff are empathetic they understand our needs as a family;" "They let us in before visiting to put our minds at rest and let us stay all day."
 - Patients felt that communication between the nursing and medical staff was good. Patients were given full explanations and feedback following the ward rounds and given the opportunity to ask questions. One patient told us "they are very effective in how they manage my condition and they put my mind at rest" and another said "I feel fully involved in my care."
 - Feedback from the various patient experience surveys confirmed that this was not unusual. The hospital score highly in the cancer patient experience survey 2014 for issues such as 'staff explained the operation in an understandable way', 'patients were given a choice of different types of treatment and 'the patient's rating of care was excellent or very good'.
 - In the 2014 CQC in-patient survey the hospital scored highly in the questions 'Were you involved as much as you wanted to be in decisions about your care and treatment' and 'Did a member of staff answer your queries about the operation or procedure?'

Emotional support

- Feedback from the CQC in-patient survey and the cancer patient experience survey for 2014 demonstrated that patients were always given appropriate emotional support. The hospital had a high score for the questions such as 'Did you find someone on the hospital staff to talk about your worries and fears?' and 'Did you feel you got enough emotional support from staff during your stay?'
- Staff assessed patients' psychological wellbeing and any previous issues which would need to be considered before admission where possible. This enabled staff to put in supportive measures where possible. For example finding appropriate means of supporting patients living with dementia such as involving family in their care or organising community psychiatric support for patients with on-going body image concerns.

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- We saw evidence of behavioural assessments having been carried out, as well as the assessment of individuals psychological and emotional needs, particularly where patients had needs associated with living with dementia.
- The hospital provided pastoral and multi-faith support through the hospital Chaplain.
- The patients felt well supported during their stay in hospital and staff were “caring and understanding.” One patient told us “I feel very confident in everybody to solve my problems.”
- Patients and staff told us about the rehabilitation flats where patients could learn to adapt to their condition and come to terms with their physical and psychological trauma in a supportive environment. One patient told us “They are kind, they encourage my independence but I know they are there if I need them.”

Are specialist burns and plastic services responsive?

Good



We rated the surgical services at QVH as good for responsiveness. The specialist services undertaken by the trust were responsive because the needs of patients throughout the south east of England, the local people, commissioners and stakeholders were taken into consideration when planning services. The trust operated a ‘Hub and spoke’ system so that patients who lived a great distance from the trust could benefit from the QVH staffs skills and experience. Referral-to-treatment times were appropriate generally met the recommended 18-week target. There were established care pathways of care through the hospital from admission to discharge. There was innovative use of telemedicine to aid the urgent assessment of injuries, improve patient experience and prevent unnecessary hospital admissions. For burns patients there were clear admission criteria in order to manage the hospital’s relative clinical isolation and noncompliance with the national burns standards in relation to providing essential support services. Service level agreements with other hospitals within the burns network ensured that patients were triaged to the most effective location for their particular physical needs. The

effective management of elective and trauma cases meant that operations were rarely cancelled. Complaints were acknowledged, investigated and responded to. Information was shared to promote learning and prevent reoccurrence.

Service planning and delivery to meet the needs of local people

- The QVH provided specialist burns, plastic surgery and trauma services to the south east population of England and south London.
- In 2014 the burns service accepted 1,007 adult referrals. This was an increase from 886 in 2013. Of these, 201 patients required inpatient care and 29 needed treatment in the critical care unit. Of the referrals, 32 patients were accepted for specialist surgical reconstruction required due to significant skin loss from causes other than burns for example necrotising fasciitis.
- Eight patients received specialist rehabilitation care in the ‘burns rehabilitation flats’ facility.
- QVH is the major regional centre for complex, microvascular breast reconstruction. This included breast reconstruction for breast cancer, breast asymmetry, breast reduction and congenital deformities.
- In 2014 the breast team performed a total of 230 flaps. This was a 22.3% increase on 2013. Breast reconstruction was performed immediately after the mastectomy in 43% of cases, representing a year-on-year increase from 39% in 2013 and 26.3% in 2012.
- The QVH hand surgery department undertook one quarter of all elective plastic surgical operations at the trust and accounted for 80% of the trauma surgery at the hospital. In 2014 the trust carried out 208 primary repairs of flexor tendon injuries. Skin cancer care and surgery
- The hand surgery department provides a regional hand surgery service to Kent, Surrey and Sussex with outreach hand surgery clinics and therapy clinics in Medway, Dartford, Faversham, Hastings, Horsham and Brighton. The elective surgery includes all aspects of hand and wrist surgery including post traumatic reconstructive surgery, arthritis, musculo-skeletal tumours,

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Dupuytren's disease and peripheral neurological and vascular diseases. The trust provided a 24-hour trauma service with access to two dedicated trauma theatres for inpatient and day-case procedures.

- The trust's Melanoma and Skin Cancer Unit (MASCUC) is the tertiary referral centre for all skin cancers across the South East.
- QVH is the Kent and Sussex surgical centre for head and neck cancer and was recognised by the Royal College of Surgeons as a training centre for Training Interface Fellows in Advanced Head and Neck Oncology Surgery.
- In 2014/2015 QVH saw 55 new cases where each of the pre-treatment and surgical resective pathology results were discussed at an MDT meeting. Each of these cases underwent major head and neck surgery at QVH.
- The maxillofacial consultant surgeons supported by surgical staff, specialist nurses, dieticians, physiotherapists, psychological therapists and speech and language therapists saw over 750 cases.
- The trust's corneoplastic unit, including the eye bank, is a specialist centre for complex corneal problems and oculoplastics. The specialist cornea services include high-risk corneal transplantation, stem cell transplantation for ocular surface rehabilitation, innovative partial thickness transplants (lamellar grafts) and vision correction surgery.
- The hospital did not meet the National Burns Standard as there was not on site specialist services for caring and treating patients with major burns injuries. Serious burn injuries require the input of other specialities such as nephrologists, diabetologists and repertory physicians as multi-organ failure is often a complication of severe burns. The nearest hospital to offer these services was 45minutes away.
- To mitigate against the risk of deteriorating burns patients the hospital had strict admission criteria together with three sessions a week from a general physician. There was also service level agreements with the nearest hospital and close working between this hospital and others in the local Burns Network. The hospital recognised that the degree of clinical isolation of the burn service was not ideal and was working with the general hospital to move the burns service.

- The hospital did not offer an onsite haematology service. Theatre staff told us how it took two hours to cross match blood for surgery as this was managed off site. However they hospital kept emergency stock of six units of O negative blood on site to mitigate against the delay that may cause harm to patients. We noted that during the past 12 months there had been eight incidents relating to transfusion or blood issues of which five were related to transportation or not having a transfusion service on site.
- The hospital also supplied an emergency 'Crash' call out team to the private hospital within the grounds of the QVH. The 'Crash' team included two site practitioners, the aesthetic registrar, plastics SHO and a member of theatre staff. Although the private hospital was in the grounds of the QVH if the Crash Team was attending an emergency at the private hospital this would mean they were not available in the QVH.

Access and flow

- Access to the hospital was through direct referral via the consultant or through the trauma coordinators. The trauma coordinators operated 24 hours a day, seven days a week and triaged all referrals.
- The hospital demonstrated innovative use of telemedicine to assess and treat patients in neighbouring hospitals and the community. Cameras had been funded for local emergency departments who could send photographs through to the hospital for immediate assessment and advice.
- We saw this in action where a paramedic from the local ambulance service sent photographs of an elderly patient's wound through to the trauma coordinator. The nurses were able to provide advice and a treatment care plan over the internet and avoid hospital attendance and admission for the patient. The district nursing service was alerted and a copy of the wound care plan sent to the GP surgery.
- We were told that the Trauma Coordinators were supported by a registrar. If required a consultant from QVH could also attend the referring hospital to assess an injury.
- We spoke with staff in the pre-operative assessment clinic and noted there was a good flow through the department. Each patient was allocated a one hour slot

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and 20 patients were booked. The clinic was nurse led with slots booked for anaesthetists through the week. There was an on call registrar available for urgent advice if required.

- There was an effective system to select if elective patients were suitable for surgery by postal triaging followed up by a telephone assessment. On site Echo Clinics were available to provide further assessment of patients' suitability with close links to the patients' GP. This ensured the staff had the most recent patient reviews and all relevant information was available.
- All patients followed standard pathways for local anaesthesia, general anaesthesia and sedation.
- 82% of cancer patients met the 62 day wait from referral to definitive cancer treatment target. This included liaison of treatment shared with other care providers.
- 93.5% of patients met the referral to treatment times of 18 weeks.
- Bed occupancy varied both above and below the England average over the last year.
- Theatre utilisation for May, June and July 2015 were approximately 80% across all 13 operating theatres. Utilisation rates were monitored daily and monthly for example: at the time of the inspection the elective surgery was running at 75% and 72% for non-elective surgery on a specific day.
- The number of operations cancelled was 122 during the year 2014/2015, for non-clinical reasons, this represents 0.6% present of the total operations undertaken and is below the England average of 0.8%. Three patients were cancelled on the day of surgery for non-clinical reasons where the 28 day guarantee was not met. Three urgent operations were cancelled for non-clinical reasons for a second or subsequent time.
- On the day of our inspection a patient's admission was cancelled due to transport problems with the local NHS ambulance service. The patient was booked for 10.00am and by 18.00pm they had not arrived at the hospital.
- The trusts data indicated that surgical activity had changed since 2012. For example: inpatient plastic surgery was 1,000 in 2012 and had reduced to 800 in 2015 whereas day case plastic surgery had increased from 2,200 in 2012 to 2,700 in 2015.

- More in depth work had now started in looking at the reasons for surgical delays and ways to improve the theatre utilisation rates. One example given was patients not being ready for theatre.
- We saw the discharge lounge was small and not large enough to cope with the increased capacity of patients flow. There was a plan to move into some space within the recovery area which would improve the situation.
- Discharge arrangements were discussed with patients as part of the admission process.
- Discharge prescriptions were usually processed within two hours although it was usually quicker.
- There were 207 delayed discharges between April 2013 and May 2015 50% of these were due to awaiting care package in the patient's own home or waiting further NHS non-acute care. This delay was higher than the England average. However patients need complex packages of care given the specialist nature of their surgery.
- The patients we spoke with felt that the journey through the service was quick and timely.

Meeting people's individual needs

- The hospital provided a variety of surgical services, both elective and trauma including surgery for burns, breast reconstruction, hand, head, neck and ophthalmic surgery.
- An outreach burns nurse was appointed to visit patients in their own home for continuing care which might otherwise keep them in hospital. The nurse liaised closely with district nurses and wound care nurses in the community offering teaching sessions and advice.
- Staff confirmed there was access to clinical nurse specialists, including the dementia nurses, breast care nurse and stoma care nurses, as well as the head and neck nurse. The clinical nurse specialists provided emotional support to patients as well as learning and development support for staff.
- The Burns Unit had on site psychological support to address issues that may arise from burns injuries. Patients we spoke with said they had been offered psychological support and said "There is a nurse specialist I can turn to."

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- Patients with complex needs; such as those living with a disability or dementia, were identified at pre assessment and staff would inform operating theatre staff when these patients were attending for an operation.
- The surgical wards had a dementia lead nurse who supported patients, staff and the families of those living with dementia.
- We heard of the positive initiatives in place to support patients living with dementia such as vulnerable patients attending at the beginning of a list, where possible, so as not to leave them waiting too long. This reduced their anxiety and theatre staff would stay with the patient throughout their surgery if this was performed under a local anaesthetic. Quiet bays were used to recover patients living with dementia.
- Families of those living with dementia were able to stay with the patient. Patient passports were used to help staff know how the person preferred to be cared for.
- One specific initiative involved knitted bags for patients to touch and the 'twiddle muffs' used for confused patients living with dementia. These had been developed by the dementia lead who was also a senior theatre nurse.
- Staff were sent on specific external courses so they would be able to care for these patients more effectively.
- The trust was aware that they did not meet environmental guidelines to support people living with dementia in a care environment. The estates department had been informed to make sure that when any new decoration took place or flooring renewed that this would be taken into consideration. This included having plain single colour flooring and different coloured door frames from walls.
- The QVH had undertaken an audit to ensure they met the needs of people with a learning difficulty. This was undertaken by the learning disability liaison nurse and a person with learning difficulties. Reasonable adjustments particularly to signage had been made so that patients could navigate the wards more easily.
- The hospital had rehabilitation flat where patients could adjust to independent living. We saw how this facility helped vulnerable patients to adjust to undertaking everyday tasks in a supported environment. A psychologist explained how they were able to plan for an elderly patient's integration back into the outside world using the flat to support their independence.
- GPs were also asked to add information about their patients when referring to the trust for surgery.
- Meal times were 'protected' to ensure patients could eat their meals without unnecessary interruption, and to enable nursing staff to provide assistance to those patients unable to eat independently. A 'Red Tray' system was in place to allow staff to identify which patients required assistance with eating and drinking.
- New menus were in place which included options such as vegetarian, allergies and religious diets, patients' individual needs and any reasonable dietary request could be achieved. Examples where patients had requested take away meals and this had been actioned. However patients told us that they did not always get the food they had ordered.
- Patients felt staff respected their privacy and dignity and gave examples where they made sure they were appropriately covered when getting into and out of bed.
- The hospital had translation services were available if required, although none of the staff we spoke with had accessed them.
- The hospital maintained single sex accommodation outside of theatre recovery areas. The 47 surgical beds on Margaret Dunscombe and Ros Tilley wards were managed as one ward, this gave greater flexibility as teams could 'flip' the male and female bays to suit the needs of the patients admitted. The hospital stated they were able to maintain segregated accommodation during 2014/15 because there was also a number of single rooms available for use.

Learning from complaints and concerns

- We saw information on raising complaints was readily available for patients on all the wards and departments we inspected.
- There were mechanisms in place for shared learning from complaints through the staff newsletters, departmental and clinical governance meeting minutes.

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- The hospital stated that they took all complaints very seriously. All complaints were investigated and reviewed by the executive team. If the complainant remained dissatisfied they would actively support them in going to the ombudsman for assurance that their complaint has been responded to appropriately. The trust had taken action to improve how they managed complaints by responding to complainants on a more personal level and by improving the quality of responses.
- During 2014/2015 the trust had received 4.1 complaints per 1000 hospital spells and 1.2 legal claims per 1000 spells. This reflected any legal action against the trust by patients or carers including unfounded cases. All findings from claims were fed back to the consultant involved and the information made widely available through the joint hospital audit meeting in order that learning could take place where a claim was upheld.
- We reviewed the complaints data and noted there were 19 complaints for the period June 2014 to July 2015 in the operating theatres with the highest complaint relating being unhappy with the outcome of the patients' surgery (8) and issues with communication (5).
- The national inpatient survey highlighted that patients were not always happy with the catering service provided at QVH. Staff confirmed that a large number of complaints related to the food.
- Following the adverse feedback the trust had taken action to improve the patients meal time experience. A 'task and finish' sub group chaired by a Governor had undertaken an investigation of the food provided by the trust and the patients meal time experience.
- Following feedback from patients the menu had been abolished and a new weekly menu put in place. Staff now anticipated inpatient meal requirements and had control over the food served. We were told that this was proving successful although it was too soon to reflect in the patient surveys. This demonstrated that the hospital took action to address patient concerns where possible.
- During the inspection, we visited the surgical inpatient areas and spoke with nine patients and four relatives. They were generally positive about the quality of food,

and whether they had enough to drink and sufficient help from staff. This indicated that although the trust had taken steps to address the inpatient catering experience there remained issues.

- The trust had a policy regarding the Duty of Candour. This is a requirement on NHS services to provide support and relevant information to patients and their families when a reportable patient safety incident occurs. Staff gave examples where patients and their relatives had been fully informed and involved in the investigation and provided with regular updates.
- Patients knew how to complain and felt confident in raising concerns and complaints..

Are specialist burns and plastic services well-led?

Good



We rated the specialist burns and surgical services at QVH as good for well-led. The specialist services undertaken by the trust were well-led because there were clear strategic objectives were in place. The objectives were being developed in collaboration with staff and in line with a publicised trust vision and value set. The trust operated an effective governance structure and there were robust clinical governance and reporting arrangements in place. Risks were identified and acknowledged and action plans were put into place to address them. Action plans were constantly reviewed. There was clear leadership, and staff knew their reporting responsibilities and took ownership of their areas of influence. All staff spoke with passion and pride about working at QVH. Staff reported the culture and leadership within the trust made them feel valued and respected. Managers spoke enthusiastically about their ward or department and were proud of the teams they had working with them. The trust actively engaged with the public and staff through the patient experience group, meetings, surveys and communications. There were systems to ensure patients were heard and listened to. There were robust data collection systems in place where care and treatment was closely monitored and constant improvement was promoted. We saw the trust encouraged

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local initiatives to improve patient experience, together with national and international research and projects to improve the care and treatment of patients who required reconstructive surgery and rehabilitation.

Vision and strategy for this service

- The trust had a vision and strategy for the future which was developed with staff around the core business of 'Delivering excellence'.
- The trust's vision centred on the three areas of specialist surgery, burns and rehabilitation; routine elective surgery and services in the local community.
- From these vision five key strategic objectives of; outstanding patient experience, World class clinical service, Operational excellence, financial sustainability and Organisational excellence had been developed.
- There was a trust director with responsibilities to the board of directors for each of these objectives. Each member of staff's individual objectives related to the trust's key strategic objectives.
- The trust's strategic plans were clearly identified and promoted to the staff, governors and public on the trust website and in literature.
- All staff that we spoke to were aware of the trust's vision and could discuss it with us.

Governance, risk management and quality measurement

- Each division maintained its own risk register where potential and actual risks were analysed and monitored. We noted that all the risks on the critical care and burns risk register had been reviewed in the last four months. Some of the risks were identified several years ago but remained a risk to staff. For example manual handling of burns patients and the moving beds remained an on-going risk although there were controls in place to reduce the risk where possible.
- The divisional risk register fed into the corporate risk register. We saw that issues such as the noncompliance with blood fridge standard requirements and noncompliance with the NHS standards and service specifications for burns were included on the corporate

risk register. Each risk register identified the hazard, the cause, the controls in place and the actions taken to address or mitigate the risks. These were monitored and reviewed on a regular basis.

- The operating theatres had a theatre governance and management group meeting which was their new governance meeting, with terms of reference and formal agendas. This meeting replaced the theatre user group meetings and took place monthly but there were no formal minutes as yet.
- There was now attendance from a number of disciplines such as the lead for risk, finance, human resources, the clinical leads, nursing leads and theatre manager. Items such as a performance scorecard, incidents and risks would be discussed. However this had only just started and needed further embedding into practice.
- There was good governance of infection prevention and control with monthly infection control meetings that fed into the corporate clinical governance framework. The Infection prevention and control team produced an annual report to the board. We saw minutes of meetings where incidents had been appropriately escalated to ensure that corrective action took place.
- Surgical staff appraisals were documented at 93%. All of the staff we spoke with had undertaken recent appraisals.
- The trust had an effective programme of auditing, monitoring and researching the quality of care and treatment provided in order to identify areas where practice could be improved. Information regarding patient outcomes was fed into national data bases and used to inform future care and treatment. QVH's overall information governance assessment report score for 2014/15 was 82% and was graded satisfactory.
- The trust had a governance and risk committee structure in place with Board level oversight of quality assurance. The governance and risk committees met monthly and all quality assurance and clinical governance issues were discussed and the information reported to the trust board.
- Minutes from the meetings demonstrated that the system was embedded at local level with structured

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standard agendas complete with minutes and action logs. The minutes were available for inspection and we noted that all risks, incidents and complaints were discussed.

- Service level Agreements were in place with other organisations that provided services for QVH such as outreach clinics and theatre lists. We were told of the good working relationships with GPs and the consultants from other hospitals which was helping to improved care through better communication.
- Quality accounts were used as a multidisciplinary tool for performance monitoring across the hospital. Data was monitored through a programme of internal and external audits and reviews.
- Minutes from the clinical governance and risk meetings were available for staff to read. Information boards were in place on the wards and pre-assessment clinic, which gave information on learning, development and training opportunities; supervision and appraisals and team meeting minutes.
- Patient safety and patient experience boards were displayed in public areas on the wards which gave relevant up to date information to patients and visitors. The Family and Friends test results were displayed and documented 99% of acute inpatients were likely to recommend QVH. Any concerns that had been raised were displayed alongside of the action taken to resolve the issues; for example concerns relating to mealtimes.
- Each directorate maintained its own risk register, which fed into the corporate risk register. We reviewed the burns and critical care risk register and saw that action plans were updated regularly. For example, in the emergency alarm system was found to be inadequate in January 2015. The risk register detailed the hazard and the cause and the controls in place to mitigate the risks, together with the actions taken to address the issue.
- Senior clinicians and managers were able to raise issues for discussion and resolution through a network of performance, clinical governance and safety meetings that took place on a planned basis throughout the trust.

Leadership of service

- The clinical infrastructure is led by the deputy director of nursing and the clinical director for clinical

infrastructure, these roles are supported by matrons for elective and emergency care and speciality clinical directors. In theatres there is clinical director for anaesthetics, a theatre manager and matron.

- Since our last inspection a new senior management team had been appointed. Staff felt that the restructuring had had a positive impact, and that the director of nursing visited the wards at least once a week and the chief executive attended ward meetings on occasions.
- Operational responsibility has now devolved down to directorate level whereas before and this appears to have had a marked improvement on moral and made the system very responsive, according to the team. Any operational issues were discussed at the monthly departmental meetings.
- Staff on the wards and in the burns unit were complimentary about the support of their managers. Many of the staff we spoke with had joined the trust as juniors and progressed through training and development to positions of management and leadership.
- We observed a morning team brief session led by the consultant surgeon with the anaesthetist, junior doctors and nursing staff. This was comprehensive and we noted full participation by all team members.
- In theatres we noted that the individual theatre sessions were well led by the surgical registrar who oversaw the full team participation in the 'WHO' surgical checklist.
- The trust operated a 'Hub and spoke' model, where QVH staff would manage clinics and operating lists at other hospitals. We were told about the other hospitals which provide care under QVH management and that staff were building relations with the 'Spoke' sites to develop the skills of the staff working there.

Culture within the service

- The staff sickness and absence rates were lower than the England average between January 2011 to January 2015.
- The QVH performed better than the England average for 15 out of 21 indicators in the NHS Staff Survey.

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- The trust performed similar to the England average for nine out of 12 indicators in the GMC National Training Scheme Survey.
- The culture and ethos of QVH was a caring and supportive environment to work in started at induction. We were able to see evidence of how staff were supported, through opportunity, training and an openness of culture which encouraged people to raise concerns
- The staff we spoke with in theatre worked to the ethos; “we can do better and will do better”.
- Staff were confident in escalating concerns and knew how to do this. Several staff gave examples where they had told their manager of a problem and it had been quickly addressed.
- Consultants said they liked everything about working at the hospital from the “Interesting cases”, the “good facilities”, “protected study time” and “wonderful support”.
- Junior doctors were well supported and although the hospital was busy at times they were able to ask for senior help. One junior doctor told us "This is the best place I've ever worked."
- Consultants were encouraged to attend each other's clinics or operations to exchange knowledge, information and assistance. Examples were given including well they all worked together when dealing with firework injuries which often involved operating on both burn and hand injuries at the same time.
- Communication appeared to be open between staff of all grades including managers. Staff gave examples where the director of nursing had asked them to contact her direct if there was a problem.
- All staff felt valued, respected and were proud to work at the hospital.

Public engagement

- The trust facilitated a Patient Experience Group. The group met regularly to discuss issues related to patient experience including reviewing inpatient surveys and undertaking PLACE visits. PLACE visits are patient-led assessments of the hospital care environment, where

local people go into hospitals as part of teams, to assess privacy and dignity, food, cleanliness and general building maintenance. The assessments take place every year with the results reported publically.

- The surgical department had engaged with local groups in the community to make ‘twiddle muffs’ for patients living with dementia. These were hand knitted muffs which could be placed over cannulas and placed on wrists for patients to touch and play with. Groups engaged with this project included the library group, the McMillan group and the lace making group. The ‘twiddle muffs’ had been developed by the dementia lead who was also a senior theatre nurse.
- The patient experience group was chaired by the director of nursing and quality. The group looked at all information relating to patient experience at the hospital and had made a number of changes as a result, for example appointment and reminder letters had been revised as a result of patients’ feedback that they could be improved.

Staff engagement

- Throughout the hospital we found a sense of community and team work amongst all the staff we spoke with. Staff were enthusiastic and committed to the care they provided and proud to work for QVH. We saw many examples where they had undertaken charity events or supported the hospital in various ways on their days off.
- Staff gave examples of why they liked working at the QVH and these included how they all helped each other and shared experiences to improve patient care and that because they felt the trust looked after its staff well this impacted on a positive experience for patients.
- Immediate managers were supportive and encouraged staff to report issues
- We spoke with ward staff the majority of whom had worked at the hospital for several years, and saw excellent team working and the training.
- The most recent NHS staff survey results showed QVH better than the national average with a score of 4.6 staff recommendation of the trust as a place to work or receive

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- treatment. The national average is 4.12. The trust continued to review staff feedback to identify trends and make plans to further improve staff engagement and experience.
- In theatres we found there was lots of communication, through a range of means. However staff did not always have regular team meetings as these were often taken up with training sessions. There were other opportunities for staff to raise concerns and staff confirmed they were generally happy.
- There were staff notice boards available throughout the surgical wards and theatres giving staff information about local and trust wide issues including training, development and team meeting minutes.
- Staff meetings were held in all the departments on a regular basis. We looked at a selection of the minutes from various staff meetings and noted that all staff were able to contribute, matters of concern were discussed and any learning disseminated.



Innovation, improvement and sustainability

- The staff were seen to be innovative and highly motivated to maintain and improve the quality of care.
- We found that staff were encouraged and given opportunities to use their initiative to solve problems. Local examples included the 'twiddle muffs' used for confused patients living with dementia. These had been developed by the dementia lead who was also a senior theatre nurse.
- The trust had developed a video for patients undergoing certain anaesthetic procedures. They told us that the aim was to decrease patient's anxiety. The video had won first prize at the Pre-operative association awards. Audits were taking place to assess the impact of the video information.
- We heard how patients who had undergone reconstructive surgery volunteered to visit patients who

were considering the surgery to show them the end result. Staff also attended a support group for breast patients as volunteers to give advice and speak with the women and their partners.

- The creation of the burns outreach nurse post was an innovative solution to the problems of dealing with burns in the community. We spoke with the nurse who was exceptionally enthusiastic about her role and was undertaking a great deal of teaching to improve the care of burns patients in the community and neighbouring hospitals.
- The telemedicine initiative demonstrated innovative practice that was being used to improve patient outcomes and reduce hospital admissions. Specially trained staff were able to view photographs of burns and trauma cases in distant hospitals or in the community, then provide an assessment and give advice over the phone and electronically. This reduced hospital admissions and speeded up the preferred treatment for the patient. The telemedicine initiative was one way the hospital was attempting to address its relative isolation from the referral base.
- The QVH was constantly investigating new procedures and researching ways to improve patient outcomes. New techniques developed by the trust were now used in the care of patients all over the world. For example, burns reconstructive surgery, cell culture and hypotensive anaesthesia. The trust worked closely with other research, academic and industrial organisations to improve patients' outcomes.
- In 2014/2015 the trust recruited 518 patients to participate in research approved by a research ethics committee, which was a significant increase from 2013/14.
- QVH was involved in conducting 36 clinical research studies in 2014/15, involving clinical staff in four medical specialties as well as professions allied to medicine. This demonstrated the trust's commitment to improving the quality of care and contributing to the wider health improvement.

Critical care

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

Information about the service

The hospital has a critical care unit (the unit) with three beds funded and was built approximately 10 years ago, and can flex to a further two single rooms previously used for burns dependant on acuity and workforce.

The unit fluctuated between the number of Level 2 high dependency Unit (HDU) and Level 3 intensive care unit (ITU) beds depending upon the complexity of its patients and would staff the unit on this basis. Bed occupancy was 100% in five out of the last 12 months and in two months the occupancy dropped to 0% on some days.

Level 2 beds are for patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.

Level 3 beds are for patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

Patients cared for on this unit had undergone either head and neck reconstructive surgery, plastic or maxilla facial surgery. The unit also cared for patients suffering from a burns injury with no more than 40% body surface area burns.

It was difficult to extract data specifically for the unit as all activity, data and meetings had been part of the wider burns unit. The unit were only just starting to look at themselves as a critical care unit and so evolving an individual identity.

The unit partially complied with the Core Standards for Intensive Care Units (CSICU), having no consultants trained in intensive care medicine being the main reason for non-compliance.

The unit did not submit data to the Intensive Care Network Audit Research Centre (ICNARC) as it was a small and specialised unit and would not have sufficient data to make meaningful judgements about their service. However, the trust sent its data to the burns national database, the South East Coast Critical Care Network and the South East Burns Network. This included admissions and readmissions data, delays in discharges, reasons for transfers of patients and information about rehabilitation

During the inspection, and in order to make our judgements, we visited the unit; we talked with one patient and 22 staff including nurses, doctors, physiotherapists, support staff and managers. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. We reviewed two care records and prescription charts, other documentation and performance information provided by the trust.

We carried out focus group sessions with staff and a local listening event for patients and relatives to come and tell us about their experiences.

Critical care

Summary of findings

Prior to our inspection the organisation had been open with the CQC and declared a weakness in out of hours and critical care medical cover on the basis that the organisation does not have any Intensive Care Medicine (ICM) recognised consultants, however the consultants all have CCT (completion certificate of training) in anaesthesia have received training in intensive care but do not have CCT in intensive care medicine. It is a small unit and does not use national benchmarks, has no colocation of imaging, medical or surgical support and is dependent on a single senior doctor on site out of hours who, may be pulled in several directions at once to attend unwell patients either in ITU or elsewhere, whilst also having an obligation to manage trauma patients in theatre.

The unit was clean and staff adhered to infection control policies and protocols.

Medical staffing did not comply with the CSICU and the Critical Care Networks Service Specification Standards (D16) 2015.

Nursing staff had the relevant qualifications and worked flexibly to cover the peaks and troughs of bed occupancy rates.

Safeguarding training was being undertaken and staff were well versed with looking after patients who may lack capacity to make a decision.

The unit did not participate in ICNARC. However, the trust sends its data to the burns national database, the London and South East Coast Critical Care Network and the London and South East Burns Network.

We heard staff talking with a patient in a compassionate and professional manner. Privacy and dignity was maintained.

Staff worked in a flexible manner in order to ensure all patients were looked after when demand increased.

There were no delays in patients being admitted to the unit, no elective operations were cancelled and no patients were refused admission to the unit when referred by another medical professional.

The unit had no individual clear vision and strategy although it was part of the burns unit governance programme and as such the unit did not have its own entity. For example there were no mortality and morbidity meetings and no dedicated critical care governance meetings. These would be picked up, through the wider burns unit arrangements. However we saw no issues which would compromise patient care.

There was a strong culture of teamwork and staff spoke of being proud of their unit.

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Are critical care services safe?

Requires improvement 

Overall the services within the unit required improvement.

Prior to our inspection the organisation had been open with the CQC and declared a weakness in its out of hour's provision and critical care medical cover.

We were given examples where incidents had changed practice. All incidents were analysed and reported monthly to the burns management group meetings for further discussion and action.

There was a critical care outreach service led by the site practitioner team who were available 24 hours per day, 365 days a year. The team provided advice, support and care for any patient whose condition deteriorated as well as supervision and support of staff caring for these patients in the clinical setting.

Controlled drugs (CDs) were stored in locked cupboards, which were secured to the wall. All CD registers we looked at were completed appropriately.

Medical staffing did not comply with the CSICU and the Critical Care Networks Service Specification Standards (D16) 2015.

Safeguarding adults, Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLS) was included on corporate induction of all clinical staff and is included in mandatory patient safety training which staff attend annually.

Incidents

- At QVH all incidents were reported through the trust's electronic reporting system. There was an incident reporting policy and procedure in place. This was readily available to all staff on the trust's intranet. Staff we spoke with were aware of the policy, knew how to report incidents and told us they were encouraged to report incidents. Two members of medical staff told us they did not always have time to complete an incident form.
- When we reviewed the risk investigation process we saw that there were clear prompts included to ensure that the process was followed.
- A drug error occurred at the time of the inspection which we found was not documented or reported appropriately. The error was then documented in the patient's notes and subsequently reported to the anaesthetist taking over for the next shift. The nurse responsible for the patient overnight verbally handed the details to the nurse caring for the patient during the day.
- There was no evidence of the incident being reported straight away on the electronic incident reporting system and nothing documented in the nursing notes. This was brought to the attention of staff by CQC inspectors whilst on the unit. We asked the trust to report on the outcome of their investigation following this incident.
- There were no never events between May 2014 and April 2015. Never events are serious wholly preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers (Serious Incident Framework, NHS England March 2013).
- There were no serious incidents reported on STEIS occurring during the same period. STEIS is a patient safety reporting and learning framework tool, and reports serious incidents requiring investigation and reporting to the National Reporting and Learning Service (NRLS)
- Between August 2014 and August 2015 the unit experienced 119 incidents of which 18 were rated as minor and the remaining 96 rated as causing no harm. The most reported incidents were related to unplanned admissions to the unit (24) followed by drug errors (22). For unplanned admissions each patient would be discussed on an individual basis with the anaesthetist on duty or on call at that time. Of the unplanned admissions 13 were direct from theatre, 8 were admitted from wards as their condition had deteriorated, 1 was an incorrect admission by ambulance, and 2 were not classified, but were appropriate admissions.
- There were no morbidity and mortality meetings specifically for critical care. However, mortality and morbidity meetings took place for both burns and anaesthetics and were also discussed regionally within the burns network and national burns meetings. Mortalities occurring from critical care would be

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discussed at these meetings where necessary. Of the five patients who died at the QVH in the year ending October 2015, all died from complications of severe burns and co-morbidities.

- Staff were aware of and understood the Duty of Candour. The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other relevant person within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has or may have occurred.

Safety thermometer

- The NHS Safety Thermometer was in use and was being monitored and displayed for patients and relatives to view in the reception area. The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harm such as: the development of pressure ulcers, catheter related urinary tract infections venous thromboembolism (VTE) and falls.
- The Safety Thermometer for May 2015 to October 2015 showed there had been 13 patients with pressure sores, of which 3 were acquired in the hospital, no methicillin resistance staphylococcus aureus (MRSA), three falls no complaints, 43 compliments and 100% compliance with hand hygiene procedures.

Cleanliness, infection control and hygiene

- The unit was clean and tidy when we inspected.
- There was a trust approved infection prevention and control policy in use within the unit and staff could direct us to the policy. Staff had ready access to these policies and procedures that were stored on the trust's intranet. We found that staff were aware of the principles of the prevention and control of infection (IPC).
- There was also a 'Critical Care Operational Policy' dated March 2015 which included infection control practices which should be taken specifically for patients with burns.
- The hospital had a dedicated infection control team, which provided support to staff. The infection control

team's responsibilities included attending policy review, auditing and promoting good infection control practice through attending relevant meetings and advising and training staff.

- There were infection prevention and control (IPC) link nurses who were responsible for cascading training and information and for ensuring staff were compliant with infection control best practices.
- The link nurses undertook regular infection prevention and control audits in order to make sure all staff were compliant with the trust's policies such as hand hygiene and the use of personal protective equipment (PPE).
- Personal protective equipment (PPE) was available to staff.
- We observed staff adhering to infection control policy and saw them use personal protective equipment such as gloves and aprons. We saw staff adhered to the 'bare below the elbow' policy. The hand hygiene and bare below the elbows audit undertaken in July 2015 showed that of 42 moments observed staff were 100% compliant.
- We saw a junior doctor not adhering to the operational policy relating to access to the unit in that staff should change into the units 'green scrubs' rather than stay in the operating theatres 'blue scrubs'. This worried the unit staff as there were strict criteria to avoid infections needed to be adhered to. The junior doctor was challenged about his behaviour.
- We saw that equipment in the sluice area displayed stickers to indicate that it had been cleaned with the date of cleaning and computers had wipe clean keyboards.
- We spoke with the unit's cleaner who showed us cleaning records, documentation to support the change of curtains, legionella's checks on showers, cleaning schedules and general cleaning duties which were undertaken. The unit's cleaner also kept a message board so staff could see what duties were being carried out and also maintained a check on the information needed to support the piloting of a national research project.

Environment and equipment

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- The hospital has a critical care unit (the unit) with three beds funded and was built approximately 10 years ago, and can flex to a further two single rooms previously used for burns dependant on acuity and workforce.
- The unit was appropriately furnished and met the required building regulations and also met the needs of patients.
- The equipment used in the unit was serviced and maintained by an external provider. There were systems in place to monitor, check and maintain the equipment. We saw the equipment logs and the records of the monthly equipment checks and servicing that took place including training logs for any new equipment. All the equipment we saw had been labelled to verify it had been electrically tested within the past year. We saw paper records of staff training for medical devices such as defibrillators and syringe pumps. These records documented what training had been provided and the date when staff needed an update.
- Portable appliance testing (PAT) testing on all electrical equipment was up to date
- Nursing staff on the unit had maintained resuscitation and emergency intubation equipment with daily, documented checks. There were no gaps in the daily checks of the resuscitation equipment.
- The unit had identified a lack of Carbon Dioxide (CO₂) monitors which either did not work or regularly malfunctioned. This had been placed on the risk register in July 2015 and had been reviewed and was to be added to the corporate risk register. The unit had plans in place to ensure there was a monitor when needed but the monitors used had different settings and three of them took up extra space at the bedside. This meant it was possible to only provide CO₂ monitoring reliably for two patients at one time. There were no reports that this had caused harm to patients
- Naso-gastric tubes (which are tubes inserted through the nose into the stomach so patients can be fed) when inserted were checked by testing the acidity prior to feeding a patient to ensure this tube was still in the stomach. There was a policy in place for the management of naso-gastric tubes and included x-ray checking. This was good practice.

- COSHH (Control of substances hazardous to health) assessments had been recently completed on the unit and that some substances were not suitably stored.

Medicines

- Between November 2014 and October 2015 there were 20 drug errors reported on the unit. 13 were related to controlled drugs (CDs) where the amount of the liquid drug was less than it should have been. This was due to not being able to draw up the precise amount of drug which resulted in a small amount of the CD being reduced. Seven related to an error in administering or prescribing drug. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential misuse. It is important that controlled drugs are therefore, stored securely.
- There was a drug error during the inspection which has been described above.
- CDs were stored in locked cupboards, which were secured to the wall. All CD registers we looked at were completed appropriately.
- Medications incidents were reported via an electronic reporting system and a local investigation was undertaken if an incident occurred.
- Records showed medications were kept at the correct temperature and so would be fit for use. Refrigeration temperatures were checked and recorded each day.

Records

- When not needed patients' notes were kept in a locked cupboard in a room outside the unit.
- The records included multidisciplinary input from other healthcare professionals. For example, the records included entries made by dieticians, physiotherapy and occupational therapists. Medical personnel also contributed directly to the records, with commentary on treatment, diagnosis and required interventions.
- The unit's daily assessment charts provided a format for assessment and care planning for patients.
- We could find no record of patients being reviewed within 12 hours of admission by a consultant intensivist which meant the unit did not comply with the CSICU.

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- However according to the trusts local data; the unit was 100% compliant with the standard of patients being seen within 12 hours of admission by both a consultant anaesthetist and a burns consultant.

Safeguarding

- The trust had a safeguarding vulnerable adults and children policy, and guidelines were readily available to staff on the trust intranet.
- There were safeguarding leads in the hospital who acted resources for staff.
- Staff we spoke with confirmed they had received safeguarding training as part of mandatory training.
- In total 100% of anaesthetists had undertaken level 1 safeguarding for adults, and 76% had received level 2 training.
- 100% of registered nurses had undertaken level 1 safeguarding for adults and 83% level 2 training.
- Children were not admitted to the unit for treatment.

Mandatory training

- We reviewed the training matrix that documented staff mandatory training. We saw from performance dashboards provided that there were gaps in the achievement targets.
- Mandatory training for anaesthetists varied across each topic for example: adult basic life support (BLS), paediatric BLS, conflict resolution, health and safety, and equality, diversity and human rights attendance rates were approximately 90%. However, attendance at moving & handling, information governance, infection prevention and control governance and emergency planning was approximately 100%.
- The overall mandatory training for nursing staff was c90% for example: adult basic life support (BLS) was 95%, paediatric BLS was 83%, conflict resolution 77% and information governance 88%.
- Mental capacity training for nursing staff was 72% and 79% for anaesthetists.
- The hospital had three training coordinators who worked with the staff to facilitate learning.

Assessing and responding to patient risk

- Ward rounds took place at regular intervals. There were ward rounds in the morning and evening seven days a week and led by the consultant anaesthetist in charge on the day.
- There was a critical care outreach team which was provided by the site practitioner team who were available 24 hours per day, 365 days a year. This service was provided by a senior medical team. The team provided advice, support and care for any patient whose condition deteriorated as well as supervision and support of staff caring for these patients in the clinical setting. They also provided support and communication with relatives and carers so they fully understood what was happening.
- This team also assisted with the transition process for patients being stepped down from the unit to step down or the ward to ensure safe transfer. It meant that staff receiving the patient were fully confident and competent to take over the patients' care.
- The site practitioners were able to assess a deteriorating patient's condition and ensure that all necessary investigations and treatment were commenced in a timely fashion, liaising with the surgical teams as required. If unable to stabilise a patient in the ward environment they would assist in arranging and transferring the patient to either the step-down unit, critical care unit or ambulance transfer to another hospital.
- Patients in CC had ITU charting of their physiological parameters.
- However, when patients were being transferred to a ward staff told us they would complete at least three records on the NEWS chart so that staff on the ward would have an indication of the patient's last three observations. We looked at a patient's record at the time of the inspection which showed regular monitoring of the patient's condition.
- The unit used an intensive care delirium screening checklist which had been adapted from the Bergeron model dated 2012. This was a checklist of eight items based on features of delirium: altered level of consciousness, inattention, disorientation, hallucination or delusion, psychomotor agitation or retardation,

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inappropriate mood or speech, sleep/wake cycle disturbance, and symptom fluctuation. If a patient scored more than four this would be escalated to the senior nurse on duty for further investigation.

Nursing staffing

- The nursing establishment was based around a three bed critical care capacity, but activity was variable between April 2014 and March 2015. According to data provided by the trust the unit had a vacancy rate of 6.8 WTE (32%), turnover of 21.4WTE (25%) and sickness absence of 214 days (5%) for registered nurses which resulted in an 18% use of bank staff. Bank nursing activity was factored into business planning to manage peaks and troughs of activity. Patient safety was maintained by the use of bank and agency staff.
- For health care assistants (HCAs) there were no vacancies therefore no turnover of staff and a sickness rate of 8 (4%).
- The unit used the Association of UK University Hospitals (AUKUH) dependency tool to help assess acuity. This had been adapted to take account of the complexities of burns patients in the critical care environment and included five levels of care, the criteria to make a decision on the level of care and guidance on the care required.
- This resulted in a requirement of three ITU nurses and one healthcare worker to cover the three beds. Most of the patients within the unit were either burns patients or had undergone major head & neck surgery. The latter who were rapidly stepped down to enhanced ward level care compared to the burns patients who generally spent prolonged periods of time within this environment and had significantly complex needs.
- The use of this tool along with professional judgement was used to identify if additional qualified nursing time was needed to safely provide care and meet the patients' needs. It was also used as part of a risk assessment when moving staff to another area due to short term absence or higher acuity in another clinical area.
- All agency staff were critical care trained many employed regularly on the unit. There were always three permanent CC trained nurses on each shift so the impact was low.

Medical staffing

- Prior to our inspection the organisation had been open with the CQC and declared a weakness in out of hours and critical care medical cover on the basis that the organisation does not have any ICM recognised consultants, it is a small unit and does not use national benchmarks, has no colocation of imaging, medical or surgical support, and is dependent on a single senior doctor on site out of hours who, may be pulled in several directions at once to attend unwell patients either in ITU or elsewhere, whilst also having an obligation to manage trauma patients in theatre. The impact of this can be seen in the drug error described above under incidents.
- The unit had a consultant anaesthetist assigned to the unit throughout the day with an on call consultant anaesthetist covering from 1700-0800. Senior post fellowship trainees in anaesthesia were rostered to work either a day shift or a night shift and would cover the unit along with the three ward areas. In addition to this cover once the consultant surgical anaesthetist had completed the post-operative element of their involvement with the major surgery patients they attended the unit to review and discuss the plan of care for the evening and night shift. There was also presence and input from the burns and maxillo-facial consultant "of the day" and during out of hours period to provide advice and or support to patient as required. At night the senior fellow in anaesthesia formed part of the hospital at night team which comprised of a senior fellow anaesthetist, a CT2 in plastic surgery and two site practitioners. Consultants were on call for all specialities and could and were called for advice and attendance to the unit as required.
- Consultants all have CCT in anaesthesia and have received training in intensive care but do not have CCT in intensive care medicine" and as such the unit did not comply with the CSICU. However there was a service level agreement (SLA) with a local trust whereby two physicians who were ICM trained covered some day time sessions. The SLA outlined shared governance arrangements to provide general intensivist cover to the unit. This involved rapid access for general advice, investigations, and occasional transfer of unstable

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patients. We were led to believe this cover would mean a presence on the unit but this was not always the case. Consultants at QVH have extensive knowledge and experience of burns, head and neck ITU.

- Access to teaching and governance meetings between the neighbouring trust and the Queen Victoria Hospital (QVH) teams was being encouraged.
- According to data provided by the trust, there were 18 consultant anaesthetists, with a vacancy rate of 0.7WTE (2.4%), turnover rates were 0.7WTE (6.5%) and a sickness rate of 94 days (0.9%). There was no locum staff used between April 2014 and March 2015.
- The intensive care component for patients on the unit was provided by a one in five rota of consultant anaesthetists with extensive burns intensive care experience.
- These anaesthetists covered the ten Monday to Friday sessions, with two anaesthetists covering the weekdays. Out of hours cover was provided from the anaesthetic pool. Anaesthetists with burns/ ITU sessions covered the unit and burns operating theatre sessions three days a week.
- There was a senior anaesthetic trainee allocated to the unit during the day who also covered the unit and trauma theatre in the evenings and at weekends.
- There was a general anaesthetic rota (1:15) to cover out of hours and at weekends. An evening consultant to consultant handover took place highlighting any concerns and action plans; and if patients were unstable over the weekend period an informal arrangement would involve one of the burns anaesthetists in their on-going care.
- We saw an episode where a patient became very agitated directly following surgery and required medical assistance to reduce their anxiety. We were told the patient became very agitated and was becoming a danger to himself. Due to the lack of medical cover the doctor on call could not attend this situation for two hours as they were busy in the operating theatre and attending a medical emergency on a ward. This meant the patient was left in an anxious state until the anaesthetist could see them. We found this had been reported as an incident.

- We observed an early morning medical handover for the unit which was part of the multi-disciplinary burns team handover. The anaesthetic trainee and the consultants had a good knowledge of the unit's patients and were able to contribute actively to the discussions and as such appeared effective.

Major incident awareness and training

- The trust Major Incident Policy was being reviewed. The unit had an escalation plan and also had a business continuity plan in place.
- Staff could tell us what they would do in the event of a major incident and how they would go about making sure their patients were safe.

Are critical care services effective?

Requires improvement 

Treatment by all staff, including therapists, doctors and nurses was delivered in accordance with best practice and recognised national guidelines and patients received treatment and care according to guidelines. The unit did not participate in ICNARC. However, the trust sends its data to the burns national database, the South East Coast Critical Care Network and the South East Burns Network.

Both medical and nursing staff had access to education, training and development. Patients were at the centre of the service and the main priority for staff. Staff were continually updating their skills and competencies and were proactively supported to obtain new skills and share best practice.

Pain charts were used to ensure patients were receiving medication for their pain. However we saw one patient whose pain was not being addressed in a timely manner.

Staff acted in the best interest of patients and knew how to support patients' rights. Staff understood the complexities of working with the deprivation of liberty standards (DoLS). A number of patients had a DoLS applied and were reviewed daily in line with local protocols.

Evidence-based care and treatment

- The unit did not submit data to ICNARC as it was a small specialised unit and would not have sufficient data to make meaningful judgements about their service.

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However, the trust sent its data to the burns national database, the South East Coast Critical Care Network and the South East Burns Network. This included admissions and readmissions data, delays in discharges, reasons for transfers of patients and information about rehabilitation

- It also sent similar data to the developing areas research network (DARN) which was a mechanism for recording activity for critical care and burns. This data was reviewed by the senior management team and discussed at the network meetings.
- This data showed the activity was so small the unit often reached a percentage that could not be shown on the presentation graphs. For example out of the 19 units contributing to the network, the graph showing the unit's percentage of admissions could not be seen on the graph. This was because the numbers were too small. This was similar to some smaller units within the report.
- However, using this data the unit had eight delayed discharges over four hours in the reporting period of April to July 2015.
- There were a number of guidelines for common intensive care conditions in place demonstrating best practise such as: Ventilator-associated pneumonia (VAP) care bundles and Central Line-Associated Bloodstream Infections (CLABSI) guidelines (Matching Michigan).
- The unit carried out a gap analysis relating to its compliance to CSICU. The main area of non-compliance related to the lack of a consultant in intensive care medicine, the lack of dedicated mortality morbidity monitoring and no standard mortality ratio (SMR) data for critical care. However, mortality and morbidity monitoring was discussed at the burns mortality meetings. Five patients died due to the severity of their burns and comorbidities. This SMR data is important as it will be part of the NHS Standard Contract for Adult Critical Care and an indicator for the Critical Care Networks Service Specifications Standards D16 2015. The unit had plans in place following the gap analysis to ensure it became compliant with the CSICU standards such as: it's SLA with a local trust for medical intensivist cover and developing its own mortality and morbidity meetings.

- An audit of the acutely ill patients in hospital National Institute for Health and Care Excellence (NICE) clinical guideline 50 was undertaken in September 2015 which showed full compliance with the guidelines. For example all patients transferred from the unit to step down had full documentation in place with appropriately completed medical records.
- Acute kidney injury guidelines for the unit were in development by the units director and lead nurse and the sepsis guidelines for the trust were about to be implemented in line with national and international guidance. The sepsis working group had been initiated and led by the unit director and lead nurse. These guidelines had been circulated at the time of the inspection.
- Staff were undertaking work to support patients with tracheostomies following the National Confidential Enquiry into Peri-Operative Deaths (NCEPOD) report- 'On The Right Trach?' and had carried out a self-assessment based on the recommendations.
- The unit was compliant with the majority of the recommendations such as: having a difficult airway trolley/fibre optic laryngoscopy available and all unplanned tube changes to be reported locally as critical incidents and investigated.
- There were some areas where the unit was partially compliant and needed further work such as: capnography being available at each bed space and continuously used when patients were dependent on a ventilator. Monitoring equipment needed upgrading in order to be compliant and a business case had been submitted to acquire funding.

Pain relief

- QVH had a pain management service that was nurse led with support from consultant anaesthetists with an interest in pain management.
- The Pain Team worked in collaboration with the unit to help manage the patients' pain control.
- The Pain Team also supported staff and patients with any pain issues through information and education.
- A pain scoring tool was available to assess pain levels and this was recorded on ITU charts.

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- We saw records of a patient who required their dressings to be changed. This was a very painful procedure and we heard the patient crying out in pain over a protracted period of time.
- We looked at the patient's notes and saw there was no evidence of the effectiveness of the analgesia being used to reduce the patient's pain during the dressing change. The notes did not make it easy to determine whether the analgesia was effective or not.
- There was no recording of routine pain assessment scores on patient records with any space to record a running score so staff could not see how much analgesia the patient was given.
- We noted the patient was experiencing a significant amount of pain at the time of the dressing change which led us to believe the patient was not receiving sufficient analgesia. We informed staff at the time of our inspection and this was being investigated.
- The unit reviewed this patient's pain control and changes had been made in how the patient's dressings would be carried out.

Nutrition and hydration

- The unit used the Malnutrition Universal Screening Tool (MUST) tool to ensure patients were receiving the appropriate nutrition.
- The dietician told us there was no total parental nutrition (TPN) used on the unit. This was a decision made by the trust. Medical staff told us that as the indication for TPN was failure of the gastro-intestinal tract, this would be an organ failure too complex for the critical care team. We were told sometimes patients had to be transferred for gastro-intestinal problems usually constipation from opiates and as there were no gastroenterology/general surgical expertise.
- TPN is a method of feeding a patient intravenously bypassing the usual process of eating and digestion.
- Where patients needed a naso-gastric tube or a percutaneous endoscopic gastrostomy (PEG), the dietician was available to give advice if needed.
- There was a wide range of nutritional supplements available on the unit to ensure patients received sufficient nutrition when they were not always able to eat.
- We saw fluid monitoring in place for the one patient we saw which demonstrated hourly and daily input and output totals were being documented. The one patient we saw was able to take oral fluids which were being encouraged.
- Where patients could eat, meals had been modified after feedback from patients and local produce was used and was cooked on site.
- The chef was a member of the trusts nutritional steering group which meant that any changes needed to the menus would be discussed and agreed with the most appropriate people.
- There was an audit planned to look at planned calorie versus actual calorific intake for patients staying on the unit.

Patient outcomes

- Senior medical staff told us they were working hard to quantify outcomes for patients as there were no current formal benchmarking criteria for this specific patient group. The unit used data submitted to the South East Coast Critical Care Network such as admissions delayed over four hours, readmissions within 24 hours, delayed discharges more than four and 24 hours, night time discharges, transfers out for non-clinical reasons and information about rehabilitation.
- According to trust data there were on average two readmissions to the unit every month and two burns patients transferred out to another hospital with two more patients (not burns patients) also transferred out this financial year.
- The two burns patients were transferred as they had suffered more than 40% burns and other complications. These were reported as incidents.
- There was a trust wide Saving Lives audit undertaken between July and September 2014 which showed there had been a significant decrease in the number of audit forms returned from all departments. This made drawing any accurate or comparable data difficult. It was found additional training was required for insertion of central lines and insertion of urinary catheters.

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- The Saving Lives programme was to deliver a programme which will reduce Healthcare Associated Infection, facilitated by the use of seven techniques known as High Impact Interventions (HII).
- A more recent local audit took place between January and July 2015 using a different audit process which meant in an increase in the amount of data being used for audit purposes.
- This improvement in the data collection resulted in a more comprehensive audit and demonstrated 100% compliance with the care bundles. The audit also showed more work was needed in improving documentation to support care.

Competent staff

- 75% of registered nurses were in possession of a post registration award in critical care.
- There were a number of new starters to the unit this year and we saw two new members of staff being inducted to the unit. Both nurses told us they felt much supported and had been welcomed into the unit by the team.
- New starters to the unit had a full induction to critical care and had a period of six weeks supernumerary status and mentoring.
- All agency staff used were critical care trained many employed regularly on the unit, and had their competencies checked by permanent staff.
- There both had an induction booklet which included competencies to be completed. Both induction books were comprehensive.
- Nursing staff had opportunities to develop their skills and careers and staff were supported to undertake degrees. Two members of staff had been funded (through charitable funds) to attend the critical care nurses conference in Australia so they could learn and share new ideas with other critical care nurses.
- Middle grade doctors and consultants used the Continuous Professional Development matrix set out by Royal College of Anaesthetists to make sure they were up to date in current practices.
- According to data provided by the trust, between April 2014 and March 2015 the appraisal rate for anaesthetists was 85%, nursing staff 84%.

- We saw posters directing staff to training sessions on the unit for example: training in the use of glucose pumps.
- The unit partially complied with the Critical Care Networks Service Specification standards D16 2015 for having a competent resident medical practitioner with advanced airway skills as there was an anaesthetist on site. However, as this resource was shared with operating theatres and the anaesthetist was not always available and this may compromise the care of patients needing more intense airway management.

Multidisciplinary working

- There was a strong multi-disciplinary team (MDT) ethos with anaesthetists, surgeons, nurses, pharmacists, therapists and dieticians working with both burns and head and neck pathways.
- All patients received the minimum of 45 minutes of active therapy for at least five days per week and more where necessary.
- Patients having head and neck surgery follow a multi-disciplinary pathway of care. Their stay in the unit was usually short which reduced the risk of critical care related rehabilitation needs.
- There was no distinct follow up service for patients discharged from the unit. The unit was keen to explore this so as to understand the impact of prolonged admission to the unit. Due to the geographical spread of patients they were followed up as part of the outpatient care within the regions.
- There was joint working with a local NHS trust as part of the SLA with a local trust for the provision of blood transfusion, haematology and biochemistry services. This ensured the unit was partially compliant with the critical care networks D16 service specifications standards.
- Staff on the unit told us they had good working relationships with the police specifically if patients living with a mental health condition try to abscond.

Seven-day services

- Maxillofacial surgery took place on a Wednesday and Thursday with the majority of patients being discharged by the weekend. All patients still in the unit at the weekend received a multi-disciplinary review.

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- There was a pharmacy service Monday to Friday 9am to 5pm and no out of hours pharmacy service on site, however urgent advise and supplies were available from an other trust.
- Whilst there was no on site laboratory or blood transfusion service, we were told by senior medical staff, results could be responded to within an hour. Requests for additional blood if needed for an emergency could be sought and received within two hours. The hospital kept an emergency stock of six units of O negative blood on site to mitigate against the delay that may cause harm to patients.

Access to information

- The majority of information was by paper with an intention to look at an electronic record in the future but there were no plans to do this at present.
- Information could be accessed via the trusts intranet and we saw staff knew how to access evidenced based information such as care bundles and trust policies.

Consent and Mental Capacity Act

- Consent training was provided to all staff on induction. Patients gave their consent when they were mentally and physically able.
- The trust had delivered training on the use of the Mental Capacity Act. Staff within the unit were aware of the Mental Capacity Act and staff used the guidance when assessing if a patient was being or could be deprived of their liberty. We saw patients on the unit had their mental capacity assessed as their conditions changed.
- We saw a patient with a DoLS in place and were being looked after by two registered mental health nurses (RMNs). This was carried out in a professional and courteous manner, and the relevant documentation was correct.

Are critical care services caring?

Not sufficient evidence to rate

There were three patients on the unit at the time of the inspection. Two of these patients due to clinical issues it was inappropriate to interview them or to observe treatment and care given.

We heard staff talking with a patient which was done in a compassionate and professional manner. Privacy and dignity was maintained.

We were unable to rate this as there was insufficient opportunities to observe care.

Compassionate care

- At the time of the inspection there were three patients on the unit. Two of these patients had a mental health problem and as such it was inappropriate interview them.
- We could see only one patient being cared for on the unit. We heard staff talking with the patient and carrying out observations and daily routine tasks.
- Curtains were drawn around the patient to ensure privacy and dignity and voices were lowered to avoid private and confidential information being overheard.
- There was no unit specific Friends and Family Test results as patients are not discharged home from CC. For the trust Friends and Family Test for the whole organisation in September 2015 (48% response rate) 97% of people attending the trust would recommend it to others.
- There were no relevant inpatient survey results to be seen but there were thank you letters and compliments displayed at the entrance to the unit.
- However, at the local listening event patients and relatives told us The hospital had "something really special about it" and "staff and care were excellent."

Understanding and involvement of patients and those close to them

- There were no visitors we could speak with at the time of the inspection so we were unable to make a judgement.

Emotional support

- To help patients understand more about their illness the unit staff had introduced patient diaries. Research has shown using patient diaries reduced the stress after they had been discharged for the unit.
- There was an End of Life policy which was dated April 2015, which met with latest guidance. The hospital had undertaken an audit earlier this year against the policy

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for the 5 patients who had died; all of the patients were cared for in line with policy. However one patients end of life documentation was incomplete as she died very soon after admission.

- Staff, patients and relatives had access to counselling services.
- There was a bereavement lead that would give advice and guidance to staff and support staff to give appropriate and sensitive care but there was no dedicated bereavement service available for relatives. As patients are usually not from the local area, then staff advised them to seek support in their local area.
- Staff confirmed there was access to clinical nurse specialists, including the dementia nurses, breast care nurse and stoma care nurses, as well as the head and neck nurse. The clinical nurse specialists provided emotional support to patients as well as learning and development support for staff.
- The hospital provided pastoral and multi-faith support through the hospital Chaplin.

Are critical care services responsive?

Good 

The unit was responsive to patient's needs. Staff worked in a flexible manner in order to ensure all patients were looked after when demand increased.

The unit had no delays to admit patients over four hours, no elective operations were cancelled due to bed pressures in the unit and no patients was refused admission to the unit when referred by another medical professional.

Interpreting services were available for people whose first language was not English and we saw patients with a learning disability or living with dementia were well supported.

Service planning and delivery to meet the needs of local people

- The QVH provided specialist burns, plastic and trauma services to the south east population of England and south London. Consultants told us that QVH had a good reputation for giving patients excellent outcomes.

- Senior medical staff told us that planning a service for local people had its challenges as they were a tertiary referral centre and as such were determined by the patients who were transferred to them.
- Clinical staff told us that services tended to react to external patient needs and each patient was assessed regarding their level of care if they were a planned admission. However for burns and trauma patients this was assessed on admission.
- Patients who required more advanced intensive care were transferred to other intensive care units in a local acute trust.

Meeting people's individual needs

- The unit had plans to fit sky windows, these were Internal 'fake' windows with relaxing scenes, day & night, sunrise & sunset settings and aided reducing disorientation to day/night cycles. The unit was waiting for these to be purchased and were funded by charitable donations.
- Dementia clocks had been ordered for the unit which were large digital clocks with simple information displayed in a non-complex format. This aided orientation to time/place/person and day/night cycle for patients living with dementia and also combated delirium. This was also funded by charitable donations.
- Patients living with a mental health problem would be cared for by the mental health team for the local mental health trust in conjunction with the unit. We were able to see this on the inspection.
- Staff told us there were increasing concerns in obtaining full registered mental nurse (RMN) cover as some patients needed more than one RMN at a time however there was no evidence to support this claim.
- Where patients living with a personality disorder or mental health issue were admitted to the unit the referring accident and emergency department would be asked to complete a full risk assessment in collaboration with the mental health team. The outreach team had a policy for managing these situations and would review the patient prior to admission to the unit.
- There was a waiting area for relatives on the unit and access to a coffee/tea machine. The coffee/tea machine

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was implemented after feedback from relatives. There was no on site accommodation if relatives wanted to stay overnight with their loved ones however, visiting times were flexible.

- We saw a number of leaflets about people's stay on the unit and a guide for relatives and patients about sepsis which were handed out when the need arose.
- There was a policy for 'care of a patient (child/adult) with acute mental health needs' on the trusts intranet site. Staff knew about the policy and could show where the policy was stored. This included an algorithm to follow for these patients when admitted and discharged from the unit.

Access and flow

- The unit had an admission policy which described the types of support and care the unit could provide such as: respiratory support i.e. intubation and ventilation, single or multiple organ support, monitoring of arterial lines and central lines, continuous monitoring and further investigation and optimisation and stabilisation of patients prior to transfer or theatre.
- For unplanned admissions each patient would be discussed on an individual basis with the anaesthetist on duty or on call at that time.
- There were weekly multi-disciplinary meetings held on a Monday to discuss the weeks operating lists and bed requirements for the week ahead.
- Between April 2015 and the end of September 2015 there were 93 admissions to the unit, 64 were planned admissions, 11 unplanned, 18 tertiary referrals (from another NHS organisation). 12 of these were burns patients and six patients having had maxilla- facial surgery.
- Bed occupancy was at 100% in five out of the last 12 months but in two months the occupancy rate on some days was 0%. Staff would undertake training and work in the burns unit, if there were no patients.
- Length of stay was no more than one day as the majority of head and neck patients were moved on to step down beds within 24 hours of arrival on the unit. The longer

stay patients were almost exclusively major burns. The numbers of these were in decline, in line with national trends, but also in line with the strategic direction of the London and South East Burns Network

- The South East Coast Critical Care Network Quality Report 2015/16 showed 100% of patients were admitted within four hours of the decision to admit to critical care. There were 8% delayed discharges for the first quarter of 2015 and no non-clinical transfers out and no discharges during the night.
- The unit had transfer and discharge guidelines within its critical care operational policy which stated all patients being discharged or transferred 'must have had a full assessment from the surgical and anaesthetic teams demonstrating the patient was physiologically stable for transfer to a lower level of care'.
- **Learning from complaints and concerns**
- There had been very infrequent complaints to the unit. There were two complaints for the period June 2014 to July 2015, one related to poor communication and the other with taking consent.
- Action plans were developed and included; identifying the problem, specific actions needed to be taken in order to address the problem, who would take responsibility for the actions to be completed and a progress update and final evaluation.

Are critical care services well-led?

Requires improvement 

The unit could not demonstrate a dedicated stand-alone vision and strategy as it was part of the burns unit governance programme. As such the unit did not have its own entity. For example there were no mortality and morbidity meetings and no dedicated critical care governance meetings. These would be picked up, through the wider burns unit arrangements. However we saw no issues which would compromise patient care.

Since an inspection in August 2015 by the local Clinical Commissioning Group, the unit had started to review its own governance arrangements.

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Staff felt engagement was at the right level and felt confident they could discuss any concerns with their leaders with ease and in the confidence they would be listened to.

Staff felt confident about risks being discussed and actioned. Risk registers demonstrated that risks were identified, recorded and actioned appropriately.

There was a high level of satisfaction with staff telling us they enjoyed working within the team. Nursing and support staff provided flexibility within the department to provide high quality care that met patient's care needs.

Vision and strategy for this service

- The service had a development plan for the next three to five years as part of the wider Burn Care Network Service Development Plan.
- However the wider trust strategy for the future of services at QVH had taken into account the level of critical care that patients will need.
- Senior staff told us there was an intention to share more services with BSUHT over the next four to five years and consolidate the service. Currently a review of how services are provided to patients with burns is being undertaken and this is being led by Trust in conjunction with health partners and with BSUHT.

Governance, risk management and quality measurement

- The unit did not have its own governance processes in place however we saw the unit was incorporated into the burns unit governance programme.
- The unit had identified some areas for improvement such as: developing a dedicated governance and operational structure for critical care; instigating critical care specific governance meetings with trust executive team representation; developing documented, reproducible standards for critical care service delivery; instigating dedicated critical care mortality & mortality meetings and developing processes for collecting, presenting and reviewing outcome data for the unit.
- There were five risks on the units risk register; two relating to equipment, one raising concerns about new starters working on the unit before undergoing an induction programme, manual handling and the inability to meet the NHS burns unit standards. All five

risks had actions plans attached to mitigate the risks and were regularly reviewed. Senior staff told us the risk register was still in development although progress had been made on closing the risks.

Leadership of service

- The unit was led by a consultant anaesthetist along with the emergency care matron. And was part of the emergency care directorate.
- The unit had a Critical Care Operational Policy dated March 2015 and included information on the admission, discharge and operational policy for critical care services within the burns centre.
- On a day to day basis the unit was well led, staff worked well as a team and staff were confident in their line manager.
- Staff told us they felt well supported and had the opportunity to develop and learn.

Culture within the service

- There was a strong culture of teamwork and staff spoke of being proud of their unit.
- Staff felt supported and spoke to us about the service being clear and open.
- Support services were available for all members of the burn care team.

Public engagement

- The unit had access to charitable funds. These were used for such things as facilities for patients and education for the staff.
- The unit had support groups for post burns patients. These were patient led and received sponsorship through various charities.

Staff engagement







- Staff felt supported and felt proud to be part of the trust.
- We saw a poster on the unit inviting HCAs to a listening group meeting in November 2015 so that they could voice their opinions about working at the trust and on the unit.
- In the NHS Friends and Family test September 2015, 73% of staff said they would recommend this organisation to friends and family as a place to work.

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Innovation, improvement and sustainability

- The unit had developed training material for general Accident and Emergency (A&E) staff in the immediate management of burns patients and liaised with A&E departments across Kent, Surrey and Sussex.

Services for children and young people

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

Information about the service

The Queen Victoria Hospital provides inpatient services for children requiring surgical paediatric services, both elective and trauma including burns surgery, hand surgery, head and neck surgery and ophthalmic surgery. There are no designated paediatric theatre lists and children are generally operated on wherever possible as the first patients on the list. Where several children require surgery on the same lists the consultant in charge of the list will decide on clinical priority. According to the trusts data between April 2015 and October 2015 there were 1174 episodes of children's surgery of which 616 related to trauma surgery and 558 to elective surgery. The current referral criteria for acceptance at QVH for children with burns is:

- No child for inpatient treatment under the age of 6 months
- Maximum burn under the age of 1 is less than 10%
- Between the ages of 1 and 5 maximum burn size of 15%
- Above the age of 5 maximum burn size is 20%. On average there are 72 burns referrals a month and 7 paediatric patients per month admitted, with burns.

Peanut Ward has 9 beds and are all in single occupancy rooms with the facility for 1 parent to stay overnight with their child in the same room. 6 of the 9 rooms have ensuite bathrooms. There is a paediatric assessment unit attached to Peanut ward where children have initial assessment of their needs before being admitted or transferred to other units. The service is supported by general paediatric consultants from a nearby acute trust with which QVH has a formal partnership. Both hospitals work closely together and often share the care of patients.

Summary of findings

Overall we rated children's services as good. We found that the care children and young people at the Queen Victoria Hospital receive was outstanding. We received positive feedback from patients and their parents about the care, facilities and staff on Peanut Ward, and other areas of the hospital used by children. There was a good culture of reporting incidents and we saw evidence of changes to practice as a result of investigations, and there were robust systems in place. We saw that emergency equipment and medicines were appropriately stored and checked in line with protocols. Additionally patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information. The hospital responds well to patients needs and supports children with complex needs in an innovative and caring manner. The environment was clean and well maintained and appropriate for caring for children and their parents, with overnight accommodation available on Peanut ward for parents. Staff work hard to ensure that children who have had body changing surgery are supported through a network of mentors. These mentors are children who have similar life changing surgery.

Services for children and young people

Are services for children and young people safe?

Good



The Children and young people's services are safe and rated as good. The children's services had had no serious incidents reported in relation to the care of patients using the service and there are good incident reporting systems in place. We found that Peanut ward and the Paediatric Assessment Unit were clean and well maintained, with dedicated in house cleaning staff, and the environment was conducive to safe and appropriate care for the children using it. We saw that emergency equipment and medicines were appropriately stored and checked in line with protocols. Additional patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information. The trust used a combination of recognised tools to help ascertain nurse staffing levels within the children's ward, There is no dedicated paediatric full time cover at the hospital. There are visiting paediatricians and paediatric advice is available on a 24 hour basis from a neighbouring NHS trust. All children being admitted for routine surgery are assessed prior to admission.

Incidents

- There were no 'Never Events' reported in paediatric services in the period August 2014 to September 2015. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There have been no serious incidents reported relating to children's services.
- There had been no reported cases of methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile (C. diff) for children's and young people's services in the past 12 months.
- Trust policy stated that incidents should be reported through a commercial software system enabling incident reports to be submitted from wards and departments. All the nursing and medical staff we spoke to stated that they were encouraged to report incidents via the electronic incident data management system.

- Staff described the process for reporting incidents and told us they were encouraged and felt comfortable using the system. They told us they received feedback which was disseminated by email, and at monthly ward meetings, which we observed in the minutes of these meetings.
- We saw that a root cause analysis (RCA) was completed as part of the investigation of incidents. RCAs identified learning from incidents and lessons learned from incidents were shared across teams. We reviewed the most recent incident which related to an incorrect GP name and address on a discharge letter, which resulted in a change of practice when discharging children.
- Queen Victoria Hospital NHS Foundation Trust commissioned two root cause analysis workshops for staff within the hospital with an aim to establishing a standardised approach for investigation. We saw records to confirm that senior managers who undertake RCA investigations had received the appropriate training.
- Incidents relating to paediatrics are initially investigated by the ward manager and then discussed at the monthly Risk Management Meeting before being signed off
- We looked at a selection of minutes for ward and matrons' meetings held during 2015, and subsequent divisional governance meetings. These demonstrated that safety incidents and the outcomes of their investigations were standing agenda items and that the data was used to monitor performance, track risk trends and cascade learning back to teams.
- The trust reported that duty of candour information is included in compassion in care induction session and risk management session. The number of staff who have attended trust induction incorporating the duty of candour sessions since 27th November 2014 is 203. Since February 2015, 53 junior doctors and 66 consultants have participated in duty of candour training.
- We asked staff about their understanding of the new regulations concerning duty of candour. Most were able to describe the concept and understood the

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organisation's responsibility for transparency and openness. When we reviewed the risk investigation process we saw that there were clear prompts included to ensure that the process was followed.

Cleanliness, infection control and hygiene

- Overall, we found that the Department of Health's "Code of Practice on the prevention and control of infections and related guidance" was complied with in children's services.
- We found that Peanut ward and the Paediatric Assessment Unit were clean and well maintained, with dedicated in house cleaning staff. Cleaning rotas were available for scrutiny and regular audits of cleaning undertaken to monitor the effectiveness of cleaning regimes.
- Monthly infection control audits were undertaken within Peanut Ward and the Paediatric Assessment Unit and the results of these were visibly displayed on the ward. However, we noted that no "green is clean" stickers were used to indicate when equipment had been cleaned. A staff nurse explained that although the items may have been cleaned by night staff, it was standard practice for all staff to clean equipment before use. This meant that there was no robust assurance process in place to demonstrate equipment was clean and safe to use.
- For the year to date, children and young people's services was achieving 100% compliance with the national institute for clinical excellence (NICE) national specifications for cleaning. We saw that gloves, aprons, and other personal protective equipment (PPE) were readily available and used by staff.
- We saw there were effective arrangements in place for the storage, handling, and disposal of clinical waste. We observed that sharps management generally complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw that sharps containers were used appropriately and that they were dated and signed when brought into use. Non safety sharps were commonly in use within the paediatric unit. Retractable sharps were available specifically for blood taking but we were told that "Paediatricians don't like safety sharps."
- However, we saw a sharps bin in the sluice room located at floor level with no access control to the room. This

meant that unauthorised people would have access to the items. There were also a stock of cardboard urine disposal bottles on the floor potentially exposing them to contamination and making cleaning difficult.

- There was an infection control lead for children's services who was present on the ward when we visited.
- Adequate hand washing facilities and hand sanitising gels were readily available. 'Bare below the elbow' policies were adhered to and we observed staff taking appropriate action. The importance of all visitors cleaning their hands was prominently publicised and we observed parents and other visitors using hand gels and washing their hands. We observed that staff washed their hands in line with the World Health Organisations guidance "Five moments of Hand Hygiene." Hand Hygiene audits that we viewed showed 100% compliance.
- The trust operated an infection control score card giving performance against a range of infection control indicators, including hand hygiene compliance and adherence to the high impact interventions known to reduce infections and cleanliness audits. The wards had large display boards with key infection prevention and control messages and the performance score card for their ward.

Environment and equipment

- We found the environment within the Paediatric Assessment Unit and Peanut ward appropriate for children and young people. It was well maintained, light, airy, cheerful and suitable for children.
- A full manual for medical devices was kept with clear records regarding each item in use within the department. We saw evidence of the training logs regarding equipment. For example the blood glucose machine reflected the training undertaken for the past several years. Records were available to demonstrate that equipment such as the blood monitoring machine and the syringe drivers received regular servicing.
- We found that resuscitation equipment stored on the resuscitation trolley was readily available and located in a central position. The trust policy identified the systems to ensure it was checked daily, fully stocked and ready for use. Daily checks should be recorded. We checked the trolley on Peanut ward and found that it

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had been completed in line with policy with the exception of a missed check on 1/11/2015. We found that the checks for the Blue Bag emergency response kit which were required on a monthly basis were not being consistently undertaken. They had not been checked for February, March, May and October 2015.

- We saw that fridge temperature checks were undertaken and documented.
- Staff told us that Electrical Medical Equipment (EME) was well maintained centrally by the EME department. They said that it was very unusual for them not to be unable to access equipment when it was needed.
- We saw that Portable Appliance Testing (PAT) labels were attached to electrical systems showing that it had been inspected and was safe to use.
- Environmental assessments were undertaken and updated appropriately. On the children's ward we saw that there was appropriate fire-fighting equipment available throughout the ward and assessment unit with a clear fire evacuation plan displayed and evidence to support that all staff had undertaken fire training.
- We saw that COSHH assessments had been completed appropriately for flammable and potentially harmful substances. Although these items were stored in a cool, well ventilated room away from ignition and heat they were not in flammable resistant metal cupboards.
- We spoke with staff who explained the systems they followed when they encountered environmental problems or maintenance issues. They described the system and reported that generally it worked well.

Medicines

- Patient Group Directions (PGDs) were in use on Peanut ward and well managed. These were limited but found to be in-date, authorised for use and signed by authorised staff. PGD training for staff was run by the non-medical prescribing lead. Nurses attended training before being signed off to use PGDs.
- We looked at four separate paediatric drug charts. We found they contained some prescribing information (e.g. drug calculations, paracetamol dosing) as it was recognised that surgeons did not have in-depth knowledge of paediatric prescribing (risk mitigation).
- Drug charts that we reviewed recorded appropriate allergies, patient weight details and contained no undocumented omitted doses. The medicine reconciliation (MedRec) was documented as completed by pharmacy with the prescriber's identification recorded on the front page of drug chart.
- We were told that staff from the Pharmacy visit Peanut ward from Monday to Friday. Three of those days are covered by a paediatric pharmacist and the remaining two by other pharmacists.
- The ward manager demonstrated a clear understanding of pharmacy/supply support out of hours.
- We saw that robust key management controls were in place with access to drug cupboards limited only to authorised staff. Trained nurses had extra permission using a swipe card to access key box. Keys to controlled drug cupboards were held by the nurse in charge.
- We found that medicine cupboards were orderly, neat and tidy.
- We looked at controlled drugs (medicines liable to be mis-used and requiring special management) in Peanut ward. We checked order records, and CD registers and found these to be in order. We spot-checked some medicines and found that stock balances were correct. We saw ward staff checked stock balances of CDs daily. Quarterly audits were undertaken by the Pharmacy department with liquid CD balances being checked as action in response to an incident. This meant that controlled drugs (CD) were securely stored and administered according to current guidance and legislation.
- We saw that medicines were stored in dedicated medicines fridges when applicable. These fridges were clean, tidy and not overstocked. Records were available to us showing that daily checks were undertaken using the fridges built-in digital thermometer. Room temperatures were also recorded to ensure that drugs were stored in a temperature controlled environment.
- Ward did weekly expiry check on all opened medications and monthly expiry check of all medications.
- We saw that a six monthly review of stock held on the ward was undertaken by the paediatric pharmacist.

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- Over-labelled discharge medicines were securely stored and available for use.
- The nursing team told us that they felt empowered to challenge doctors prescribing.

Records

- We viewed the staff training record for children and young people's services. We saw that 100% of operational management staff had completed mandatory training in information governance.
- Documentation for admitting patients and assessing needs and risks was child-centred.
- We looked at three sets of notes on Peanut ward and found them to be accurate and legible. We found both medical and nursing records were appropriately completed with dates and times recorded. Patient Information was easy to find.
- The care pathway records used for children's surgery documented the child's care and treatment from pre-assessment, surgery, recovery and through to discharge. The documentation used included nationally recognised surgical safety checklists and prompts for staff to ensure multidisciplinary working between nursing and medical staff, as well as information sharing with children, young people and parents.
- Patients' records were managed in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information.
- Leaflets explaining patients' rights to access their medical records were available and the trust's website carried information on people's rights under the Freedom of Information Act 2000.
- We saw that there had been an audit of patient records within children's services in June 2015 with actions identified to address any areas requiring improvement. For example of 39 sets of records reviewed only 74% recorded that all children returning from surgery had observation charts completed incorporating PEWS.
- Records documented that appropriate safeguarding procedures had been followed and appropriate referrals to other services such as mental health teams and social services were timely.

Safeguarding

- We were told that the ward manager on Peanut ward was currently filling the role of Safeguarding lead as the post is currently unfilled however the director of nursing (DoN) was the safeguarding lead for the QVH, and visited the ward regularly, because the ward is small any concerns are raised with the DoN.
- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral. We were given examples of concerns they had identified and referrals made. Staff told us that they generally received feedback on the outcome of referrals.
- There were two designated Band 6 safeguarding nurses who liaised closely with social services, health visitors and school nurses. These nurses had experience with looking after children and liaising with social services. They reported that whilst there were no difficulties liaising within the local community other local authority safeguarding processes all differed which presented problems.
- Staff in the minor injuries unit, were aware of their responsibilities for safeguarding children and had clear links with appropriate agencies when they were concerned about a child's wellbeing.

Mandatory training

- We spoke with the Clinical Teacher who described how they worked with the Paediatric Ward Manager to ensure that all staff participated in mandatory training. Records were available to show that over 95% of staff had received mandatory training for Medicines, Manual Handling and Fire.
- We saw that 100% of staff had undertaken level three safeguarding training.
- Intravenous drug administration training records displayed in the treatment room were seen to have been last updated in 2013.
- Compliance rates for medical staff paediatric life support training are within the plastics unit 80% and 100% in anaesthetics.

Assessing and responding to patient risk

- The trust performs a wide range of procedures. In 2015-2016 there were 2,500 ward admissions of which

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445 were 0.5-2 years, 878 3-10 years and 1185 over 10 years old. Children under six months old are not admitted. These admissions led to 2000 surgical procedures of which 15000 were completed as a day case. No patients under 3 years of age had surgery out of hours and no non burns surgery patients required transfer out of hours. The trust monitors and reviews acuity on a monthly basis.

- The trust operates an admissions criteria to ensure that no patient admitted to the hospital is not capable of supporting all normal bodily functions.
- The trust has a well-developed document detailing the organization's standards of care for children's services. This supports the admissions criteria and aims to ensure that other healthcare providers do not refer children who do not meet the admissions criteria. In 2015-16 there were 850 referrals to the trust of which only four were refused admission.
- In the rare event of a child attending the MIU with a condition outside of the admissions criteria a full resuscitation, stabilization and transfer protocol is in place.
- The trust risk register detailed one risk which related to the organisation not being compliant with national guidelines from Royal College of Paediatrics and Child Health. These guidelines "Facing the Future Standards for Paediatric Services - April 2011" are not being met due to lack of Consultant Paediatrician level input within five hours of admission for a medically sick child following a burn.
- We saw that the trust had stringent control measures in place to mitigate this risk by careful selection of caseload, both elective and non-elective, together with a service level agreement for support from The Royal Alexandra Children's Hospital. The level of support included on site presence for advice during the working week, safeguarding management and clinics three days per week.
- The care of children out of hours falls to the nursing staff of the children's ward and the resident medical cover. There is also access to 24/7 phone advice, telemedicine facilities and onward referral of unwell children not considered suitable for management at the Queen

Victoria Hospital. In addition, all paediatric nursing team and site practitioners have paediatric life support and/or EPLS. A paediatric early warning score is applied for all children.

- We noted that the assessment processes for treatment was detailed and thorough with a variety of additional pre-admission tests being undertaken. For example we saw from one consultants assessments for Syndactyly (this is a condition of webbing of the toes) how information was sent to the parents of the patients outlining the condition and corrective procedures. Detailed Information and investigations were then undertaken to identify any underlying conditions might affect the consideration of any surgery.
- We saw an example of a child admitted for day case surgery who was found to have underlying cardiac issues which had not previously been declared by the parents. The patient had been immediately taken off the theatre list until the consultant was able to consult with patient's cardiac consultant, ensuring the condition could be managed appropriately at QVH. As a result the child was able to have surgery later on the same day.
- A policy was in place for the management of children requiring care which could not be managed at Queen Victoria hospital, with transfer arrangements in place to a tertiary centre, (tertiary centres are large hospitals providing specialist care).

Nursing staffing

- The trust used a combination of recognised tools to help ascertain staffing levels within the children's ward. Planned nursing ratios were based on the number of children in each age group with those aged two or under requiring a minimum of 1:3 and those older requiring a minimum of 1:4 unless they had more complex needs where staff aimed to have 1:3 cover.
- Nurse staffing levels met national guidance and the staff reported that there was sufficient staff to meet the needs of the children in their care.
- Nursing levels were displayed within the ward area. On the day of our unannounced visit we saw that the actual staff matched the number of planned.
- The ward manager reported that there were currently no vacancy nursing posts within the service.

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- Agency usage was very low with ward nursing teams filling any available bank shifts. When agency staff were employed they were known to the service and area.

Medical staffing

- The data regarding medical staffing showed that the trust exceeds the England average in terms of skill mix, 42% (39%) are consultants, 9% (9%) middle career, 47% (38%) registrars and 1% (15%) junior doctors.
- The trust employs five consultant anaesthetists who have additional qualifications in the paediatrics. These consultants lead and oversee all paediatric anaesthesia. The trust uses an electronic anaesthesia record keeping system to maintain a record of anaesthetist caseload by age group. The trust also monitors intervention rates and outcomes at consultant level and these are reviewed during the process of appraisal. Case mix review for surgeons is approached in a similar manner.
- There is clear guidance and a program of consultant support that allows appropriately experienced Specialist Registrars to anaesthetize children.
- There is no dedicated paediatric full time cover at the hospital. There are visiting paediatricians and paediatric advice is available on a 24 hour basis from a neighbouring NHS trust. All children being admitted for routine surgery are thoroughly assessed prior to admission.
- The hospital at night team included: Site nurse practitioner, CT2 Plastic surgery trainee, SpR Anaesthesia, resident on site 24/7 (theatre/ITU/ward cover), Plastic Surgery CT2 resident on site 24/7 (ward cover), Dental FY2 resident on site to 10pm (ward cover). On call 24/7 medical professionals consist of: Maxillofacial SpR non-resident, Corneoplastic SpR non-resident (ward cover eyes only). On call consultant cover included: Anaesthetics, Plastic, Corneoplastic and Maxillofacial surgeons all provide 24/7 non-resident on call service.

Major incident awareness and training

- Senior staff were aware of the location of the major incident plan and were well versed in its contents and their role in the event of an incident. The trust does not have an Emergency department, so it is unlikely it would be a first receiving site in the event of a major incident.

- Senior nursing and clinical staff reported that they had received major incident awareness training. Records demonstrated that staff had this training.

Are services for children and young people effective?

Good



Services for children are effective and rated as good. We found that the services was involved in a number of national and international research programmes and their protocols were based on national guidance. The service uses a variety of pain relieving assessment tools to meet individual needs. There were choices in the menu offered each day and we were told that the food provided was 'good'. The menu card was given to patients to select their menu in the morning and hot meals were served twice a day. Sandwiches and snack boxes were available throughout the day. We were able to see clearly that staff were well trained and competent to care out their role and good multidisciplinary working was evident across the children's services. Staff were able to describe the legislative requirements regarding consent and confirmed that policies and procedures were available to ensure that informed consent was obtained from the appropriate individual. Staff were able to describe the concept of Gillick competencies and the arrangements for seeking consent from children and young people where they had been assessed as being competent to make decisions regarding their care and treatment.

Evidence-based care and treatment

- The trust's hospital protocols were based on the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH) guidelines. Local policies were written in line with this. Staff knew where to find policies and local guidelines, which were available on the intranet. There were systems in place for ensuring that policies were reviewed following changes to national guidance.
- Consultants and nursing staff from a range of specialties were engaged in the development of national and international treatment guidelines for burns and plastics, as well as engaging in international research programmes.

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- There were a range of clinical pathways and protocols for the management and care of various medical and surgical conditions which had been developed in conjunction with healthcare professionals from a range of specialties.
- Nursing staff confirmed clinical governance information and changes to policies and procedures and guidance had been cascaded down by the matron and ward manager via emails, special meetings and discussion at team meetings, which were held monthly.
- The trust did not meet national guidance on managing burns patients as the hospital did not have the on-site facilities that a large district general hospital would provide; such as specialist renal, haematology and intensive care facilities.
- However substantial work had been undertaken in ensuring that the hospital was able to care safely for the patients that were admitted.
- A robust triaging system was in place to ensure that patients who were severely burnt or who had life threatening complications were not admitted. Any such patients were diverted through the Burns Network to the nearest hospital with suitable facilities to manage, not only the patients immediate burns, but any complication that might develop as a result.
- Patient records included an assessment of each patient's nutritional requirements. The service used the adapted Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) to assess nutritional risk for all patients.
- Patients with poor food and hydration intake were observed closely. The care pathway observation chart included a section for nurses to monitor the food and fluid intake of these patients. This ensured patients' nutritional and hydration needs had been monitored and maintained.
- There were choices in the menu offered each day and we were told that the food provided was 'good'. The menu card was given to patients to select their menu in the morning and hot meals were served twice a day. Sandwiches and snack boxes were available throughout the day.
- We saw that children had drinks readily available by their bedsides.
- Specialist paediatric dieticians were available to support the wider multidisciplinary team.

Pain relief

- We observed that a variety of tools were used to assess pain, depending on the age of the child and their ability to understand information. The pain assessment chart was embedded in the BPEWS chart. Paediatric pain recorded in designated format within paediatric care records using most suitable method for age and understanding. Children select the tool they wish to use. This included a pain assessment tool using 'smiley faces' which means the child chooses a face that best describes their own pain.
- The specialist pain management nurse worked with a link consultant supported by two staff nurses one of whom is a paediatric nurse, who is currently on leave, however anaesthetists have both paediatric and adult pain management competencies.

Nutrition and hydration

Patient outcomes

- Staff understood the National Institute for Health and Care Excellence (NICE) guidelines and stated that these were referred to in discussions with staff about patients' care and treatment.
- The service had a programme of audits that would be undertaken at a local level across the children's service to monitor the quality of care provided to children and young people.
- The trust had a programme of auditing and monitoring the quality of care provided. Staff gave us examples of recent audits that included pain, nausea and vomiting and other complications post operatively. They told us that the staff would audit any area to identify areas where practice could be improved. They gave several examples from pain audits, to records and outcomes for clinical procedures.
- The majority of the children's services caseload is low complexity minor lesion or injury day surgery. The trust has made a number of attempts to measure associated outcomes but has found response rates to be low. However, a focus on five outcome measures postfinger

Services for children and young people

nail repair has indicated a 100% satisfaction rate for patients with a greater than 90% positive response to receipt of explanation of procedure and the return of normal function within ten days of surgery. In addition, a number of multiple case review papers have been formally published by consultants in national publications.

- The service tracks a set of indicators for paediatric practice. Mortality rate is not applicable, readmission rates are currently at 1%. The service monitors all patient transfers.
- Between May 2014 and April 2015 there were 5 unplanned transfers to other units as a consequence of patients deteriorating. All cases were reviewed through the paediatric governance group meeting.
- The burns unit review and submit outcome data on a quarterly basis. This provides a national benchmark against other burns services. The 2015/16 quarter 1 scorecard indicated 100% compliance with all indicators for which data was provided including receipt of daily pain assessment, screening for psychosocial morbidity and screening for functional morbidity.
- The service specializes in hand surgery for congenital conditions. Whilst benchmarking is difficult in this specialist area the service has published two extensive case reviews detailing outcomes for patients who have had syndactyl release and patients who have had corrective surgery to address absent digits.
- The service performs further highly specialist ocular surgery, for which benchmarking is again difficult. The service has however published numerous review papers in national and international medical journals.
- The service also performs orthodontic and maxillofacial surgery. For these procedures patient outcomes are reviewed on a quarterly basis by consultant. For the time period April – June 2015 all consultants received a greater than 95% score for providing the appropriate information to the patient and family, and more than 84% patients responded as being fully satisfied with their treatment. Although over a third of patients considered treatment to take longer than anticipated over 95% considered the overall impact on the straightness of their teeth to be better than expected.

Competent staff

- During our inspection we saw that Nursing and Midwifery Council registration was seen, recorded and then monitored by the ward manager. Records kept on the human resources management tool used colour coding to indicate when individuals registration became due for renewal.
- Staff reported that they had attended induction on starting employment and had attended mandatory training, including basic life support.
- Staff told us that study days provided a safe environment to discuss issues, problems, mistakes and to learn from their colleagues.
- We spoke with the clinical paediatric educator who described how their role involved with working across the trust staff designing and arranging specific training and supporting staff in response to their individual developmental needs. This included training other Allied Health Professionals such as ambulance staff. An example of this was the development of auscultation of chest and immunisation training for paediatric staff.
- When we spoke with Junior doctors at a focus group we were told that they were happy with the training and support given to them. They reported good access to teaching opportunities and said that they were encouraged to attend education events.

Multidisciplinary working

- Overall, staff reported good multidisciplinary working with other services within the trust and with external organisations, such as local authorities and general practitioners, who had made referrals.
- Multi-disciplinary ward rounds were carried out daily in Peanut ward, with doctors, nurses, therapists and a pharmacist.
- There was an onsite psychological therapy department including a paediatric psychologist. The trust had a service level agreement in place with Sussex Community Partnership NHS Foundation Trust, to support the trust as and when a child required CAMHS support during an assessment or an inpatient stay at the hospital.
- The trust provide a transition service to help children who have spent many years under the care of the consultants at the hospital who need to have their

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future treatment in an adult environment. As the trust does not have specific paediatric only consultants the child/adult will retain their consultant. This service is provided by the ward paediatric nurses/play specialist and a programme of transition is followed and completed. This process applies to all specialties, but is more prevalent in burns and corneo plastics.

- Play specialists were available each day and provided a service to children accessing clinical services in inpatients and outpatients.
- Staff reported that there was a paediatric working group with good access and working relationships with paediatrics at Brighton hospital.

Seven-day services

- There were consultant ward rounds seven days a week on the Peanut ward, and they were available out of hours through on-call arrangements. This meant that patients would have round the clock access to a specialist consultant.
- Peanut ward operates a 24-hour service, however very few children having routine surgery stay overnight.
- The pharmacy department was available to meet the needs of children on Peanut ward including out of hours by an on call service.

Access to information

- We spoke to clinical staff who told us they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for their patients. We were told that when necessary and required patients' old notes were retrieved from the hospital archives without delay.
- Consultants and junior doctors we spoke with told us they felt there was excellent communication between medical and nursing staff.
- We saw there were systems to ensure the transfer of information when a patient moved between the assessment unit and ward and these were supplemented by a verbal handover.

Consent

- Parents on the wards confirmed that their consent had been sought prior to treatment of their child. They described how the procedures had been explained to

them by both doctors and nurses. They felt they had been given very clear information and were well informed before they signed the consent form for surgery and treatment.

- Staff were able to describe the legislative requirements regarding consent and confirmed that policies and procedures were available to ensure that informed consent was obtained from the appropriate individual. Staff were able to describe the concept of Gillick competencies and the arrangements for seeking consent from children and young people where they had been assessed as being competent to make decisions regarding their care and treatment.
- Staff were aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were able to describe the arrangements that were in place should the legislation need to be applied. Staff reported that the least restrictive form of deprivation would be used and decisions were made in conjunction with the wider family unit, specialist social workers, clinicians and nurse specialists.

Are services for children and young people caring?

Outstanding



Overall we rated caring as outstanding

We saw many examples of outstanding care on Peanut ward, where children were treated with compassion and kindness.

Care was centered on children and their families were involved in all aspects. Parents felt involved in the care of their child and participated in the decisions regarding their child's treatment, and that staff were aware of the need for emotional support to help children and families cope with their care and treatment.

Children with burns had the opportunity to be supported during aftercare, by mentors who had been previous patients, this had been developed by staff.

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Patient and parent satisfaction survey questionnaires were available and the results were published on the trust dashboard, together with the action taken to improve the service. 100% of patients recommended the service in the Friends and Families test.

Compassionate care

- Throughout our inspection, we witnessed good staff interaction with patients and parents. We observed how the nurses assisted parents and children during recovery from a surgical operation, with compassion and skilled care.
- Parents were all complimentary about the care and the staff who cared for their child. Both children and parents were treated with compassion, dignity and respect.
- Parents and patients told us how they specifically liked the individual rooms which afforded them a high level of privacy. One mother told us “Having a room to himself keeps the noise out”. The patient told us they felt safe and really liked having the privacy of their own room so they could have their family with them.
- Curtains were located around the weighing area within the assessment unit to protect the dignity of children being weighed. Staff told us that children especially teenagers were often very sensitive when being weighed.
- We observed a caring approach from a burns consultant during a paediatric burns assessment. There was a good provision of information given to parents regarding follow up and further surgical management of their child’s condition.
- Parents were complimentary about the medical and nursing staff and they felt their child was in safe hands.
- There was good staff interaction with patients and parents. Both children and parents were treated with compassion, dignity and respect.
- Facilities were provided for parents to stay overnight with fold down beds, and a parents room with tea, coffee and refrigerated services available for them to use.

Understanding and involvement of patients and those close to them

- Parents felt involved in the care of their child and participated in the decisions regarding their child’s treatment.
- Parents felt well informed before they signed the consent form for surgery and other treatment. They felt involved in the care and in the decisions regarding their child’s treatment. One parent said, “I was able to meet with the surgeon on two occasions before signing the consent form. I was given sufficient information in order that I could make an informed decision. As a family, we have all been involved in planning the care for our child.”
- Another parent told us “that staff talked with and included my son in everything, they spoke and gave information clearly pitched at his level and in a way he understood and felt part of. When my son was in surgery the nursing staff kept me informed of progress throughout.”
- Patient and parent satisfaction survey questionnaires were available and the results were published on the dashboard, together with the action taken to improve the service. 100% of patients recommended the service in the Friends and Families test.
- Parents reported they were given appropriate information and the proposed treatment was explained to them by both doctors and nurses.

Emotional support

- In our discussions with staff they were aware of the need for emotional support to help children and families cope with their care and treatment. All the parents and relatives we spoke with confirmed this during our discussions with them. The nursing staff on Peanut ward received a lot of positive comments from parents in regards to providing parents and children with emotional support.
- Psychological support could be offered to patients with complex health needs. The paediatric bariatric service referred all patients to a psychologist whose role it was to help support the adolescent in the lead up to, and following, their surgery in order to enhance recovery and to adjust to physical body changes, as well as to support the emotional wellbeing of the individual.

Services for children and young people

- Children with burns had the opportunity to be supported during aftercare, by mentors who had been previous patients.

Are services for children and young people responsive?

Good



Services were responsive to the needs of children and rated as good. In terms of planning the hospital provides services mainly to children out side of the local population, as it is a specialist unit. The environment was adapted to suit individual needs, as the children using the services were mostly receiving care for very differing and complex conditions. There have been only 2 complaints about children's service at the trust in the last year and these were responded to appropriately.

Service planning and delivery to meet the needs of local people

- The Queen Victoria hospital is specialist hospital, and children do not in generally come from the local population, to use services.
- In the minor injuries unit where local children are seen, the care is provided from suitably trained staff to meet their needs.
- According to the trusts data between April 2015 and October 2015 there were 1174 episodes of children's surgery of which 616 related to trauma surgery and 558 to elective surgery. On average there are 72 burns referrals a month from other hospitals, some of these children do not meet the strict criteria for admission to the QVH, or do not require admission to a burns unit. Of these 7 patients per month are admitted with burns on average.
- The current referral criteria for acceptance at QVH for children with burns is that no child under the age of 6 months can be admitted for inpatient treatment, the maximum burn has to be less than 10% for children under 1 year old. Then for older children the burn must be less than 15% for ages 1 to 5 and 20% above age 5.

- The service is supported by general paediatric consultants from a local acute trust with which QVH has a formal partnership. Both hospitals work closely together and often share the care of patients.

Meeting people's individual needs

- Peanut ward, the assessment centre and the minor injuries unit catered for the needs of individual children. There was accommodation available for parents to stay on the ward with children overnight.
- Treatment rooms within the Paediatric Assessment Unit were named and themed, such as Freddie Frog Room, Lilly Ladybird, Terry Turtle Room and Dizzy Dolphin Room. Staff told us this was important for children as when they frequently attended it afforded them comfort and familiarity.
- We heard how other services responded to support children – for example how a Keloid body suit to reduce the effects of keloid scarring was made for a child within an hour of the request.
- We were given a further example by staff of how special arrangements were made for an autistic child to have additional visits to the ward before undergoing any surgery. Surgery was then undertaken when the child's anxiety was reduced and they were fully comfortable with the surroundings, staff and the procedure.
- There were information leaflets available for many medical conditions, including child-friendly leaflets on diabetes, dog bites and asthma.
- Children were always placed on theatre lists early in the day which meant that they were often admitted as early as 7.30 a.m. However, this did mean that families travelling from outside the area sometimes found it difficult with young families.
- Activity facilities were provided with toys, colouring books and games to entertain children on the ward. Play activity specialists covered the ward to assist inpatients.
- The wards operated flexible visiting times to enable parents to visit or to stay with their child at all times.
- Translation services were available to those patients and families for whom English was not their first language.

Services for children and young people

Access and Flow

- Access to the hospital was through direct referral via the consultant or through the trauma coordinators. The trauma coordinators operated 24 hours a day, seven days a week and triaged all referrals.
- The hospital demonstrated innovative use of telemedicine to assess and treat patients in neighbouring hospitals and the community. Cameras had been funded for local emergency departments who could send photographs through to the hospital for immediate assessment and advice.
- We were told that the Trauma Coordinators were supported by a registrar. If required a consultant from QVH could also attend the referring hospital to assess an injury.

Learning from complaints and concerns

- Information was available for patients to access on how to make a complaint and how to access the Patient Advice and Liaison Service. A dedicated member of staff within the department, including the matron, reviewed all formal complaints received and concerns were raised with the Patient Advice and Liaison Service. All concerns raised were investigated and there was a centralised recording tool to identify any trends emerging. Learning from complaints was disseminated to the whole team to improve the patient experience within the department.
- Information was readily available for patients who wished to make a complaint, but who may have needed support to do so.
- The children's service at the trust had received two complaints in the period 2014/15. Neither complaint was with regard to any child coming to harm as a result of their treatment.

Are services for children and young people well-led?

Good



Overall we rated well-led as Good and there was a service-level clinical strategy for child health, which was aligned to the trust strategy. The strategic vision included both short and long-term priorities for the next one to two

years and three to five years respectively and included developments regarding the environment, finance, service provision and governance arrangements. There was a governance framework in place with responsibilities defined that monitored the outcome of audits, complaints, incidents and lessons learnt throughout the service. We looked at copies of governance meetings, risk registers, quality monitoring systems, and incident reporting practices. These showed that the management systems in place enabled learning and improved performance, and these were reviewed on an on-going basis. Staff told us that members of the senior management team were visible and approachable. Staff within the paediatric service told us the Director of Nursing and matron were visible and accessible. We observed the matron advising ward managers and staff on Peanut ward on several occasions. The Director of Nursing holds the position of executive lead for children's services and safeguarding. This is supported by a non-executive director who has a leadership background in children's services.

Vision and strategy for this service

- Staff told us that they were aware of and supported the trust vision and values.
- There was a service-level clinical strategy for child health, which was aligned to the trust strategy. The strategic vision included both short and long-term priorities for the next one to two years and three to five years respectively and included developments regarding the environment, finance, service provision and governance arrangements.
- There is on-going discussion between the trust and a local acute trust regarding the move of paediatric inpatient burns provision to the Royal Alexander Children's Hospital in Brighton. We saw minutes of the meetings held by the paediatric task and finish group, and an overseeing steering group. We noted that a new project manager has just been appointed to oversee the project.
- The Director of Nursing holds the position of executive lead for children's services and safeguarding. This is supported by a non-executive director who has a leadership background in children's services.

Governance, risk management and quality measurement

Services for children and young people

- There was a governance framework in place with responsibilities defined that monitored the outcome of audits, complaints, incidents and lessons learnt throughout the service. We looked at copies of governance meetings, risk registers, quality monitoring systems, and incident reporting practices. These showed that the management systems in place enabled learning and improved performance, and these were reviewed on an on-going basis.
- The clinical governance committee met monthly and was primarily concerned with the delivery of safe, high quality patient centred care, and to provide assurance to the team that care was safe. The systems that were regularly reviewed by the committee included: performance; incidents; risk; patient experience; quality improvements and sharing best practice; guidance and frameworks; health and safety updates; and information governance.
- The clinical governance committee was attended by an anaesthetist, the clinical educator, a pharmacist and the pain nurse and includes ward staff, the deputy director of nursing and . We saw from minutes of these meetings how incidents, complaints, risk and innovation were discussed and improvement and learning developed to be cascaded to staff teams. Minutes of Peanut ward meetings held monthly reflected that this information was in turn discussed appropriately.
- The trust risk register detailed one risk which related to the organisation not being compliant with national guidelines from Royal College of Paediatrics and Child Health. These guidelines "Facing the Future Standards for Paediatric Services - April 2011" are not being met due to lack of Consultant Paediatrician level input. The trust had put control measures in place to mitigate this risk which was reviewed on an on-going basis.

Leadership of service

- Staff told us that members of the senior management team were visible and approachable. Staff within the paediatric service told us the Director of Nursing and matron were visible and accessible. We observed the matron advising ward managers and staff on Peanut ward on several occasions. A ward manager told us they had regular bi-monthly meetings with the matron.

- We saw clinical leaders and managers encouraging supportive, co-operative relationships among staff and teams, and compassion towards patients. Staff were highly complementary about the frontline management team.
- When we spoke with junior doctors they told us that consultants were very approachable and supportive.

Culture within the service

- We saw that staff worked well together in multidisciplinary teams to provide holistic care to children. Staff told us the culture of the service was focused on meeting the needs of children, young people and their families.
- Staff described an open culture, where they were encouraged to report incidents, concerns and complaints to their manager. Staff we spoke with told us they felt able to raise concerns and felt that the organisation was transparent with a "non judgemental, no blame" culture.
- The staff that we spoke to were extremely proud to work for the organisation and felt that the care they provided was excellent. None of the staff we spoke with said they had experienced bullying from their colleagues or supervisors.

Public and Staff engagement

- The trust informed us that they used the Friends and Family Test (FFT) to collect feedback about services. In October 2015, 98% of inpatients said they were extremely likely/likely to recommend QVH to their friends and family.
- Staff within the paediatric service had been instrumental in developing unique aftercare opportunities for patients. One such initiative was called the CREW camp. This stands for challenging, recreational, educational weekend for all patients which is funded by local businesses and provides educational activity weekends for up to 30 ex patients. A committee of eight staff have been established to run the event which selects nominated children who they consider would get the most benefit from the activities.
- Patients told us that staff go the extra mile with staff voluntarily using their annual leave to run activities such as the CREW camp which enables children to realise

Services for children and young people

their own potential and capabilities. We heard how patients also now attend to support patients as mentors. Adult burns patients are also very active in raising funds to support these initiatives.

- Staff and volunteer workers told us that the trust newsletter was a valuable and interesting publication.
- The results of the NHS staff survey showed that the trust scored better than average for the extent to which staff think care of patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work, and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.







Innovation, improvement and sustainability

- The trust developed and actively uses a Telemedicine Referral Image Portal System which has been developed in collaboration with the London and South East of England Burns Network. Telemedicine is the use of telecommunication and information technologies in order to provide clinical health care at a distance.
- Telemedicine was chosen as the SE Coast Regional Winner in the 2008 Health & Social Care Awards in the category of "Innovative Information & Communications Technology" and went on to be a runner up at the National awards.
- This Innovative use of telemedicine allows trained staff to view a burn injury at a distance either in another hospital or via ambulance staff photos and give appropriate advice, assessment and advise transfer to most appropriate location.
- We saw how the staff used telemedicine between the four hubs for the assessment of patients utilizing the imaging process between hubs. For patients this means significantly less trauma as they can be assessed with

minimal travelling to ensure that they were receiving the best treatment in the most appropriate location. Staff described how they don't need to continually undress wound and undress child for various specialist to view as photos can be taken and shown to the surgical /burns and relevant teams.

- Junior doctors told us how this system is used to support their training and develop expertise when attending outpatient clinics in other locations.
- The trust has embarked on a Review of Paediatric services which are due for completion in February 2016. This review is being led by the non-executive director responsible for Quality Improvement, who has paediatric experience and previously held a Director of Nursing position.
- A new one stop shop has been commenced in the last 12 months for babies born with minor accessory digits where photos are requested prior to their first appointment at the Trust. This allows the photos to be reviewed by the paediatric surgeon and has resulted in most of these babies being treated within the ward environment under local anaesthetic on the same day as the appointment with no follow-up required. The feedback from the parents has been extremely good and has significantly improved the timeliness of this pathway for the families which enables patients to be treated at a much younger age.
- The trust is in the process of introducing nurse-led burns assessments. This is following the development of patient group directions for Peanut Ward and the Paediatric Assessment Unit and skill competencies. Nursing staff are assessed by the lead burns clinicians and following successful completion of competencies they are able to carry out the assessment of minor burns and plan the management.

Outpatients and diagnostic imaging

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

Information about the service

The Queen Victoria Hospital (QVH) outpatient department offers 60 to 70 clinics per week comprising of plastics, maxillofacial, corneoplastics and trauma as the main specialities. Cardiology, rheumatology, breast and general ear nose and throat clinics were provided as and when necessary for the local population. Some clinics were provided at other sites across Kent and Sussex. However the majority of clinics occurred on the QVH site. In the year August 2014 to July 2015 there were 162,554 outpatient attendances at the QVH site. A further 25,795 appointments were attended at 10 other sites across Kent and Sussex.

The diagnostic and imaging department carried out plain x-ray, cone beam computerised tomography (CT), non-obstetric ultrasound and fluoroscopy. MRI scanning was available two days a week via a visiting mobile scanner. One echocardiography clinic was available per week. Ultrasound and x-ray were available Monday to Friday 08:30 – 17:00.

There was a large therapy service situated in a spacious multidisciplinary therapy unit called the rehabilitation department. This provided specialist hand therapists, neurological therapies, a musculoskeletal and community based physiotherapy service, occupational therapy, speech and language therapy, and dietetics.

The sleep disorder centre is the largest sleep centre in the South East outside London, with a catchment area encompassing the whole of Sussex, much of Kent and Surrey, as well as parts of Hampshire. The centre diagnosed and treated all aspects of adult sleep medicine, for

example respiratory problems, insomnia and sleep related movement disorders. Overnight diagnostic sleep studies were performed six nights a week and outpatient medical and technician led clinics daily. There were six in-patient beds and four consulting rooms including a technician clinic room.

The prosthetic department was co-located with the MacMillan service and has the largest maxillofacial and general prosthetics department in the country. It provided a wide range of support to orthodontists and to maxillofacial and plastic surgeons.

We spoke to 10 patients and 38 staff including allied health professionals, nurses, doctors, health care assistants, technicians, radiographers, clinical scientists, clerical staff, and managers. We visited the rehabilitation unit, main outpatients and outpatient department 1 (OPD 1), the corneo department, the diagnostic and imaging department, the prosthetics department and the sleep centre.

The inspection was a combination of observation and focused interviews with key personnel. We looked at 3 sets of medical records, examined equipment and the environment and reviewed trust data and information.

Outpatients and diagnostic imaging

Summary of findings

There was a positive culture of reporting incidents and staff were aware of and used the incident reporting process. Clinical areas were visibly clean with cleaning rotas and check lists in place. Not all equipment had not been regularly checked and tested. Medicines were well managed with good support provided by the pharmacy team. Patient records were safely stored and their availability at clinic appointments was on the whole, good. There were safeguarding policies and procedures in place and staff were aware of safeguarding leads. Staff were up to date with their mandatory training.

Staff were aware of and followed best practice guidelines and evidenced based practice. There was good use of outcome measures both subjective and objective and these were used to ensure best practice was implemented. There was good access to internal and external training. All staff we spoke with had received an appraisal although this was not verified on the trust's recording system. There were competency frameworks in place for new and existing staff. Staff were aware of and implemented the principles of consent as identified in the Mental Capacity Act 2005.

Patient dignity and privacy was respected and maintained by staff where possible. Staff were kind, considerate and caring. We saw positive interactions between patients and staff. The results of the friends and family test were positive with 98% of patients stating they would recommend the service to family and friends. Patients told us they felt they were listened to and that they received good information about their care, explained in a way that was easy to understand.

Outreach outpatient clinics were available for patients across Kent and Sussex so that patients could receive a service close to their home. Where waiting lists for specific services had developed, plans were in place to reduce waiting times. Staff were aware of the trust complaints policy and were able to describe what they would do in the event of a patient making a formal complaint. Learning from complaints and concerns was shared at team meetings. There were practices and procedures in place to meet the needs of vulnerable people and patients with complex needs.

There was no specific strategy for outpatients, diagnostic and imaging and therapy services. Although there was no overall governance of these services, service managers attended trust meetings and information was shared with teams at regular meetings. Risks were identified by teams but were not regularly reported on department risk registers.

There was good leadership across the trust and staff felt supported and valued. Managers were visible and approachable. There was a culture and ethos of team working across the trust and staff morale was good.

Sustainability of services within the prosthetics department was well managed.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



There was a positive culture of reporting incidents and staff were aware of and used the incident reporting process. Infection control and hygiene was good and there were regular audits undertaken to ensure the standards were met. The main outpatient department was bright and welcoming but other areas were in need of decoration. All departments were clean and this was regularly audited. Not all equipment had been regularly maintained but the trust had plans to rectify this. There were limited suitable treatment areas that maintained patient privacy.

Medicines were well managed with good support provided by the pharmacy team. Patient records were safely stored and their availability at clinic appointments was good. Staff were aware of safeguarding processes and training had been received. All staff we spoke to said they were up to date with mandatory training. Environmental risk assessments had been completed ensuring patient safety. There was adequate staffing in each of the departments inspected. There was a major incident plan in place and staff had received appropriate training.

The kitchen in the therapy department remained open and there were no locks on any of the drawers where sharp knives were kept. Staff were not aware of the potential danger of this situation.

There were no alarms within the therapy department so staff were unable to call for help in an emergency situation. There were also no alarms in the toilet, which was located externally to the department. Therefore if patients or a member of staff needed help or assistance there was no way of raising an alert.

Incidents

- There was a positive culture of reporting incidents and staff were clear about the incident reporting process and were able to describe how it worked and the outcome of any investigations. Incidents were discussed at departmental meetings and staff were encouraged to report all incidents so that learning would improve practice. There were 230 incidents reported in the last 12 months.

- There were seven serious incidents reported in the last 12 months and one never event which related to wrong site surgery, (never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented). Of the seven serious incidents three related to confidential information leaks and these all occurred in a two month period at the beginning of 2015. An investigation had been undertaken and as a consequence, changes in practice in the outpatient department had been implemented. For example single and double sided photocopying batches, were not separated and a copy of a letter sent to a patient had another patients details on the reverse. The action and learning from this resulted in a change in photocopying processing to ensure that batches were appropriately sorted to reduce the risk further.
- An incident occurred in the therapy department that was not reported in a timely manner and no changes in practice had occurred as a consequence. The incident happened the week prior to the inspection and had still not been reported when we spoke to staff a week after the event. The incident involved a patient that had not been collected from the therapy department by patient transport, as arranged. When the therapy department was due to close, arrangements had been made for the patient to be transferred to another department and the patient was therefore, well looked after throughout the delay. However no incident had been recorded.
- There is a duty on all NHS providers to provide patients and any other relevant person, information in the event a reportable safety incident occurs. This is called the duty of candour. Staff were not trained in the duty of candour but were aware of the principles and described a culture of openness and honesty. We saw that this had been discussed at departmental meetings.
- Trusts are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (medical exposure) Regulations 2000 (IR(ME)R). Procedures were in place to report incidents to the correct organisation, including CQC, and a review of practices occurred when incidents were reported. We saw all incidents were recorded internally on the trust

Outpatients and diagnostic imaging

incident reporting system and within radiology there was timely notification of reportable incidents to the IR(ME)R inspectorate and the Health and Safety Executive (HSE) as appropriate.

- Staff were aware of how to report an incident and understood the Duty of Candour, and training is undertaken.
- For example patients who were affected by information leaks were apologised to and informed of the outcome of the investigations.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other relevant person within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has or may have occurred.

Cleanliness, infection control and hygiene

- Policies and processes were in place to ensure there was effective management of infection control, hygiene and cleanliness.
- Clinical staff had access to personal protective equipment as needed, such as disposable gloves and aprons, and these were worn when appropriate. We observed clinical staff were bare below the elbow, in keeping with trust policy, to help prevent the spread of infection.
- Monthly audits of staff hand hygiene were undertaken in all departments. We saw that the results and learning from audits had been discussed at team meetings.
- Quality and performance information about infection control was displayed in public waiting areas. For example infection control and hand hygiene audit results were posted on the notice board. The results of the last hand hygiene audit in July 2015 was 100%. Patients were therefore able to see the performance of clinics and how staff met the standards.
- Patients told us they had seen, and we observed, staff using the hand hygiene dispensers. Appropriate

numbers of dispensers were available and we observed patients and staff using them. There was lack of information displayed about how and when to use of the gel dispensers in all departments.

- Cleaning checklists of the environment were displayed in waiting areas and there were regular cleaning audits undertaken. In the most recent environment audit, departments scored an average of 88% compliance.
- All equipment was labelled with 'clean' labels and these were dated and signed.
- We saw that waste was separated and in different coloured bags to signify the different categories of waste. This is in accordance with HTM 07-01, Control of Substances Hazardous to Health (COSHH) and Health and Safety at Work Regulations.

Environment and equipment

- The therapy department was clean and tidy and all equipment was safely stored and safety checked.
- There was a lack of individual clinical rooms within the therapy department. This compromised the privacy and dignity of more sensitive patients for example the women's health service.
- The main outpatient area was bright and welcoming and situated in a new building. Conversely, outpatient department 1 was in an old part of the building and was dark and drab and the lights, which were on all the time, made little difference. The treatment area in OPD1 was cramped accommodating four curtained cubicles along with all dressings and treatment equipment. Staff maintained dignity of patients ensuring the curtains were closed during treatment sessions but privacy was an issue with everyone in the clinical area able to hear conversations.
- Self check-in stations were available in outpatients but these were only in English. Reception staff were available to check in patients who did not want to use or were unable to access the self check in machines.
- Waiting areas in outpatients were clean and tidy and patients had access to a range of information leaflets, although these were only available in English. In the main outpatient department there was a separate waiting area available for patients who required additional privacy due to health needs.

Outpatients and diagnostic imaging

- The trust had identified that not all equipment had been maintained as frequently as required. There was a range of equipment within outpatients that had not had annual maintenance checks. These were all considered to be low risk and plans were in place to ensure all equipment was listed and appropriately maintained.
- There was an annual check of all equipment in the prosthetics department and the department closed for two days in May for this to happen. Records were kept of this deep clean.
- Cardiac arrest trolleys were available in the main outpatient department and outpatient department 1. These were correctly secured and record of checks of equipment had been completed.
- The kitchen in the therapy department remained open and there were no locks on any of the drawers where sharp knives were kept. Staff were not aware of the potential danger of this situation.
- There were no alarms within the therapy department so staff were unable to call for help in an emergency situation. There were also no alarms in the toilet, which was located externally to the department. Therefore if patients or a member of staff needed help or assistance there was no way of raising an alert.

Medicines

- We checked the storage of medicines in the outpatient clinics and found that all medicines were stored securely in a locked cupboard or locked fridge. We saw examples of accurate and up to date fridge temperature checks to ensure the correct parameters were maintained. The clean utility room was accessed via a code controlled door. Medicine and fluid cupboards were locked in the utility room and the fridge key was stored inside the controlled drugs cupboard.
- There was good security and control of prescription pads in the Corneo department and each prescription was easily auditable. However this was not the case in the main outpatient department. There were five part used FP10 prescriptions pads, from another trust in a locked cupboard in the clean utility room. Access was controlled but there was no audit trail in place to know

what was held in the cupboard against what had been issued. FP10 prescriptions could therefore be misused and or lost without easily detecting the incident had occurred.

- There was good support provided by the pharmacy department. They issued replacement prescriptions on a one for one basis. Patients were counselled on medicine use at the dispensary and this was supported by information leaflets where appropriate. The pharmacist provided a medicines helpline number for patients to access in the event of any queries.

Records

- Records were safely stored in most services. We observed that notes in outpatient department 1 (OPD1) were held in a treatment room and the door was left open. Staff were aware of a potential security breach and ensured the door was kept closed until the end of the clinic. All notes in other departments were kept in a locked cupboard.
- Medical records were held off site but were sent to the departments the day before the clinic occurred. There was a process in place to ensure that where records were not available, the last clinic attendance letter was printed off and a set of temporary notes started.
- All patients we spoke to told us their notes were always available at the clinic.
- A clinical notes audit was completed every six 6 months in the therapy department. We looked at three records within the therapy department. In two sets of records there was no evidence of an initial assessment, a problem list, a treatment plan or goals. The other set of records was fully completed.
- All records were hand held i.e. there were paper records and there was no electronic storage of patient information.

Safeguarding

- There were policies and procedures in place to protect adults and children from abuse and staff told us they were able to access these on the intranet. Hard copies were held in the policies file in the staff room.
- Staff were aware of the safeguarding process, who the trust lead was and were confident to raise safeguarding concerns. For example one member of staff was

Outpatients and diagnostic imaging

concerned about the relationship between a patient and their carer. The safeguarding lead was not available so this was referred to the site practitioner who responded to the situation and a safeguarding referral was made.

- The trust targets for 80% staff trained level 1 safeguarding training in adults and children had been achieved or exceeded for all staff groups within the outpatient departments.

Mandatory training

- An appropriate and comprehensive portfolio of mandatory training was available to all staff groups.
- All staff we spoke to told us they were up to date with mandatory training. We observed a manager's training spreadsheet which listed all staffs training and this demonstrated that staff were up to date. However, information we received from the trust indicated that not all training was up to date.
- For the outpatients department the trust data indicated strong compliance with the 80% target.
- However compliance was much weaker in orthodontics notably Medical staff basic life support (adult 73% and paediatric 45%), Information Governance (all staff groups below 70%) and Medical staff infection control (73%). A similar pattern was indicated in the data for the sleep clinic.

Assessing and responding to patient risk

- Environmental risk assessments had been completed in each of the departments. Staff were aware of the need to ensure equipment was safely stored and there were no risks of slips and trips.
- The sharps policy was observed in the main outpatient and therapy departments and was also available on the intranet. We observed staff implementing this policy and sharps boxes were stored in lockable cupboards when not in use.
- Staff within outpatients, diagnostic imaging and the therapy department had received training in emergency life support (resuscitation) exceeding the trust target of 80%.

- Patients deteriorating rapidly in the departments would have immediate resuscitation and be transferred to an appropriate emergency department via ambulance. There had been no reported incidents of this nature.

Staffing

- There were minimal vacancies in outpatients and the level of staff sickness was low. In the corneo department the vacancy was 2.42wte and sickness levels were 1.9%. In outpatients the vacancy was 0.64wte and sickness levels were 3.4%.
- Temporary staffing was primarily used in the corneo department. No agency staff were used in outpatients but bank staff were, although this was minimal.
- There was a local induction checklist for each department that staff were required to complete prior to commencing full duties. All newly appointed staff were supernumerary for the first two weeks so that induction, competencies and orientation was completed.
- There were no vacancies in the diagnostic and imaging service or the therapy services.
- All clinics were led by consultants or nurse practitioners.

Major incident awareness and training

- There was a business continuity plan in place for the outpatients department. Staff had received major incident awareness training and we observed the lock down action card in one of the departments.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Staff were aware of and followed best practice guidelines and evidenced based practice. There was good use of outcome measures both subjective and objective and these were used to ensure best practice was implemented.

There was good access to internal and external training. All staff we spoke with had received an appraisal although this was not verified on the trusts recording system. There were competency frameworks in place for new and existing staff. Staff were aware and implemented the principles of consent as identified in the Mental Capacity Act 2005.

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Evidence-based care and treatment

- Staff were aware of national and best practice guidelines. For example staff working in hand therapy services were following evidence based practice when implementing tendon repair guidelines as stipulated by the British Association of Hand Therapists (BAHT).
- Staff were aware of trust policies and procedures and were able to demonstrate where these were available on the intranet and within the department.
- Staff told us there was a dementia strategy in place in the outpatient department. There was a dementia lead within the trust and plans were being developed to ensure the environment was more friendly and less clinical. A butterfly scheme was in place where patients who attended with carers would receive urgent attention and waiting times would be kept to an absolute minimum.
- We saw comprehensive policies and procedures in place in the imaging department and these were in line with regulations under IR(ME)R and in accordance with the Royal College of Radiographers standards.

Patient outcomes

- The sleep clinic were using five patient pathways and patient reported outcome measures were being used on respiratory patients. These related to quality of life outcomes and the EPWORTH sleepiness scores (ESS). A recent audit of the ESS had shown that 59% of patients had seen a drop in their score, meaning patients were less sleepy during the day. Plans are in place to develop these outcome measures further.
- There was good use of outcome measures and auditing of intervention in the therapy department. For example a falls group had been set up and the outcomes of treatment were audited against three valid outcomes. The results of the audit called balance and bones, was displayed in the department for all staff and patients to see.
- Research and audit was an integral part of the prosthetics department. Audits were regularly undertaken to improve services for patients. For example the eye socket in patients requiring a false eye often droop due to the weight of the false eye. Clinicians had researched different materials and now use a much

lighter material. This was audited from a patient satisfaction perspective but also clinically in reducing the number of eye infections and the consequent use of antibiotics.

- Changes in process had occurred as a result of an audit that had taken place to reduce the number of did not attends (DNAs). DNA rates in physiotherapy were 13%. The audit identified that appointments were given too far in advance (two months). The department now offer appointments four weeks in advance and text messages are used to remind patients of their appointment. A re-audit has not been conducted but anecdotally staff reported that there had been a reduction in the number of DNAs.
- An audit was being undertaken on the outcome of those patients who were splinted after injection and whether this prevented surgery.
- Subjective outcomes were widely used by outpatient and therapy staff. For example how patients viewed their pain levels at the start of treatment and recording a score at each intervention. This allowed therapists to adjust the treatment and ensure the most effective treatment was provided.

Competent staff

- Appraisal rates varied across the different departments. We were told by senior staff that all appraisals (100% according to data sources) had been completed in the diagnostic and imaging department and local information confirmed that all diagnostic and imaging staff had received an appraisal in the last year.
- The trust information about the sleep clinic showed 83% of staff in all staff groups had received an appraisal in 2014/15. In orthodontics only administrative and clerical staff (50%) did not exceed 90% completed appraisals in 2014/15.
- All staff we spoke to said they had received an appraisal and in some instances they had received a six monthly review. Low numbers of administrative and clerical staff had received an appraisal according to trust data.
- A range of internal training events were available to staff. These were planned for the year, displayed in the staff room and discussed at team meetings. Therapy staff

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informed us there was weekly in service training where staff had the opportunity to discuss complex cases. Admin and clerical staff told us they had attended internal courses on leadership and mentorship.

- Therapy staff told us they received weekly or fortnightly supervision dependent on the grade of staff. In other areas supervision occurred four to six weekly. No formal records were kept of these meetings.
- Staff told us they were supported to attend external training events. For example one member of the therapy team was due to complete injection therapy training alongside the consultant so that the service could be offered more widely. The world conference in orthodontics was attended by dental nurses in outpatients. A presentation was given at the team meeting to share learning.
- The diagnostics and imaging department ensured all appropriate staff had received up to date training. For example, all surgeons had received IRMER training and checks had been undertaken to ensure certificates were in place before use of theatre equipment commenced.
- Staff within prosthetics kept up to date with latest advancements and were part of the national prosthetics group. Each qualified member of the team had published articles in peer review journals and were involved in teaching nationally and internationally.
- Nurses within corneoplastics had taken an extended scope role to provide nurse led clinics for follow up appointments. This meant that patients were able to be seen quickly and more frequently. Staff were planning to share their experience with another local trust so that patients living on the south coast could be seen locally.
- All technicians within the sleep clinic had completed the registered polysomnographic technology training.

Multidisciplinary working

- There was evidence to support good multidisciplinary working in the therapy department and occupational therapists, physiotherapists, speech and language therapists and the dietician attended team meetings. The manager of these services attends a team leaders meeting which is held across the trust every month. A range of agenda items such as incidents, complaints, audit updates and workforce are discussed. Information is cascaded as appropriate.

- Staff within outpatients told us there was good multidisciplinary working in outpatients and we observed a therapy led clinic where therapists, nurses, health care assistants and doctors worked together. However, outpatient department meetings tended to be single specialty and only nurses met monthly whilst therapists had a separate monthly meeting.
- Good relationships have been developed with neighbouring trusts in the provision of services not available at the hospital. For example there was a service level agreement in place for patients to receive urgent CT scans and out of hours reporting when the radiologist was not available on site.
- The diagnostic and imaging department and outpatients held 15 minute huddle meetings every day so all staff were aware of the plans for the day.
- The radiologist chaired the Radiation Protection Committee. Quarterly meetings were attended by the radiation protection supervisor, the service manager and the radiation protection advisor. We observed minutes of meetings where incidents, complaints and training were discussed.
- The sleep clinic had developed a good working relationship with another Trust that also provided sleep services in order to benchmark services. Staff also attended the southern sleep services network, which met quarterly and provided clinical support to staff.
- Two patients told us they thought there was good communication between the hospital and the GP and or dentist so everyone was up to date with what was happening.

Seven-day services

- The X-ray department had on call out of hours rotation between four radiologists and worked with a local acute trust to provide this service. During the working day the service was available 5-8pm weekdays and 8-8 at weekends.
- Seven day services were not provided in outpatients or therapy departments. Some outpatient clinics were held on a Saturday to cope with demand. This was also the case in the sleep clinic.

Access to information

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- Medical records were held off site and were sent to the relevant department the day before the clinic occurred. Reception staff monitored the availability of patients' notes. If patient notes did not arrive they would be searched for and if they could not be found a temporary set would be developed for clinic; the latest letters and test results were included in the temporary file.
- Patients told us their notes were always available when they attended follow up appointments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had received up to date training in the principles of the mental capacity act for example in diagnostics and imaging service 87% of staff had received training compared to 100% of healthcare scientists working in the sleep clinic.
- There was a Mental Capacity Act flow chart incorporated into a brightly coloured best interest decisions form and staff explained when this would be used.
- All patients told us consent was sought and was not assumed. One patient told us consent was sought at every appointment.

Are outpatient and diagnostic imaging services caring?

Good



Overall we rated caring for outpatients and diagnostic imaging services as good. Patient dignity and privacy was respected and maintained by staff where possible. Staff were kind, considerate and caring. We saw positive interactions between patients and staff.

The results of the friends and family test were positive with 98% of patients stating they would recommend the service to family and friends. Patients told us they felt they were listened to and that they received good information about their care that was explained in a way that was easy to understand.

Compassionate care

- The NHS Friends and Family Test (FFT) gives every patient the opportunity to feed back on the quality of services. Patient surveys and the FFT were regularly

carried out in outpatient services. Scores were positive and between October 2014 and July 2015 outpatient services scored consistently above 95%. The most recent result in October 2015 was 98% of patients stating they would recommend the service to friends and family.

- In the last patient survey undertaken by the Care Quality Commission the outpatient department scored better than other trusts for doctors listening to what the patient had to say, in getting answers from the doctor they could understand and having confidence and trust in the doctor examining and treating them.
- Patients told us and we observed staff were friendly, kind and compassionate. One patient told us they thought staff were competent and that they really cared. Another patient spoke about how they felt their health had been completely turned around by staff at the hospital after being treated elsewhere. They said, "all the team are great."
- Staff went out of their way to ensure patients were safe. For example one patient was escorted to pharmacy to collect an eyepatch and the member of staff ensured this fitted properly, made sure they were able to walk safely and would be safe at home. Aftercare advice was given and information about when and how to contact the department if they needed advice.
- Patients told us that their privacy and dignity was always respected and one patient said that staff in outpatients go out of their way to ensure privacy and dignity at all times.
- One member of staff was passionate about the services they provided and hand stitched all pressure garments to ensure they met the needs of the individual patients.

Understanding and involvement of patients and those close to them

- Patients were well informed about the examinations they were undergoing and about onward care and the availability of results. We observed patients being given choices in appointments and staff listening to what patients wanted.
- One patient told us he was impressed to receive an informative appointment letter and a reminder text about his appointment time.

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- There was a separate, slightly secluded waiting area for patients and carers who needed privacy.
- Patients told us they were fully involved in their care and that information about the treatment process was explained. They felt fully involved in the decisions about their care.

Emotional support

- A volunteer was available in the waiting area to assist patients in using the touch screen to 'check in'. The volunteer was also available to escort patients to secondary waiting areas or clinic rooms and to help vulnerable patients to ensure their comfort.
- One patient told us staff had discussed the care that was required, had given a good explanation of the condition and the probable outcomes. This was done in a professional, yet sympathetic way.
- A psychological therapies clinic had been developed within outpatient services for patients with life changing body image surgeries.
- A head and neck pathway had been developed to ensure all pre-operative interventions were undertaken in one day. Patients were given a named nurse who was responsible for the patient journey. Patients had their pre-assessment appointment, visited the intensive care unit, theatres and the dietician in one day so that there was minimal disruption for the patient and they were familiar with the various departments they would need to visit throughout their treatment.
- In the clinical room within the prosthetics department there was a small breakout area for patients and their carers. This was used for patients who were finding it difficult to come to terms with the physical changes that had occurred. Mirrors within this clinical area were obscured.

Are outpatient and diagnostic imaging services responsive?

Good 

Overall we rated responsiveness for outpatient and diagnostic imaging services as good.

Outreach outpatient clinics were available for patients across Kent and Sussex so that patients could receive a service close to their home. Where waiting lists for specific services had developed, plans were in place to reduce waiting times.

Staff were aware of the trust complaints policy and were able to describe what they would do in the event of a patient making a formal complaint. Learning from complaints and concerns was shared at team meetings.

There were practices and procedures in place to meet the needs of vulnerable people and patients with complex needs.

Service planning and delivery to meet the needs of local people

- A new partnership to provide musculoskeletal services across central Sussex had recently been developed. QVH physiotherapy service had been part of the planning of this and it was anticipated that where there were no key performance indicators externally but that these would be developed in house.
- QVH offers general medical, paediatric outpatient care and care for the older person. Rehabilitation after joint surgery or stroke, for mobilisation problems or flare-ups of existing conditions such as respiratory disease is available along with treatment for patients with Parkinson's disease, strokes and other musculoskeletal disorders.
- Musculoskeletal physiotherapy had seen a steep increase in the number of referrals over the last six months and there were long waiting times for assessment and treatment. The manager of the therapy department told us that a number of different options had been considered to reduce the waiting times. A band 5 physiotherapist had been employed on a fix term contract to help reduce the waiting list.
- There were a large number of outpatient clinics that were held at other sites across Kent, and Sussex. This was so that patients could access services locally.

Access and flow

- There were 162,554 outpatient attendances at the QVH site between August 2014 and July 2015. A further 25,795 appointments were attended at 10 other sites across

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Kent and Sussex. There were 33,169 therapy attendances between August 2014 and July 2015. The sleep clinic had seen a 14% increase in the number of referrals between August 2014 and July 2015.

- 9.6% of appointments were cancelled within six weeks of the date of appointment and 3.9% of appointments were cancelled more than six weeks of the date of appointment.
- Did not attend (DNA) rates for the period January to December 2014 were consistently lower than the England average. The outpatient department sent a text message prior to the appointment as a reminder to attend.
- The trust performed better than the England average for the percentage of patients waiting more than six weeks for diagnostic tests in the period January to December 2014.
- The NHS constitution states patients have the right to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected (RTT). The national standard for two week waits was 93% of patients seeing a specialist within two weeks of a GP referral. Between April 2014 and March 2015 the trust were seeing 98% of patients within the two week standard consistently above the England average.
- The trust has consistently attained the 93% target of patients being seen within two weeks of an urgent GP referral. The has been less consistent in attaining both the 31 day diagnosis to first treatment and the 62 day referral to first treatment targets but has been successful in the last three quarters of this year.
- Although the percentage of incomplete pathways within 18 weeks was below the England average between September 2014 and October 2014, the trust performed consistently above the England average from November 2014 to July 2015 and has attained the target of 92%.
- Non-admitted referral to treatment times was generally in line with the England average, however there was a decrease in performance between Jun-14 and Nov-14 but from Dec-14 the performance recovered to above the England average. From December 2014 the trust has attained the 95% target.

- Radiology reporting times were undertaken on the same day. 100% achieved for GP referrals and patients attending the minor injuries unit. Patients told us the service received from diagnostics and imaging was quick and efficient.
- There were no reported backlogs in radiology reporting.
- There were long waiting times within the musculoskeletal physiotherapy service. Urgent patients were seen within one to two weeks and subacute patients waited 12 weeks to be seen. The longest waiting time was 16 weeks. A plan was in place to reduce the waiting times.
- At the listening event held prior to the inspection patients told us that outpatients would ring if there were cancellations to try and fit other patients in if they could. One patient told us they were actually out of the hospital before their allotted appointment time when they had arrived early.

Meeting people's individual needs

- People we spoke to told us that waiting times to be seen once in clinic were good and never more than five to ten minutes. However, this was dependant on the clinic. We observed one clinic that was running 50 minutes behind schedule. In the situation where clinics were overrunning we saw that patients and their carers were kept informed. Staff would contact the site manager to waive the additional parking charges so that patients did not become distressed and feel they needed to leave before their appointment time.
- Information leaflets were widely available across all areas but were only written in English. There was no access to leaflets in any other language.
- Staff told us they had never had any problems in booking interpreters or signers when required and the service was quick.
- There were limited materials available for patients whose first language was not English and therefore a potential risk of patients not accessing important information.

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- Easy read FFT questionnaires were available for patients with a learning disability. Patients who attended the department who had a learning disability had a passport that helped staff understand their preferences and assisted in better communication.
- There were dementia champions within the outpatient department. They had suggested some environmental changes to make the area less clinical. There was a butterfly scheme in place which meant that on arrival, staff were notified and patients were given priority so that waiting times were minimal.
- There was a positive culture of dealing with complaints and one member of staff told us the trust were proactive in responding to complaints about staff attitudes.

Are outpatient and diagnostic imaging services well-led?

Good



Overall we rated well-led for outpatient and diagnostic imaging services as good.

Learning from complaints and concerns

- Staff were aware of the trust complaints policy and were able to describe what they would do in the event of a patient making a complaint. Staff told us they would try to support the patient resolve the issue immediately at a local level. In the event of a formal complaint, staff were aware of information they could provide for the patient to help them in the process. This included knowledge of the PALS service.
- There were 17 complaints received between August 2014 and Sept 2015 relating to outpatient services and four received in relation to the sleep clinic. All had been appropriately logged and satisfactorily resolved. Learning from complaints and concerns was shared at team meetings.
- For example a child with learning disabilities had to wait in the clinic before being seen and the parent complained that more awareness training should be given to the reception staff in this matter. Also there was a lack of communication from the staff in keeping them informed that there were delays. Action was taken by the team and training in caring for people with learning difficulties attending out patients was implemented.
- Some patient information leaflets were available in the therapy department but there were no patient advice and liaison service (PALS) leaflets or posters that were obvious and visible.
- One patient we spoke to did not know about the complaints process but did not feel they would ever need to complain. They told us they would start with the reception staff.

There was no specific strategy for outpatients, diagnostic and imaging and therapy services. Although there was no overall governance of these services, service managers attended trust meetings and information was shared with teams at regular meetings. Risks were identified by teams but were not regularly reported on department risk registers.

There was good leadership across the trust and staff felt supported and valued. Managers were visible and approachable. There was a culture and ethos of team working across the trust and staff morale was good.

Sustainability of services within the prosthetics department was well managed.

Vision and strategy for this service

- There was no specific local strategy for outpatients, diagnostics and imaging and therapy services.
- The trust had a clear plan of business development via the placement of specialist outpatient clinics in other trusts across Kent and Sussex.
- The trust had recently developed a capital investment plan with the aim of improving the décor and facilities in some of the outpatient and rehabilitation services.

Governance, risk management and quality measurement

- There was a governance framework operating within each of the three business units which had recently been developed but this was not supported by specific governance meetings for outpatients, therapies or diagnostic and imaging.

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- We observed that incidents, risks, policies and procedures and complaints and compliments were discussed at monthly team meetings.
- There was a matron's dashboard within outpatients that was used to monitor performance. Each speciality received monthly information about staff sickness rates, patient feedback, outcomes of sit and see, (this is where staff interactions are observed), and the results of audits such as hand hygiene, bare below the elbow and uniforms. There were no issues identified on the dashboard that would raise concerns, for example the results of the last hand hygiene audit in July 2015 was 100%.
- Senior staff attended the trust clinical governance meetings and business unit meetings where policies and guidelines, risk registers, incidents and complaints were discussed. Information from these meetings was cascaded to teams via the monthly department team meetings. We observed the minutes of these meeting where relevant information had been discussed.
- Staff were aware of department and service risks and we observed these had been discussed in outpatient team meetings. However these were not logged on the department or corporate risk register. There were six risks identified on the unit register. Three related to incidents raised in 2013, two in 2014 and one in 2015. These risks had been recently reviewed and action plans were in place but none had been closed and no new risks identified. In diagnostic and imaging services, risks for the service had been identified and actions were in place to prevent these happening. We observed the Radiation Protection Committee Meeting minutes where risks were discussed and the risk register was attached. This was also the case in prosthetics, where risks were an integral part of their monthly meetings.

Leadership of service

- The outpatients and therapy units led by a senior manager and Matron.
- All staff we spoke to told us that leadership was good. Managers were visible and approachable. We observed good interactions between staff and saw that managers were available in clinical areas and were part of the team.

- Senior managers told us that leadership within the trust was supportive and there was an open and honest culture in working together to develop and innovate services.
- Staff told us the chief executive and director of nursing were visible and were often seen in different departments. The chief executive had recently sat in the radiology reception and helped the cleaner with their duties.

Culture within the service

- There was a culture and ethos of team working across the trust. Staff were proud to work for the organisation and morale amongst staff was good.
- Patients told us there was a good rapport amongst staff and that Doctors and nurses interacted well. It gave the patient confidence that the department was well led and that it worked well.

Public engagement

- Each department used the Friends and Family Test and patient surveys to capture patients' feedback. The trust had implemented a number of changes in response to feedback received. For example the introduction of media screens in outpatient departments providing better information about waiting times in the clinics and installing self-check in kiosks making it quicker and more convenient to register.

Staff engagement

- Staff told us they felt supported by their managers and felt confident to raise issues of concern and that these would be listened to and actioned. Staff said they felt valued by the trust.

Innovation, improvement and sustainability

- Sustainability in staffing levels within the prosthetics department was well managed. All staff working within the department had special interests and specific skills but were able to undertake all prosthetic procedures. Staff were involved in teaching nationally and internationally and two students were on placement as part of the scientific department programme training to be maxillofacial prosthetists.
- There was good innovation across outpatients. For example in the corneoplastic department nurse led

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clinics had been developed in line with best practice and NICE guidelines. A number of follow up clinics were provided which meant that patients were seen more quickly and more frequently

Outstanding practice and areas for improvement

Outstanding practice

- The trust developed and actively uses a Telemedicine Referral Image Portal System which has been developed in collaboration with the London and South East of England Burns Network. Telemedicine is the use of telecommunication and information technologies in order to provide clinical health care at a distance. Telemedicine was chosen as the SE Coast Regional Winner in the 2008 Health & Social Care Awards in the category of “Innovative Information & Communications Technology” and went on to be a runner up at the National awards. This Innovative use of telemedicine allows trained staff to view a burn injury at a distance either in another hospital or via ambulance staff photos and give appropriate advice, assessment and advise transfer to most appropriate location.
- Staff within the paediatric service had been instrumental in developing unique aftercare opportunities for patients. One such initiative was called the CREW camp. This stands for challenging, recreational, educational weekend for burns patients which is funded by local businesses and provides educational activity weekends for up to 30 ex patients. A committee of eight staff have been established to run the event which selects nominated children who they consider would get the most benefit from the activities.
- The prosthetics department was cutting edge and provided a patient focussed individualised service. Clinicians worked with patients to ensure the best outcomes were achieved. Staff were enthusiastic, dedicated and were committed to continual professional development publishing regularly in professional journals. This meant that patients received the most up to date advancements in prosthetic development.
- The patient pathway for head and neck patients was comprehensive. Patients attended a pre-assessment appointment, were allocated a named nurse and visited other departments in the hospital that would be part of the treatment intervention. There was a separate waiting area in outpatients so that patients had privacy whilst waiting to be and seen and a psychology service was available to support the emotional needs of patients coming to terms with life changing body image issues.
- The trust had made innovative use of telemedicine in order to reduce the need for hospital admission, improve the patients experience and provide teaching and learning for staff.
- Staff were taking exceptional steps to improve the hospital experience for patients living with dementia. Allowing extra time during assessment, facilitation families in supporting the patient, awareness of the environment and equipment in relation to vulnerable patients and the use of distraction accessories such as ‘twiddle muffs’ demonstrated that the needs of vulnerable patients were taken into consideration and steps taken to personalise their care and treatment.
- The burns outreach nurse post was an innovative solution to the problems of dealing with burns in the community. Patients were able to be discharged quicker with continuity of care and treatment.
- The hospital’s audit office undertook the task of monitoring and auditing the quality of care and treatment across the trust. The staff demonstrated passion and enthusiasm for improving patient experience through the use of data and audit.

Areas for improvement

Action the hospital MUST take to improve

- The provider must ensure that all medication in theatre is stored appropriately.

Action the hospital SHOULD take to improve

- The trust should continue to review how it benchmarks itself against national quality standards

Outstanding practice and areas for improvement

- The trust should review how patients pain is managed specifically when carrying out dressing changes.
- The trust should continue its review of governance arrangements so that critical care has its own individual agenda.
- The trust should ensure that departmental risks are identified, recorded and regularly reviewed.
- The trust should ensure there are mechanisms in place for staff and patients to raise an alert in an emergency situation.
- The trust should ensure all incidents are reported in a timely manner.
- The trust should ensure the décor is refreshed and updated in outpatient department 1.
- The trust should ensure there are adequate facilities for patients attending the hand therapy clinic and that privacy is maintained.
- The provider should ensure that all COSHH (Control of substances hazardous to health) products should be stored appropriately.