Care Quality Commission

Royal National Orthopaedic Hospital NHS Trust

Royal National Orthopaedic Hospital NHS Trust (Stanmore)

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Medical care	Outstanding
Surgery	Good
Critical care	Good
Services for children and young people	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal National Orthopaedic Hospital – Stanmore is the main location of the Royal National Orthopaedic Hospital NHS Trust. It is the largest specialist orthopaedic hospital in the UK, with 220 beds, and is regarded as a leader in the field of orthopaedics, both in the UK and worldwide. As a national centre of excellence, the trust treats patients from across the country, many of whom have been referred by other hospital consultants for second opinions, or for treatment of complex or rare conditions.

The Royal National Orthopaedic Hospital NHS Trust has been selected as one of the first specialist trusts to be inspected under CQC's revised inspection approach. It provides surgery, medical care for spinal and rehabilitation patients, critical care and children and young people's services.

The team of over 30 included CQC inspectors and analysts, doctors, nurses, Experts by Experience and senior NHS managers. The inspection took place on 7, 8 and 9 May 2014.

Overall, we rated this hospital as 'requires improvement'. We rated it 'outstanding' for providing caring and effective care but it required improvement for the services to be safe, responsive and well-led.

We rated medical care as 'outstanding' and surgery and critical care as 'good'. However the outpatient services and children and young people's services 'requires improvement'.

Our key findings were as follows:

- The fabric of the building was not fit for purpose – it does not provide an adequate environment to care and treat patients.
- There was a significant focus on culture, values and behaviours of all staff.
- Patients praised staff and the good care they received. The NHS Friends and Family Test results were higher than the national average. The response rate was extremely high.
- Staff were caring and compassionate and treated patients with dignity and respect.
- Overall staff followed good infection control practices. The hospital was clean and well maintained and infection control rates in the hospital were within a statistically acceptable range.
- Staffing levels and the skill mix of staff met patients' needs.
- The medical care for spinal injury patients and patients receiving rehabilitation was outstanding.
- Some patients had unnecessary waits at their outpatients appointments.
- The children and young people's service was not responsive to their needs.

We saw several areas of outstanding practice including:

- Outstanding clinical outcomes for patients.
- Innovative surgery was being carried out to improve patients' quality of life. For example, limb lengthening for patients with skeletal malformation.
- The executive board demonstrated leadership and vision for the hospital.
- Staffing levels and the skill mix of staff met patients' needs.
- Effective multidisciplinary working putting the patient first.
- The services provided by the Spinal Cord Injury Centre (SCIC) and on the Jubilee Rehabilitation Unit (JRU) were consistently person centred and responsive to their needs.
- A hotel-based rehabilitation programme supporting patients to recover from surgery and have a normal daily life.
- A ward dedicated to providing wound care to patients with appropriately skilled staff.
- Some wards had started to use a drink container that attached to equipment and could be kept with patients at all times to ensure patients were kept hydrated, especially during rehabilitation sessions.
- The training for surgical trainees was excellent

Summary of findings

- The education for children and young people's was well integrated into the service, and inclusive and innovative teaching methods meant that children and young people could continue to access learning throughout their hospital stays.

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

Importantly, the trust must:

- The design and layout of the premises is suitable for all service users.
- To continue focus significantly on culture, values and behaviours of all staff.
- The paediatric resuscitation equipment is checked regularly to assure it is ready for use if required.
- The World Health Organisation (WHO) surgical safety checklist is used and completed at each stage of surgery and radiology.
- Staff that treat children and young people are up-to-date with the appropriate level of safeguarding training.
- The needs of children and young people are considered in scheduling operations.
- The learning from incidents is widely shared.

In addition the trust should:

- Develop the services across seven days.
- Review its use of opioids prescribed for pain relief for older people as it is recognised as can be a contributory factor in falls and increased confusion.
- Consider the mechanisms in place for identifying if equipment including mechanical ventilators, cardiac monitors and mattresses used to prevent pressure ulcers are clear to all when testing is needed.
- Ensure all staff are aware of support mechanisms such as the employee assistance programme. The RCN recommends there should be formal support mechanism available due to the challenging and highly specialised nature of the service provided, particularly with children and young people.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Outstanding ☆	The medical wards were safe, effective, caring, responsive and well-led. Staff were very caring and patients were consistently at the heart of their own care. They were involved in all aspects of their care. The service was designed and delivered to meet the all the needs of patients. Patients had access to rehabilitation therapies that assisted them in a normal life following surgery. There was enough staff with the appropriate skills to provide care. Patients had good outcomes and received the care and treatment they required when they needed it. There was good multi-disciplinary working. The local leadership was valued and staff felt supported. .
Surgery	Good ●	Overall, patients received safe, effective, compassionate care delivered by knowledgeable, skilled staff. Patients expressed their praise for staff, and their delight and satisfaction in the outcome of their surgery. The trust is a recognised world leader in treating patients with complex orthopaedic conditions, and has a record of using pioneering treatment to achieve very good outcomes, which were published as part of research programmes. The trust is a tertiary centre, and performs a higher proportion of revisional surgery than other trusts Adherence to the World Health Organization (WHO) surgical safety checklist was not embedded by all staff carrying out surgery or interventional procedures in theatres and radiology.
Critical care	Good ●	Patients received appropriate care and treatment in accordance with national guidelines. There were sufficient numbers of staff on duty, and enough equipment to meet patients' needs. Systems were in place to monitor the quality and safety of patient care provided. Staff were knowledgeable and compassionate. They were aware of the incident reporting systems and told us that they were encouraged by senior staff to report incidents and raise awareness of patient

Summary of findings

			safety issues. Patients were fully informed and satisfied with the outcomes of their treatment. They told us that they were cared for in a supportive way, and found staff very friendly.
Services for children and young people	**Requires improvement**		The service was effective and caring, however it was not responsive to meet the needs of children and young people and not always safe and well led. The ward environment was inadequate; it was small and did not provide sufficient facilities. Due to the location of the ward, children and young people ward is the only ward where patients have to be taken outside in order to access and return from theatres. Leadership within the children and young people's service was fragmented. Progress of some of the actions following the external review carried out in 2005 and 2009 were not completed and acknowledged by the trust.
Outpatients	**Requires improvement**		The service was safely managed caring, effective but it required improvement in its responsiveness and leadership. Patients told us that the service was responsive to their clinical needs; however some clinics ran late most of the time. 26% of the clinics started late. There was no key performance indicator for sending out clinic letters following consultation to patients and their GPs. A significant proportion of letters were not sent out for over one month. There was an exception within the trust that letters regarding patients who had cancer would be sent out within 48 hours. The leadership team were aware of the issues but had not addressed them as they were not responsible for the clinical divisions who booked appointments.

Requires improvement

Royal National Orthopaedic Hospital NHS Trust (Stanmore)Orthopaedic Hospital - Stanmore

Detailed findings

Services we looked at
Medical care (including older people's care); Surgery; Critical care; Services for children and young people; and Outpatients

Contents

Detailed findings

Background to Royal National Orthopaedic Hospital NHS Trust (Stanmore)

The Royal National Orthopaedic Hospital NHS Trust is the largest specialist orthopaedic hospital in the UK, with 220 beds, and is regarded as a leader in the field of orthopaedics, both in the UK and worldwide. As a national centre of excellence, the trust treats patients from across the country, many of whom have been referred by other hospital consultants for second opinions, or for treatment of complex or rare conditions. Its inpatient activity was 15,842 in 2012/13 and 111,144 outpatient activity. It carries out a high number of hips and knee replacements, many on patients who have undergone the procedures before.

The trust plays a major role in teaching. 20% of all UK orthopaedic surgeons receive training at the trust, and their teaching and clinical effectiveness are enhanced by the trust's work in research and development, and academic links with University College, London. The trust provides services at two locations – Stanmore in Middlesex, and a Central London outpatients facility in Bolsover Street.

The Royal National Orthopaedic Hospital NHS Trust has been selected as one of the first specialist trusts to be inspected under the CQC's revised inspection approach.

Our inspection team

Our inspection team was led by:

Chair: Professor Norman Williams, President, Royal College of Surgeons

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission

Team Leader: Hayley Marle, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant orthopaedic surgeons, consultant specialist paediatrician, junior doctor, orthogeriatrician, critical care intensivist, orthopaedic nurses, student nurse, children's nurses, operational managers, physiotherapist, occupational therapist, pharmacy inspector and an expert by experience.

How we carried out this inspection

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the trust's key referrer of patients, NHS Trust Development Authority, the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Health and Care professions Council (HCPC), Parliamentary & Health Service Ombudsman (PHSO), NHS Litigation Authority, the royal colleges and the local Healthwatch.

We held a listening event in Stanmore on 6 May 2014, when people shared their views and experiences of the hospital. Some people who were unable to attend the listening events shared their experiences through email or telephone.

We carried out an announced inspection visit on 7–9 May 2014. We held focus groups with a range of staff in the hospital, including senior nurses, junior doctors, consultants, student nurses and healthcare assistants, administrative and clerical staff, physiotherapists, occupational therapists, and pharmacists. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas, theatres and outpatient 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 would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at the Royal National Orthopaedic Hospital.

Detailed findings

Facts and data about Royal National Orthopaedic Hospital NHS Trust (Stanmore)

1. Context

- The trust provides services at two locations – Stanmore and Bolsover Street (outpatients only)
- 220 beds across 13 wards at the Stanmore location
- Largest specialist orthopaedic hospital in the UK
- 20% of all UK orthopaedic surgeons receive training at the trust
- Population: the trust treats patients from across the country, many of whom have been referred by other hospital consultants for second opinions or for treatment of complex or rare conditions
- Staff: 1,354 as at 31 March 2014
- Surplus (deficit) £2.1 million (2012/13)
- The trust provides a range of neuro-musculoskeletal healthcare, ranging from spinal injury or complex bone tumour to orthopaedic medicine and specialist rehabilitation for chronic back sufferers.

2. Activity

- Inpatient admissions: 15,842 (2012-13)
- Outpatient attendances: 111,144 (2012-13)
- Deaths in hospital: 8 (2013/14) – 5 in ITU

3. Bed occupancy

- General and acute: 73.2% (October-December 2013). This is below the England average (87.5%). It is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital when above 85%.
- Adult critical care: 61.4% (lower than England average 82.9%)

4. Intelligent Monitoring

- Safe: Risks = 0, Elevated = 0, Score = 0
- Effective: Risks = 0, Elevated = 1, Score = 1
- Caring: Risks = 0, Elevated = 0, Score = 0
- Responsive: Risks = 0, Elevated = 0, Score = 0
- Well led: Risks = 2, Elevated = 0, Score = 2
- **Total:** Risks = 2, Elevated = 1, Score = 4

Risk: Composite risk rating of ESR items relating to staff registration

Risk: Healthcare Worker Flu vaccination uptake

Elevated Risk (score two points): PROMs EQ-5D score: Knee Replacement (PRIMARY)*

*Complex case mix needs to be considered at a specialist trust

5. Safe:

- Two Never events were reported by the trust between December 2012 and January 2014
- 13 reported serious incidents between December 2012 and January 2014
- National reporting and learning system (NRLS) April 2013 and March 2014

Deaths: 1

Severe: 28

Moderate: 272

Total: 301

- Overall, there was a lower incidence of grade 3 and 4 (more serious) pressure ulcers reported in the last 12 months when compared with the England average.
- There was a low number of patients suffering from venous thromboembolism (VTE) reported when compared with the England average. (Source: Safety Thermometer February 2013 – February 2014).
- For 11 out of 12 months the trust was below the England average for patients fall with harm (Source: Safety Thermometer February 2013 – February 2014).

6. Effective:

- One elevated risk: PROMs EQ-5D score: knee replacement (primary)

7. Caring:

- CQC inpatient survey (nine applicable areas): The trust performs above the expected range for six out of the nine applicable sections. The trust performed the same as other trusts for waiting list and planned admissions, nurses and care and treatment.
- FFT inpatient: Above the England average for three out of four months (November 2013 to February 2014).
- The trust had a consistently high response rate to the FFT

Detailed findings

- Cancer patient experience survey (69 questions) Above England average for 13 questions; average for 31 and below average for 25 questions.
- The patient led assessment of care environment scored the hospital at 80% or above for cleanliness, food, privacy, dignity and wellbeing and facilities.
- The hospital had 25 reviews on NHS Choices (October 2008 to May 2014), and was rated as 4.5 stars out of 5.

8. Responsive:

- Cancelled operations: Similar to expected or tending towards better than others
- Better than average on notice of discharge
- Overall waiting times were good

9. Well led:

- Staff survey (28 questions) Above England average for 4 questions; average for 10 questions; below for 14 questions.
- 27 of the question scores remained the same as in 2012.
- Sickness rate 3.5 %; Below 4.2 % which is the England average.
- GMC training survey:The trust was better than expected in trauma and orthopaedic surgery for workload and access to educational resources.
- The trust was worse than expected in two areas, induction and educational supervision in Anaesthetics.

10. CQC inspection history

- Three inspections at the hospital since its registration in April 2010.
- The trust was non-compliant in respect of the outcome safety and suitability of premises with a minor impact on patients since 31 January 2013.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding
Surgery	Requires improvement	☆ Outstanding	☆ Outstanding	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	☆ Outstanding	Good	Inadequate	Requires improvement	Requires improvement
Outpatients	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	☆ Outstanding	☆ Outstanding	Requires improvement	Requires improvement	Requires improvement

Notes

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

Medical care (including older people's care)

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

Information about the service

Medical care in this report refers to patients who received care at the Spinal Cord Injury Centre (SCIC) and on the Jubilee Rehabilitation Unit (JRU). Both of these offer rehabilitation for orthopaedic conditions and injuries, including physiotherapy, occupational therapy and pain management. The SCIC has 26 beds and has access to five beds on Angus McKinnon Ward as wound care beds. The JRU has 22 inpatient beds.

Therapy and pain management programmes are also offered by JRU for up to eight patients, who are accommodated in two local hotels every three weeks. The JRU is a specialist rehabilitation unit, offering a range of residential therapy and pain management programmes every weekday.

The SCIC is one of eight in the country, and one of three centres in the south east. It mainly accepts referrals from two trauma centres, the Royal London Hospital and St Georges Hospital. It also has an outreach team.

We inspected these wards over a period of two days. We spoke with 15 patients and 26 members of staff. We observed care, viewed 15 patient records, and a variety of other staff and trust records.

Summary of findings

The medical wards were safe, effective, caring, responsive and well-led.

Staff were very caring and patients were consistently at the heart of their own care. They were involved in all aspects of their care. The service was designed and delivered to meet the all the needs of patients. Patients had access to rehabilitation therapies that assisted them in a normal life following surgery. There was enough staff with the appropriate skills to provide care. Patients had good outcomes and received the care and treatment they required when they needed it. There was good multi-disciplinary working. The local leadership was valued and staff felt supported.

Medical care (including older people's care)

Are medical care services safe?

Good

The nursing and medical staffing levels and their skill mix were appropriately set. As recommended by the Francis Inquiry 2013 senior nurses worked supernumerary roles. All the clinical areas were clean, infection control and hygiene guidance was complied with. Risks to patients were effectively monitored, patients were assessed and monitored for the prevention of pressure ulcers, UTI, falls and infections. Staff reported incidents and learnt from them to improve the service for patients.

Incidents

- Staff were aware of incident reporting procedures and the responsibility of staff if an incident required investigation. Staff on both wards told us they learnt from incidents, and that these were discussed within their teams.
- Incidents were reported, learning was identified, and they were discussed in ward meetings in SCIC. We saw the investigation into one recent incident on SCIC, which showed that a root cause had been identified, and action had been taken to prevent a further incident in the future.
- JRU had increased its nursing staff numbers, and changed the use of an office, in response to an incident. However, although JRU also held ward meetings, there was no clear record that incidents were discussed. There had been a recent incident on the unit, and we were not assured from any of the ward meeting minutes we looked at, to show the outcome of the investigation and what learning staff could take across the service.

Safety thermometer

- The latest pressure ulcer incident reports we reviewed showed that none of the acquired ulcers had occurred in either SCIC or JRU. Pressure ulcers were audited on a monthly basis.
- Safety thermometers were displayed in both wards, showing each month's compliance with hand hygiene, MRSA and C. difficile cases, falls, pressure ulcers, completion of nutrition assessments, and incidents.
- Staff were aware of their responsibility to reduce incidents, such as falls and pressure ulcers; there was also an understanding that they undertook positive risk to support patients to become more independent and mobilise.
- SCIC data showed that there had been two C. difficile cases since January 2014; all reported pressure ulcers were acquired prior to admission since the start of 2014, and there had been no reported in the last five months. Nutrition assessments had a 94% completion rate in March 2014.
- In JRU, the last reported falls were also in January 2014; there had been no infections in 2014, and nutrition assessments completed were 100% in March 2014.

Cleanliness, infection control and hygiene

- There had been an infection outbreak (streptococcus) in SCIC that was reported on in June 2013. This showed that three staff and two patients had acquired the infection, with concerns that there had been cross infection. The investigation showed that there had been a lack of infection screening, a need for throat swabs, the strategy to stem the outbreak was slow, there had been a lack of leadership, and a need for the policy to be updated. We found that the relevant policy had been updated within the timeframe recommended.
- All the equipment and areas we reviewed were clean, and cleaning checks had been recorded on a daily basis. Equipment was additionally cleaned prior to its next use, such as gym therapy sessions.
- All of the staff we observed followed infection control guidance. Staff washed their hands when entering and exiting a ward area, and when attending and leaving a patient. Hand washing gel was in place at the entry and exit of wards, and at patient beds.
- There had been no incidents of MRSA bacteraemia in either of the wards we inspected. Records showed that patients were assessed for infections on arrival, such as with swabs for MRSA and checks for E Coli. The last hand hygiene audit for SCIC in 2014 showed compliance at 93%, but we did not receive one for JRU.
- One patient had an infection on a ward. The patient records showed that they had been reviewed by the infection control team, and appropriate procedures to prevent its spread were in place, such as putting the patient in isolation, and the wearing of personal protection equipment when entering the patient's room. We observed that staff complied with this. An

investigation was ongoing as to whether the infection had been acquired at the hospital, or whether it was acquired before admission. Initial indications were that it had been acquired outside of the hospital. However, this did not prevent the patient having therapy, and when they had a therapy session, we observed staff being vigilant of infection control.

Environment and equipment

- The majority of equipment we saw had been checked on a daily basis, and was within date before it required reconditioning, replacing or PAT testing. This included resuscitation equipment, computers, and observational monitoring equipment.
- All the manual handling of patients we observed was conducted safely. This included use of hoists by two members of staff, strapping patients when they were on tilt tables, and using tugs to transfer patients through the sloped corridor between wards.
- The environment caused a risk for transfers and storage. We observed a patient who was being transferred between wards. The patient had a spinal injury and an acute condition; therefore they had to avoid unnecessary movement. This meant that the patient could not be transferred using the tugs. We saw the risk of unnecessary movement was mitigated by using eight porters to transfer the patient.
- Due to the lack of space, equipment was being stored in inappropriate places. One example we saw was a commode stored in a shower cubicle.
- The hospital patient group visited both the SCIC and JRU in 2013/14, as part of their programme of visiting units to see if the hospital could make any improvements. They requested that the SCIC risk assess the fire services access to the unit, as they felt it may be difficult for the fire services to access the unit in an emergency. In JRU, the patient group pointed out the need for a bed pan washer and a wheelchair accessible toilet. We observed that JRU's toilets were wheelchair accessible.

Medicines

- Patients told us, and records confirmed, they received their medicines when required.
- We observed one patient sensitively being given medicines during a therapy session.
- Medicines were appropriately stored in a controlled medicines cupboard, and controlled medicines were always administered by a member of staff, even if the patient was self-medicating.
- There was a current self-administration policy in use. Patients were assessed to identify whether they could self-medicate, and to what level they could do so. We observed this policy in use.

Records

- The patient records and observation charts we checked showed that most assessments had been completed, including nutrition assessments, skin integrity assessments, modified early warning scores (MEWS), and falls assessments and observations.
- Falls were assessed with a multidisciplinary team (MDT) approach, and further assessments were completed by therapists when a patient's condition changed.
- Turning charts were completed and up to date, with ongoing monitoring of skin integrity.
- Physiotherapy records were complete, including treatment plans, goal planning and functional assessments. All of the records we reviewed were up to date, and notes were comprehensive and covered all aspects of care.
- All of the records we reviewed showed that an initial VTE assessment had been completed; however, no records showed that a reassessment had taken completed.
- None of the patient records we saw had a 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) form, and there was no indication in the records, or when speaking with patients, that one was required.
- All the integrated care pathway records we reviewed were incomplete, and some records had loose sheets which could be lost. This included information such as a patient's equipment requirements, and psychological wellbeing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All the records we reviewed showed that patients had consented to the treatment they were receiving, and the forms were clear and easy to understand.
- When we spoke with staff, they were aware of their responsibilities in obtaining consent, obtaining a best interest assessment if someone did not have capacity,

and were knowledgeable regarding Deprivation of Liberty (DoLs) applications. We saw no records where a DoLs application or a best interest assessment were required.

Safeguarding

- Staff we spoke with were aware of their requirements to report suspicions of abuse involving vulnerable adults and children, and were aware of the safeguarding lead in the trust. We were given examples of when they had contacted the safeguarding lead when they had had a concern.
- Records showed that staff were trained to level three in safeguarding children, and trained in safeguarding vulnerable adults.

Mandatory training

- Although the trust rate for mandatory training in March 2014 was 56.25% for medical and dental staff, 83.97% for nursing staff, and 83.42% for allied health professionals all of the ten staff records we reviewed showed that staff had completed their mandatory training, and that this was up to date.
- When we spoke with staff and reviewed the training booklets for doctors, they showed that their mandatory training did not include some key areas, such as VTE assessments, and pain relief.

Management of deteriorating patients

- If a patient was admitted with, or acquired a pressure ulcer while in the hospital, they could be transferred to the Angus McKinnon Ward, which was dedicated to providing wound care management to patients, with dedicated tissue viability nurse support.
- Doctors were available on-call if a patient required medical support, and this included the critical care outreach team.
- We saw MEWS being completed; we did not see a record where a MEWS score was high enough to require on-call support. All the staff we spoke with were aware of how to escalate if there was a deteriorating patient.
- A junior doctor was available out of hours if a patient deteriorated, and staff told us that this caused a number of delays when requests were made. However, they were aware of who to escalate to if they had a deteriorating patient if there was a need.

Nursing staffing

- The off-duty rota for JRU showed that they had as many as five nurses on duty at times during the day. Numbers, as well as skill mix, had been worked out using an acuity tool, which showed that each individual patient's level of care and support was taken into account; four beds on SCIC were for acute patients who had either just been transferred out of the high dependency unit (HDU), or at least required some respiratory support. A recent staffing review had set this standard.
- Records showed that this ratio and skill mix was constant in both wards, with two nurses at night in JRU, and three at night in SCIC. We were told by nursing staff that the SCIC had a policy of not admitting more than three tetraplegic patients at the same time, as it was recognised that the staffing levels could support a maximum of three patients with such dependency.
- Nurse to patient ratio on the days we inspected were 1:4.4 on SCIC (24 patients to five nurses) and 1:6.6 on JRU (20 patients to three nurses) during the day, and both sets of patients undertook therapies and rehabilitation sessions away from the ward. All the patients we spoke with told us that if they needed a member of staff, they would always arrive quickly.
- Staffing names and numbers were displayed on each ward, either on the main notice board or above the nurses' station in the patient bays. However, the displays did not show if they required number of nurses were actually working.
- The use of agency and bank staff was limited. All of the rota records we reviewed demonstrated that they had been able to fill any gaps in their nursing staffing complement.
- Each ward had a senior nurse (sister) who was completely supernumerary, as recommended by the Francis Inquiry 2013.
- A site manager was available if an issue on the ward required escalation out of hours, and they could escalate a concern to the on-call junior doctor if a patient required support from a doctor. Staff had a bleep which could be used if there was a deteriorating patient.
- JRU had a sickness rate of 4.59%, and SCIC had a rate of 4.14%, in 2013/14, which were both above the trust average of 2.72%. However, when we asked why this was high, we were told that there were a number of staff on long-term sick leave.

Medical care (including older people's care)

Medical staffing

- Staff commented that the outreach critical care team was very good, and would arrive very quickly when they were bleeped.
- There was a registrar and an extra junior doctor at the weekends.
- A service level agreement was in place with a local hospital to provide medical cover. This included a 0.5 full time equivalent (FTE) consultant per week who specialised in diabetes, four orthogeriatricians per week, and one cardiologist per week. Out-of-hours support was available on-call under the same agreement.
- Staff told us there was also a consultant urologist available on-call from another hospital, so that patients had access to specialist doctor support if required. However, this was not recorded in any formal service level agreement we received from the trust.
- On JRU, ward rounds were conducted weekly by the individual orthopaedic consultants that each patient was under. We found that three consultants were allocated to rehabilitation patients in SCIC, and these were normally the same spinal consultant a patient had previously been under if they had previous rehabilitation at the hospital.
- Patients reported that their therapy sessions were on time and not rushed, which indicated that there was not a shortage of therapists available.

Major incident awareness and training

- Each ward had a major incident policy and risk register. However, we noted a failure of gas and electricity was rated as low risk (two) in JRU, when there had been a power failure at the trust in 2013. This meant that the risk register did not reflect the actual risk of utility failure. All the staff we spoke with were either aware of the policy, or knew who to refer to, if there was a major incident in their ward.

Nursing rounds

- Records showed, and we observed that nurses conducted 'intentional rounding' on a two hour basis, 24 hours a day. The records detailed where the patient was (such as in the ward, having physiotherapy, or in a session), and whether they were asleep. Intentional rounding is where nurses are required to check whether patients are comfortable, felt well, whether they need support to go to the toilet, whether they were in any pain, if they are thirsty or want a drink, and if the patient has any other needs.

Are medical care services effective?

Good

The services audited their care. Most patients received pain relief when they required it, and this was well managed. Patients were kept hydrated and their nutritional needs were met. It was difficult for us to benchmark the effectiveness of the SCIC and JRU due to their specialisation, but comparative measurements showed that both units had good patient outcome data. Staff were trained to ensure that they were competent. Equipment was able to be tailored to individual patient needs to achieve better outcomes. Facilities were accessible and met patient's needs. There was good MDT working.

Evidence-based care and treatment

- The trusts own audits for February and March 2014 showed that the SCIC was not fully compliant with standards; however improvements in meeting these standards were being made. Non-compliance included some letters not being sent to GPs, MEWS not always being recorded, patients rarely receiving education packs, patients not always receiving standing equipment, and estimated discharge dates (EDD) not always being met.
- The SCIC was not compliant with some SCIC national service standards (in April 2014), which defines what standards SCICs should meet to be able to provide the appropriate specialist care required.
- SCIC had participated in a Spinal Cord Independence Measure (SCIM) audit, which found that the trust did not achieve the median for SCIM in eight out of the 20 patients, and in only three out of eight occasions it was shown that the clinical team had done everything possible to achieve a good outcome. However, the trust conclusion from the audit was that it was not justifiable to use SCIM as a comparative indicator, as the patient choice of speciality, patient choosing not to work on transfers, patient physique, and the general strength of some patients, meant that their scores were lower and so could not achieve the SCIM median.

Medical care (including older people's care)

Pain relief

- Patients reported that they were happy with how they were supported to manage their pain.
- On the JRU, pain relief was part of patient programmes; the programmes aimed to reduce the amount of pain relief patients required, and to support patients in becoming more independent in the way they managed their condition.
- The majority of patients said they got their pain relief when they wanted it.
- For those patients self-medicating, a daily check was made to ensure patients had taken their medication. Each patient was assessed to check whether they could self-medicate, and this was reviewed as part of their programme.
- The staff we spoke with were able to access the trusts pain management policies and procedures. We were told that there was sometimes a lack of clarity between the role of junior doctors prescribing analgesics, and the acute and chronic pain management teams for whom a referral was required. We were informed that the policies and procedures were under review, and were due to be presented to the Drugs and Therapeutics Committee by the acute pain team in May 2014.

Nutrition and hydration

- Patients told us they never missed a meal, and they always had access to a drink.
- Patients were mostly happy with the food available, and said there was a wide choice.
- They told us that the food was always served at the correct temperature, and met their cultural requirements.
- The trust had adopted the use of a new container for water, so patients could take their drink with them, as it was in a flask that could clip to most equipment, such as their bed, a table, wheelchair or walking frame.
- We saw red trays were in use, which alert staff to patients who require support to eat. Meals were given during a protected meal time, and patients told us that this was respected.

Patient outcomes

- SCIC produced an overall report of average length of stay (ALOS), when comparing all spinal injuries. This showed that ALOS was between one and eight days better on average than at other SCICs. However, as the SCIC is not linked to an acute hospital with additional facilities and clinicians, and results were based on 60 patients being treated a year on average at SCIC, direct comparison between other SCICs in the country is difficult to judge.
- When broken down to each type of spinal injury, the ALOS varied depending on the type of injury received and was similar or better than other SCIC.
- It was the only SCIC in the country being paid by payment by result. The SCIC was also measured by the International Spinal Cord Injury (ISCOS) data set.
- The JRU produced a patient outcomes report in May 2014, showing its measures by pain self-efficacy questionnaire, pain numerical rating scale, pain disability index (PDI), hospital anxiety and depression scale (HADS), SF-36 Health Survey (measure of health status against cost effectiveness), EQ5D (health outcome measure), Goal attaining scale (GAS), and Global Rating of Change Scale. Patients were measured at pre-admission, three month follow up, and 12 month follow ups. JRU analysed data from the last three years, and patient outcomes showed that most patients had positively progressed at three months. Although this progress was sometimes partly lost at 12 months, for goal achievement it was still at 82% of patients making progress. Due to the specialised nature of the service, the clinical lead said that they were unable to benchmark their patient outcome data.

Competent staff

- Records for health care assistants showed that they completed a workbook as part of their training programme, which included assessments to ensure they were competent in meeting patients' needs.
- All staff had a competency book to show what they are trained and qualified in, such as their mandatory and ward-specific training. All the staff records we saw showed that these had been completed, or were in progress of being completed if they were a trainee.
- Staff told us that they were appraised yearly and had quarterly supervision with their line management. However, therapy staff told us they had created their own appraisal system, as there had been no support from the trust.
- Staff told us that all their training was conducted during their employed time, so they did not have to use leave or carry out training in their own time.

Medical care (including older people's care)

Equipment

- SCIC provided tailored equipment for patients for their therapy programmes. This included personally-fitted physiotherapy tools.

Facilities

- JRU had access to two local hotels, which enabled them to provide rehabilitation for more patients who were well enough to stay at a local hotel and to access treatment daily at the hospital.
- JRU had equipment for therapy on the ward, such as physiotherapy steps, so that patients could have therapy near to their bed area if necessary.
- Both the wards were wheelchair accessible, and had wheelchair accessible facilities, such as bathrooms and toilets.
- A garden area and gym were available for patients on site.
- The hospital had access to a private leisure centre that was linked to the premises, which included a pool for hydrotherapy, so that patients had access to all the facilities they needed to complete their rehabilitation programmes.
- An independent living unit was available for patients, so that they could practise 'at home tasks', such as cooking and cleaning, prior to discharge.

Multidisciplinary (MDT) working

- We saw evidence of good MDT working, both internally with different specialty staff within the trust, and externally with staff from other trusts. An agreement was made with a local acute hospital for doctors and consultant cover for a variety of specialties, including cardiology.
- Patients had access to physiotherapists, occupational therapists, psychologists, nurses and orthopaedic doctors, to plan and deliver their care.
- Internal MDT working for rehabilitation patients included patient-focused, strategic and research-based MDTs.
- Patient case conferences were multidisciplinary. We observed this while on inspection, and it was also evident from the records we reviewed.

Seven-day services

- Although SCIC had nursing staff seven days a week, therapy staff and the pain team were only available on weekdays until 4.30pm. During evenings and at weekends the pain team were covered by the on-call anaesthetist. We were told there were opportunities for overtime at the weekend, but this cover was not guaranteed, as over time was optional.
- Two junior doctors were available on-call in the evening and at the weekend for the wards.

Are medical care services caring?

Outstanding ☆

There was a strong visible person centred culture. Patients told us, our observations and survey results showed that care was consistently compassionate for all patients and their families.

Patients were involved in their care and treatment, and were empowered to make decisions about their care. They were given full and easy-to-understand explanations and instructions from staff when they required them. Patients received emotional and psychological support, either as part of their rehabilitation programme if their needs were complex, or as required.

Compassionate care

- All the patients we spoke with said staff were compassionate in the way they cared for them. Comments included that staff were "friendly", "handled them sensitively", "never been on a ward where all the staff are so lovely", and "staff will do anything for you".
- Many comments compared other hospitals they visited. One patient said it was "much more personable than other hospitals" and "everyone knows your name, even the domestics". Another said that the hospital "is the best they have ever experienced".
- Staff told patients in an appropriate manner if the patient had an unrealistic goal. We observed a physiotherapist communicating with a patient, where the physiotherapist explained the goal was unachievable, and this was done in an empathetic manner.
- The Friends and Family Test results for the two wards were above the national average in three of the last four months. JRC was scored at 80 on a 63% response rate, in March 2014. Although SCIC was below the trust average of 77 at 70 on a 100% response rate, and average compared to the seven other SCICs, it was still above the national average of 64.

Medical care (including older people's care)

- JRU had started conducting in house inpatient surveys in 2013, which rated pre-assessment, programme quality, information received, attitude of staff and meeting patient expectations, as well as asking patients if there could be any improvements. The results at the time of the inspection were positive.
- The internal inpatient satisfaction survey for February to April 2014 showed that SCIC patients' responses were mostly happy with their care.

Patient understanding and involvement

- Patients told us, and records showed that they were able to set the agenda for their own care. In SCIC, the patient was asked what goals they wanted to achieve as part of their rehabilitation, and patients told us that these were nearly always accepted.
- All the patients we spoke with were very aware of their condition(s) and were aware if their condition was limiting, and how limiting it may be over a short and long period of time. Advice and information was given to patients to allow them to continue their rehabilitation at home, but also so that patients became more aware of their condition.
- Patients said any changes that were suggested were always positive, such as using different techniques to achieve a quicker or better outcome, but staff ensured goals were made realistic. These were reviewed on a two weekly basis.
- One patient told us that they had requested only female staff to care for them, and this had been arranged.
- When we observed communication between staff and patients, staff ensured that patients and their friends/ family were involved in decisions regarding their care, and any therapy they were receiving.
- Options for equipment and ongoing therapy were discussed, with risks and benefits of options outlined to the patient before they chose.
- Patients told us, and we observed clear communication from staff, so that any instructions on exercises that the staff wanted the patients to do were easy to understand.
- Friends and family of patients told us that they were kept informed about their family/friends care.

Emotional support

- All staff in the wards had a Stanmore Nursing Assessment of Psychological Status (SNAPS) card on them. This was a prompt for staff to assess, consider and document patients' emotional state.
- Psychological support was key in each patient's care, due to the type of conditions being treated. Psychology and psychiatry were core components of the service, and sessions were scheduled to take into account the psychological needs of patients.
- Recovery for many patients was over a long period of time. Patients and psychologists worked together to set achievable psychological and social goals.
- Staff were aware of whom to refer patients to if they were vulnerable, and that these were trained staff to deal with those patients. There was a psychological/ social team that met with patients once a week. Each patient on rehabilitation was allocated a psychosocial key worker, and there was also access to psychologists and psychiatrists.
- Patients told us they felt supported by staff if they needed emotional support and that a staff member would always talk to them if they became upset or felt overwhelmed.

Are medical care services responsive?

Outstanding ☆

The JRU and SCIC planned their admissions, and were flexible to the needs of patients. Some patients were assessed as not requiring to stay in hospital during their rehabilitation programmes. They stayed at a local hotel which assisted in gaining normality following surgery. The service was planned and delivered in response to the individual needs of patients. The access and flow was managed, the average length of stay and waiting lists compared well to other trusts with similar services, considering their high referral rates. Although bed capacity could be high at times, it was well managed.

Patients were referred from all over the country and staff planned proactively with a number of local authorities and other hospitals to ensure their patients continuity of care once they were discharged.

Individual needs were being met, including those of vulnerable patients.

Service planning and delivery

- The trust provided hotel rehabilitation programmes that focussed on self-management and having a sense of normality when living with chronic conditions. These programmes involved patients spending time at the

hospital but staying at local hotels as they did not need to be inpatients. This ensured that the beds within the hospital were only used for those patients who required on-site nursing care.

- Patients were assessed for suitability and safety for admission to the hotel depending upon their level of functional independence, mobility, self-care and medical co-morbidities. Therefore some were assessed as only suitable for the hospital environment and therefore waiting times varied depending upon which programme a patient was suitable for. This was complicated further as the rehabilitation ward environment has single sex limitations and therefore waiting times varied between males and females who needed a hospital rehabilitation admission
- The majority of the hospital based rehabilitation programmes ran for three weeks. Occasionally a patient would have to cancel at last minute for medical or personal reasons, or may drop out of the programme once it has commenced. Due to the significant patient commitment of a three week stay and the specific content of the rehabilitation programmes these vacancies often could not always be filled despite all efforts and therefore impacted on the trusts' bed occupancy rate 73.2% (October to December 2013) compared with the England average of 85.9%.
- The trust had on-site accommodation for families, however it was limited, and patients told us that it was usually booked up far in advance, so patients who were on long-term rehabilitation programmes sometimes struggled for their family to visit them at the hospital, or had to book private hotels or lodgings.
- The SCIC had an outreach team, which saw around 50 patients face-to-face and 80 patients by telephone every quarter, to see patients who may be admitted to the SCIC or may require some rehabilitation for their spinal injury. This compares favourably in terms of patient numbers to other SCIC outreach teams in the country.
- SCIC beds varied from 29 to 110, and despite RNOH having only 31 beds, it had still admitted 76 patients in the last 12 months.
- The National Spinal Cord Injury Strategy Board produced a paper in November 2012 to determine which SCIC's should be linked to which trauma centres. The paper reduced the amount of trauma centres linked to the hospital to two. However, as patients are still able to request a preferred SCIC, records showed that a high number of patients requested this SCIC: 334 in the last year (including those who were directly referred from the two trauma centres). This was due to some trauma centres being nearer to the hospital than to those they are officially linked to, and also due to some patient feedback from previous patients of RNOH that they liked the care there so much that they would not go to another SCIC.
- The trust identified the rehabilitation service as one they could utilise better. A business case was approved in June 2013 to improve bed utilisation from 65 to 85%, and make more use of the hotel-based rehabilitation service if appropriate for the patient.
- This would be achieved by levelling bed activity through the week, as there were currently fluctuations, where bed occupancy was low one week and high the next. There was to be a review of seven day working, rationalised scheduling of the programmes, and review of the waiting lists and patient acuity. However, there were risks that this would not be delivered due to a bed realignment project across the trust. Bed capacity, and using the JRU as a unit for lower acuity patients, showed that this had been at least partly implemented, as the bed occupancy rate in JRU was currently 74%.
- All SCIC patients have a lifetime link with the unit, so if patients require further rehabilitation, this can be arranged. It also allowed the relevant consultant to review patients on a six month or yearly basis, to ensure that they continued to achieve their goals.
- Handovers on SCIC were recorded electronically and printed out for each member of staff to refer to. Handovers included a discussion on why the patient had been admitted, any changes to a patient's condition, and any planned discharges.
- Although wards were mixed sex, bays were separated on a gender basis, and we saw this being maintained.

Access and flow

- It is difficult to make comparisons on the average length of stay (ALOS) of patients due to the specialist nature of their treatment.
- The trust speciality dashboard showed that the ALOS for medical and rehabilitation patients was 14.8 days, with a maximum wait to attend of 27 weeks. Total patients seen from April 2012 to April 2014 were 1,827.
- Case conferences were held with patients on the SCIC halfway through their stay to plan their discharge, such as contact with social services, adaptations to their properties, or purchasing of new equipment. This was

despite many patients arriving from different parts of the country, from trauma centres, other hospitals and from home. Therefore, some case managers had to make contact with many different local authorities and community trusts. Home visits were arranged with the case manager and liaison nurse before patients were discharged home. However, there were still sometimes delays with external stakeholders, including equipment contractors.

- SCIC were able to see patients who were directly referred within an average of 58 days from referral, with the longest patient waiting when we inspected being seven weeks (49 days).
- SCIC had their own bed management board, with bed management meetings which showed when patients were due to be discharged and what patients they were expecting to be admitted. This meant they could both manage flow and ensure bays were not mixed sex.
- In JRC we saw that one patient had been waiting since 30 October 2013 for a hypermobility programme, but most had been waiting since March 2014, which was within 11 weeks since pre-assessment. The JRC was not part of the national 18 week wait to be admitted and treated target due to the specialised nature of the programmes.
- JRC's waiting list was managed on a weekly basis, so programmes could be scheduled around the patients due to be admitted. There was a waiting list as each 12 bed bay was single sex, and programmes had to fit with each other: some programmes were one week, but some were six weeks. Staff monitored how many patients had been referred, but still had not completed a questionnaire or not been pre-assessed. As JRC was rarely at capacity, it had started being utilised by the trust as a ward for patients recovering from surgery, if there was a delay with a surgery patient's discharge.
- SCIC bed capacity was high and regularly around 85%; guidance suggests care can become compromised at 85%. SCIC capacity was high, as many patients who had been referred to another SCIC in the country, requested to be referred to the Stanmore location. The hospital negotiated these requests with the originally-referred SCIC, depending on whether they had capacity to take them.
- SCIC patients had case managers throughout their stay, as many patients would be treated over many weeks, sometimes months. Each patient was given an estimated discharge date on admission.
- Patients were only moved from SCIC and JRU if there was a medical need. Patients who developed pressure ulcers would be moved to Angus McKinnon Ward, where there was tissue viability nurse support, and their care could concentrate on wound management. If patients developed other acute conditions, they would either be transferred to the critical care ward, or to a neighbouring acute trust.

Meeting people's individual needs

- Reintegration practitioners were employed, so that those patients on long-term rehabilitation programmes could be supported in integrating themselves back into the social environment. The practitioners took patients into the community to visit pubs and shops, to support patients getting used to their new mobility level outside the hospital environment.
- Patients told us that call bells were answered very quickly.
- Staff were aware of whom to refer patients to if they were vulnerable, and that these were trained staff to deal with those patients. There was a psychological/ social team that met with patients once a week.
- Each patient had a named doctor indicated on notes or a display next to their bed, and were informed of which nurses were responsible for their care each shift.
- The outreach team attempted to visit every patient, either in hospital or in their own home, before they were admitted, so their treatment plan could be explained to them. This also included managing their expectations, as feedback had shown that some patients had unrealistic expectations.
- Staff were aware of how to treat and support patients with mental health and learning disability needs. This was part of their mandatory training, and all the staff records we saw showed that they had been trained in this area.
- Staff were aware of the referral process if a patient required clinical psychiatrist or psychological support, and interpreters were available for those patients where English was not their first language.
- 90% or above of patients were screened for dementia before they were admitted if they were over 75 in the last 12 months.
- Both wards had leaflets and notices available to inform patients about their conditions.
- JRU had an information booklet for anyone before they were admitted for a pain management programme. This

gave a detailed overview of what their programme would comprise of, with any guidance or rules patients needed to follow, and contact details if they had any questions. These ensured that patients were able to have a realistic expectation of the programme.
- The kitchens catered for cultural meal choices and had other options, such as gluten free and build-up drinks.
- Patients told us their faith and cultural needs were met and recorded.
- Patients told us that they were treated with dignity and respect. Curtains were closed, or they were taken to a private room if required, to have a discussion regarding their care. Curtains had a label on the front to say that the patient was not to be disturbed if the curtains were closed.
- Some of the bay curtains in SCIC did not fully cover the windows to the ward corridor, which meant that there was a risk that some patients may not have their privacy fully maintained.
- One patient told us that they had complained about the noise that another patient was making during the night. Staff listened to the patient and took appropriate action, so that the following night neither patient was disturbed.

Learning from complaints and concerns

- JRC received five concerns in March 2014 and many compliments. There had been two formal complaints in the last six months, which included a complaint about pain management, that there was poor communication and treatment from staff, and there was a delay in their diagnosis. Poor communication was also a theme in a complaint about physiotherapists. Action plans from these complaints looked into how they should be resolved with the complainant, and not what could be done to learn or improve from them.
- Staff told us learning from complaints was discussed however this was not recorded in ward meetings.
- SCIC had not received any complaints in the last six months, they had received compliments as staff encouraged all patient feedback.

Are medical care services well-led?

Good

We were told and shown that both the JRU and the SCIC had individual visions and strategies for their services, which recognised the needs of patients they were treating, and this was shared with patients. There were clear governance and risk management processes, and staff were aware of these. There was an understanding of what the local risks were. There was clear local leadership, and although we received feedback that informed us was that this was not perceived to be at executive level in fact the Clinical Director for the Unit is an Executive Lead. Both staff and the public were engaged in the performance and running of the units. Both units were progressing innovations and improvements their services.

Vision and strategy for this service

- There was a clear vision and strategy for JRU. Although it was recognised as a nationally-leading service for inpatient rehabilitation and pain management, its leadership recognised that the service needed to further enhance its status, particularly with more research into the conditions they treat, and this was part of its strategy moving forward.
- 'Development' meetings involving all ward staff showed that the vision and strategy of the service was discussed with staff, and staff were allocated roles to support improvements to the service.
- There was a clear vision for the SCIC, which included an increase of its capacity, and to consider providing more specialised services that cannot be provided at other trusts.
- The local leadership understood that although they were a specialised trust, their service provision needed to be led by the amount of patients that wanted to access their services, and the types of services patients wanted to access. However, there was a concern raised by ward leaders that the trust was too focused on financial targets rather than on patient outcomes.
- The overall clinical rehabilitation strategy included a focus to integrate the different rehabilitation units and ensure there was a single trust-wide approach, as this was currently not the case.

Medical care (including older people's care)

- Staff told us that there appeared to be no cohesion between trust-wide strategy and local strategy, and we found that local strategies did not fit under the trust-wide one.
- When we spoke with allied health professionals, although they were positive about their role in the trust, they felt they had a small voice and were not included in trust-wide strategic issues. Equipment had been purchased with charitable donations. Four business cases in the last year for funding of allied health professionals equipment had all been rejected.

Governance, risk management and quality measurement

- There were clear governance, risk management and quality measurement processes in both wards. Risk registers were held at divisional level if they required strategic or corporate input to mitigate or resolve them.
- If a risk could be dealt with locally, it was raised on the local issues log, and dealt with by the local ward and not put on a divisional risk register: JRU raised risks when equipment needed replacing and showed the actions local staff had taken with the engineering department. Once a replacement was acquired, it would come off the risk register.
- JRU team meetings showed that action was being taken from their inpatient surveys to improve the service: the last JRU survey showed that hygiene, therapy input, training and communication were areas to improve, and the ward was taking action to improve all of these areas.
- There was an understanding by the local rehabilitation leaders as to what the risks to the service were, including commissioning, capacity and finance. This was reflected in the divisional risk register, and was being mitigated by transformation programmes, monthly monitoring of the situation and for the trust to be ahead in awareness of the specialist needs of patients.

Leadership of service

- There was a clear leadership structure for the service within the organisation
- Although SCIC had a senior nurse, they had only been in post three weeks, and four different people had held this post in the last two years.
- Feedback from staff on the wards, including heads of services, was that staff felt supported by their immediate line management, but that the amount of changes of director of nursing over the last few years had given a feeling of 'turbulence'.

Culture within the service

- JRUs staff sickness rates were somewhat high at 4.59%; however, we were told that this was due to a number of staff on long-term sickness. However, there was recognition by senior staff that the service also had a high turnover of staff, although we were not given this as a figure.
- Staff reported that local leadership on both wards was visible, and staff felt open to feedback any concerns they had to their line management. Staff were aware of how to 'whistleblow'. However, senior staff on the ward said they did not feedback concerns to directorate level as when they had feedback previously; there comments were not actioned/listened to.
- Staff reported feeling part of a team and being supported by their colleagues.

Public and staff engagement

- Nursing and medical staff in both SCIC and JRU told us that they felt valued and proud to work for the trust.
- Some administrative staff in therapies felt overworked, as there had been a recent restructure which had reduced the amount of administrative full time equivalent posts from 12 to six.
- JRU actively encouraged patients to feedback their views on the service, by giving them both the inpatient questionnaire and the Friends and Family Test, together with access to a computer, to complete the surveys on the day they were due to be discharged.
- JRU ward meetings did discuss some issues that senior staff felt required discussion, such as ensuring that staff complied with trust policy for uniform/staff appearance, and any changes to the ward, such as the ward being used as a step-down from the surgical wards. There was also discussion on how the ward could progress and improve. It allowed for discussion by staff on these subjects and any other business; there was no wider discussion about trust-wide issues.
- SCIC ward meetings discussed both ward level and trust-wide issues, and allowed staff to comment on any needs or concerns they had. We noted staff suggestions for training were made which were actioned.

Medical care (including older people's care)

Innovation, improvement and sustainability

- It was clear that both wards were continually working to innovate and improve their services. SCIC were researching the factors involved in preventing good patient outcomes, such as multiple conditions and complications, and how these could be overcome or prevented. JRU staff attended external meetings with national and international experts in pain management and rehabilitation, to enhance and extend their knowledge.

Surgery

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

Information about the service

The hospital provides inpatient surgical services to adults and children on the Stanmore site. This section will detail the services provided to adults. It has six adult surgical wards with 111 beds. The adult wards are divided into single sex areas, and the trust has not reported any breaches of single sex accommodation. There were nine laminar flow operating theatres, and another being commissioned.

We visited the admissions lounge, radiology, the six wards and the operating theatre suite. We spoke with 30 patients and relatives of people using the service, together with 52 staff, ranging from domestic support staff, student nurses, nurses of all grades, junior doctors and consultant surgeons. We looked at over 38 patient's medical records, observed staff handovers, followed the patient pathway from the admissions lounge to ward, theatre and return, and observed staff interaction with patients, relatives and between the multidisciplinary team.

Summary of findings

Overall, patients received safe, compassionate care delivered by knowledgeable, skilled staff. Patients we spoke with told us they had been treated with dignity, shown respect and had been very well cared for. Systems were in place to promote patient safety, and incident reporting was positively promoted, although learning from incidents was not as widely publicised. Adherence to the World Health Organization (WHO) surgical safety checklist was not embedded by all staff carrying out surgery or interventional procedures in radiology. Safety checks of equipment were not always carried out in theatres, and records were not completed appropriately.

The trust is a recognised world leader in treating patients with complex orthopaedic conditions, and has a record of using pioneering treatment to achieve very good outcomes, which were published as part of research programmes. The trust is a tertiary centre, and performs a higher proportion of revisional surgery than other trusts; primary joint replacements are performed on patients who have underlying bone and metabolic problems, and the trust achieves outstanding results. The trust participates in national audits and submits to national data bases to benchmark their performance where possible. Patients were very keen to express their praise for staff, and their delight and satisfaction in the outcome of their surgery.

The trust was rated highly in patient and family feedback mechanisms, and we witnessed many

Surgery

episodes of kind, compassionate and caring interactions from all staff groups, and patients and relatives were universally very positive in their feedback. Care was organised to meet the needs of patients, and translation services were available; however, written information in other languages was only available on request. Elective patients were pre-assessed before admission, and were admitted via an admissions lounge. Discharge planning began very early in the patient's pathway of care, and there was a multidisciplinary approach involving patients and relatives, to ensure the safe, effective discharge of patients.

Staff on surgical wards were motivated and well-led by ward managers and by the matron for surgery. In theatres, whilst there was a motivated and enthusiastic department manager, staff were less so, and morale was low. We found that nursing in the theatre department would benefit from a senior nurse/matron to provide leadership to staff, and support the department manager to raise safety standards and morale.

Are surgery services safe?

Requires improvement

The majority of patients received safe care during their stay in hospital. The patient pathway began with pre-assessment, admission and consent processes. There was evidence of appropriate patient risk assessments being carried out and reviewed when the patient status changed. Patient records covered all aspects of care, and we saw excellent adherence to professional standards of record keeping. Incident reporting was encouraged on the wards, and most staff reported that they received feedback from incidents. This was not replicated in the theatre department, where staff reported they did not report all incidents. There was some evidence of learning from incidents, but this varied across the wards/departments. The trust had introduced the use of the WHO surgical safety checklist for interventional treatments undertaken in theatre and radiology. We observed the use of the checklist, and found that it was not embedded in practice, and medical staff did not always complete the safety checks at the correct stages, which may compromise patient safety.

There were sufficient staff with the appropriate skills available to meet the needs of patients. There was evidence of regular reviews of nursing skill mix, and increases in ward staffing complement to ensure patient safety. Staff in theatres worked additional hours to cover overruns and absences, but they also had the highest sickness rate in the trust, and morale was described as low. In the majority of clinical areas records showed that the resuscitation equipment was checked daily. We found that the paediatric resuscitation equipment in the recovery area of theatres had not been checked or cleaned for over one month. We also noted safety checks on some anaesthetic equipment were not recorded as having been done.

Incidents

- The trust reported two 'never events' and 13 serious incidents (SI) to the Strategic Executive Information System (STEIS) and the National Reporting and Learning System (NRLS) between December 2012 and January

2014. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.)

- The 'never events' related to wrong site interventions in radiology. We were provided with the root cause analysis (RCA), which identified the WHO surgical safety checklist was not used systematically for all surgical procedures. The shared learning was raised with the consultant body and within the radiology department, and new documentation specific to radiology was devised.
- Two of the never events and four of the serious incidents were attributed to theatres. Staff reported that they were aware of the two wrong site surgery incidents, but could not tell us about the other incidents.
- We observed a procedure being carried out in the radiology department. We reviewed completion of the new WHO surgical safety checklist paperwork after the procedure was complete and the patient had left the treatment room. We noted and shared with the clinicians present that the checklist was incomplete.
- The trust had an electronic incident reporting system, and incident management policies and procedures were also available to staff for reference.
- Surgical specialities reported 851 incidents, between April 2013 and March 2014, which accounted for 94.5% of all incidents in the trust.
- Staff were asked in every area if and how they reported incidents. Ward staff told us that they were encouraged to report incidents and received feedback, and all staff were able to access the electronic reporting system. However, theatre staff told us that they reported some incidents, but not all, as they did not receive any feedback, and told us nothing changed as a result of raising incidents. Managers told us they fed back to staff on an individual basis.
- Mortality and morbidity meetings were held approximately every two months, and all clinical staff were invited to attend. All medical staff spoken with confirmed that they attended the meetings and the time was protected. There were posters advertising the next meeting displayed in staff rooms on the wards.

Safety thermometer

- The trust monitored safety thermometer indicators, and produced monthly local nursing key performance indicator (KPI) reports, which were prominently displayed in all wards.
- The trust monitored safety thermometer indicators, and produced monthly local nursing key performance indicator (KPI) reports, which were prominently displayed in all wards.
- Information provided by the trust showed that pressure ulcer incidence was below the national average overall, and for patients over 70 years. Local results seen on the wards confirmed the low incidents of hospital-acquired pressure ulcers, and staff were proud of their record.
- Venous thromboembolisms (VTE's) in new patients were reported, and the trust data showed it had performed below the national average for seven months of 2013, and was just above the average in January 2014.
- The trust had a quality target set that at least 95% of patients would be assessed for VTE risk. Patient records showed that the majority of patients had been assessed for VTE, and evidence provided by the trust showed that they had met the quality target for the year. On some wards the pharmacists had completed the 24 hour reassessment and checked that appropriate prophylaxis treatment had been prescribed and administered. Records showed the trust conducted a root cause analysis when a patient developed a VTE, and this had been common practice in the trust since 2012.
- Falls resulting in the person sustaining harm were also recorded, and the trust performance was better than the national average in April and August 2013, with the most noticeable rise in patients over the age of 70. Following a patient fall, staff carried out a post-fall audit to identify contributory factors, the last audit carried out in surgery showed that of the 12 falls audited, five patients had confusion as a contributory cause.

Cleanliness, infection control and hygiene

- The trust has a low incidence of MRSA and C. difficile. The trust reported zero hospital-acquired cases of MRSA and MSSA. The number of C. difficile infections was within the 13 cases trajectory range set for the trust.
- There were infection prevention and control policies available on the trust intranet, and the hard copies seen in ward offices were in date.

- We observed all staff demonstrated good practice in following hand hygiene protocols, they complied with 'bare below the elbow' policies, and personal protective equipment (PPE) was available and used appropriately.
- Hand sanitising points were seen outside wards and departments, and staff and relatives were observed using them before entering. Hand basins were stocked with soap and disposable towels, and hand washing guidance was displayed.
- Hand hygiene audits were carried out monthly and formed part of the nursing KPI report. Most of the wards visited had high rates of compliance with hand hygiene.
- We were shown the cleaning audit results and saw compliance rates were over 95%.
- We saw that every ward had side rooms, and staff confirmed that these were used to isolate patients with infections. Signage was displayed on the door of the side rooms being used to show the precautions staff and visitors were required to take before entering the room, and how to dispose of PPE before leaving the room. There were adequate supplies of PPE available, and staff were observed to follow the instructions. The trust monitored the numbers of surgical site infections, and the trust board received a monthly update on rates of infection as part of the Patient Experience report. The Getting it right first time (GIRFT) report recorded that 612 surgical site infection cases were reported. The trust recorded an annual infection rate of 0.33% for both the initial inpatient spell, and the inpatient spell and readmission, which were below the national averages.

Environment and equipment

- It is known that the external fabric of the hospital is not fit for purpose; however, the adult surgical wards were well maintained, with adequate space for patients and staff to move about and deliver care. We saw that environmental risk assessments had been completed on Ward 4, and identified high risks were escalated and recorded on the risk register until completed. A local log of low risk issues was overseen by the ward managers.
- The operating theatre suite comprised nine laminar flow theatres with another being commissioned. There was a suggestion from staff that the layout did not 'flow' and could impact on safety within the department.
- We observed that several cushions / mattresses had been repaired using waterproof tape, and a hole in the wall had also been covered with tape.
- Resuscitation equipment was available in all wards visited. Records were seen to demonstrate that daily checks were completed and defibrillator equipment was tested.
- Records were not completed to demonstrate safety checks of some anaesthetic equipment were carried out daily

Medicines

- We saw medicines were well managed in the wards. Clinical rooms were locked, and staff swipe cards allowed restricted access. Drug cupboards were locked and intravenous fluids were stored off the floor in lockable cupboards. Controlled drugs (CD's) were checked by registered nurses at the start of each shift, and CD registers were completed in full. We saw that this was not replicated in the anaesthetic rooms in theatres. We saw CD's drawn up for use and left unattended. CD registers were not fully completed with the amount of drug administered and /or wasted.
- On the wards staff wore red tabards when administering medication, and patients reported that they received their medication when it was due or as required.
- Ward-based pharmacists checked patient prescription charts and raised prescribing queries directly with the medical staff, or made an entry in the patient notes requesting changes.

Records

- We looked at over 38 sets of patient notes during the inspection. The notes were completed by all members of the multidisciplinary team. Nursing risk assessment and point of care records were available at the bedside and were completed in full. We found the standard of record keeping was excellent, and followed professional standards on the wards.
- Every patient was assessed on admission for a range of potential risks, including malnutrition, moving and handling, risk of developing pressure ulcers, and falls. We also saw evidence of review, either when the patient condition changed, such as post-surgery, or if no changes, there was evidence of weekly review.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient's reported they received "excellent information" to enable them to understand the risks and benefits of the planned surgery. They confirmed that they had signed a consent form on their admission to the ward

and prior to surgery, but several told us they had not been offered or given a copy of the consent form. We observed several patients being consented during our visits to the wards, and they all were given a copy of the consent form.
- There was a prominent statement outlined in red in the consent booklet, reminding medical staff about ensuring the person's capacity to consent.
- There were processes in place to make applications where Deprivation of Liberty Safeguarding issues were identified. The clinical nurse specialist (CNS) was responsible for making the applications, and the trust sought advice and support from independent mental capacity advocates (IMCA) in all cases.
- Work was reported as ongoing' to improve staff understanding of the Mental Capacity Act, and training had been held for consultants and anaesthetists. The CNS provided an overview of consent and MCA as part of the trust induction programme for all staff.

Safeguarding

- There were processes in place for staff to refer safeguarding concerns. The CNS was named by staff as the person to contact, and we saw staff were provided with the safeguarding contacts list at the local authority for when the CNS was not available.
- The safeguarding lead had established good links with the local authority safeguarding team, and attended meetings. The minutes of the last meeting were seen, and demonstrated that there was trust representation.
- Staff received safeguarding vulnerable adults training as part of their mandatory training, the level of which was dependant on the role. Local records seen on wards showed the majority of nursing staff were up to date with their training.

Mandatory training

- Data provided by the trust showed that in March 2014, 82.75% of all trust staff were up to date with their mandatory training. It is of note that medical and dental staff attendance was the lowest reported rate of 56.25%, with allied health professionals and nursing rates at 83%, and administration and clerical staff at over 90%.
- We were told by the medical director that they were taking action to increase medical staff compliance with mandatory training.

Management of deteriorating patients

- The modified early warning score (MEWS) was used routinely to identify deteriorating patients. Staff told us the national early warning score was planned to be introduced in the near future. There were clear escalation instructions accompanying the observation charts. We found there was good utilisation of the MEWS during the inspection.
- There was an outreach team to support staff who were managing deteriorating patients, and they were available 24/7.
- An escalation protocol had been agreed to ensure medical support staff were informed of the patient's condition, and to ensure that prompt, appropriate treatment was provided.

Surgical safety checklist

- There was evidence that the trust had implemented the WHO surgical safety checklist in the last nine months. The checklist was launched by the National Patient Safety Agency (NPSA) in 2009. We saw variable adherence to good practice in its use, which suggested its use was not embedded in practice. Staff in theatre were seen to complete the checklist at each stage of the patient journey. We observed the checkout section of the checklist was not completed by the medical staff in radiology before a patient was discharged. Two 'never events' had occurred in radiology. Staff did not demonstrate an understanding of the importance of completing the safety checks in a timely manner.
- The trust provided the results of a WHO checklist sample audit of 55 cases in two theatres that was carried out in March 2014 to evaluate the implementation of the checklist. There was an action plan developed in response to the findings, such as repeating the audits monthly, and to use one standard form, as it was observed there were two available: one integrated into patient pathway procedures and a loose leaf version.
- The trust also provided the results of a similar audit conducted in radiology in March 2014. The findings identified that 15 out of 69 records checked were non-compliant in using the WHO checklist. The recommendations included ensuring that clinical staff complete the checklist for each radiological interventional procedure as a team, with the conversation being led by the radiologist, but the

written record of the checks being completed by someone other than the radiologist involved; the documentation must be scanned into the patient record and a follow-up audit performed within a month.
- We observed staff not completing the checklist in radiology on 8 May 2014. We were informed by staff that communication following the two 'never events' had been by email, and no additional training had been provided in using the WHO checklist.

Nursing staffing

- We were provided with the acuity tool used to set safe staffing levels in clinical areas. Staff reported a review was undertaken twice a year, and they had seen staffing levels increase as a direct result. They reported additional staff were now rostered to cover evening and night shifts. Staffing establishment figures provided by the trust showed the individual ward/department increases and rationale for the uplift.
- We observed there were sufficient staff on duty to meet the needs of patients at the time of inspection. Staffing was reviewed at the daily midday bed meeting, and we saw senior staff move staff to wards with short notice absences to help. The trust employed bank nurses who attended trust induction, and agency staff completed a short induction at the start of their first shift, and a signed record was kept.
- We observed a ward handover, which was in several stages, with the whole team in the office and then by the bedside with patient involvement. We also saw 'ward board' handover meetings between multidisciplinary team members.
- Ward managers told us they had a funded staffing complement for their ward. On two wards they reported they had recruited to all their vacant posts and were waiting for staff to start. There was an active recruitment programme, with monthly ongoing adverts supported by the human resources department. The trust vacancy data for March 2014 showed across theatres there were 19 whole time equivalent (WTE) nursing/healthcare assistants vacancies, and in the six adult wards there were 32 WTE vacancies.
- There was a high ratio of registered nurses to healthcare assistants on duty and listed on ward staffing rotas. There was one registered nurse for four to six patients, with support from HCA's. There were 40 scrub staff and 21 operating department practitioners (ODP) available in theatres. We were told every theatre had three trained staff allocated, and at night the department was staffed by two trained nurses and one ODP on-call, and this was within accepted guidance.

Medical staffing

- There were two junior doctors providing medical cover out of hours and at weekends. Concerns were raised about the escalation of identified medical issues for patients, but there was evidence that there was an experienced senior grade doctor available at all times to support them.
- Ward rounds took place daily, and there was evidence of multidisciplinary meetings to plan patient's ongoing care and treatment. There was additional medical support provided by two orthogeriatricians, who worked under an agreement with a local acute NHS trust.
- Trust information showed locum staff were employed to cover posts as needed. The records showed there were three consultant anaesthetist posts filled by locum staff.
- Consultants provided surgical cover six days per week, and there was an on-call requirement out of hours and Sundays.

Major incident awareness and training

- Staff were aware of the trust business continuity plans and escalation processes in the event of a major incident. There were site managers available to oversee operational issues, particularly out of hours and at weekends, and they were responsible for co-ordinating and further escalation of issues.
- Surgery was predominantly elective, with some emergency admissions through outpatient clinics. The trust provided information to show very few elective procedures were cancelled to accommodate emergencies.

Are surgery services effective?

Outstanding ☆

There was sufficient evidence to demonstrate the outcomes for patients with complex orthopaedic problems were consistently outstanding, and care and treatment was based on published guidance. Many patients come to

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Stanmore as there are a limited number of other services that offer the treatments they need. There were innovative approaches to care and treatment including leading and participating in research.

Evidence-based care and treatment

- Trust policies and procedures were available on the trust intranet, and staff reported that they could access them easily. The trust used the Marsden Manual to support clinical care procedures, which was available online. We saw the trust policies were reviewed and updated at regular intervals.
- Standard operating procedures (SOP's) were available in theatre, and senior nurses were responsible for updating them, and this was in progress.
- Staff could access National Institute for Health and Care Excellence (NICE) guidance online, and policies were referenced to relevant published guidance.
- Audit activity was overseen centrally, and information provided by the trust showed 89 local audits had been carried out across the trust in 2013-14. There was a detailed annual plan in completing audits which was adhered to.
- Staff were involved in local audits, and hand-held tablet devices were used to collect and submit data for checking adherence to policies, such as infection control and safety thermometer indicators.
- There was evidence of a wide range of audits carried out by all disciplines working in the trust.
- The audit department issued a newsletter providing staff with the results of recent audits, and outlining the recommendations required to improve performance. The newsletter also advertised departmental audit meetings, the contact details of the clinical audit lead, and the link to the clinical audit pages on the trust intranet.
- Enhanced recovery programmes were in place for hip and knee joint replacement surgery.
- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) review of the perioperative care of surgical patients recommendations were being adhered to. Patients scheduled for elective surgery were all seen and fully investigated in pre-assessment clinic.

Pain relief

- Patients told us their pain was well controlled, and nurses were prompt in administering pain relief.
- Patient records showed evidence that a pre-operative assessment was carried out for post-operative pain relief.
- The trust had a pain team, and staff could refer patients to the acute pain nurse for review. The service was not available out of hours or at weekends. The anaesthetic registrar covering at weekends was available to see patients of concern, and review patients with epidural pain relief.
- There were no agreed pain protocols available to manage routine post-operative pain. We were told patient's initial analgesia was prescribed by the anaesthetist and then reviewed or added to by the junior doctor, and this was confirmed in patient prescription charts.
- We looked at some patient post-operative pain prescriptions, and noted there was a heavy reliance on opiates, and patients were frequently prescribed for two at a time despite not having had analgesia before. The provider may wish to note that opioids prescribed for pain relief for older people are recognised as a contributory factor in falls and increased confusion.
- There was no apparent protocol of prescribing laxatives or opioid antidote medication routinely for patients prescribed opiate analgesia.

Nutrition and hydration

- Adult patient's nutritional state was assessed on admission to the hospital. Patients with identified risks were referred to the dietician for further assessment and dietary advice. Those patients identified as requiring support with eating and drinking were identified by a knife and fork symbol on the 'patient ward board', and the hostess was notified to serve meals on a red tray.
- The trust provided a range of meals from a menu which had been developed to meet the cultural, religious and dietary requirements of the patient population.
- Patient's feedback on the food ranged from "delicious" to "disgusting". Patients with an extended stay in hospital found the menu "repetitive and boring".
- Patients reported that they had access to adequate amounts of food and fluids. Water was freely available. We saw that one ward staff were piloting a drinking water delivery system for bed-bound patients called 'hydration for health', which enabled the person to drink without assistance and gave them some independence.
- Food and fluid charts were completed for patients identified as at risk of dehydration or malnutrition.

- Nutritional advice leaflets were available in patient day rooms, and we saw on the Duchess of Gloucester Ward that a patient notice board displayed nutritional advice to promote healing post operatively.

Patient outcomes

- We were provided with a large volume of data that was reviewed by our inspection team that demonstrated patients had excellent outcomes. We saw examples of outcome data across all specialities, which contribute to national registries where they exist, and the results were considered outstanding by our specialists. The data was also used to benchmark the trust performance against other specialist trusts.
- The service proactively contributes to improving orthopaedic surgery for patients. We were provided with multiple examples of academic articles and papers presented at conferences about patient outcomes following surgery at the trust.
- The service carries out a number of operations that only a limited number of other hospitals can offer.
- Patients were receiving innovative surgery. There was use of intraosseous transcutaneous amputation prosthesis (ITAP), which is a prosthesis implanted in the remaining part of the amputated limb.
- The sarcoma service was reviewed by an n external hospital that identified good practice /significant achievements, well established service, demonstrable good team working, excellent clinical trial recruitment, good data collection in general and well-presented activity data, excellent approach to information gathering in Histopathology and a very easy to use and accessible website.
- The nursing team had participated in the national QUIDIS Patient Information Project for bone sarcoma patients and good outcomes were reported
- The majority of patients treated were referred because of their complex health needs and the specialist nature of their orthopaedic conditions, which required the specialist services provided, such as the sarcoma service, spinal surgery and joint revision surgery.
- The trust is a tertiary centre and performs a higher proportion of revisional surgery than other trusts, and primary joint replacements were performed on patients who have underlying bone and metabolic problems; the hospital achieves outstanding results. Take on behalf on
- The Getting it right first time (GIRFT) report showed that the trust performed 167 hip revisions and 109 knee revisions in 2011-12, and the reported outcomes were similar or better than to the national average.
- The trust scored in all six headline metrics as within or above the national average. The trust was above the national average for revision rates for hips (5 years) knees (1 and 5 year).
- The trust participates in national audits such as the Patient Reported Outcome Measures (PROMs) for hip and knee replacement surgery. The knee replacement data identified an elevated risk. The trust had investigated the data, and had determined that it related to the filters applied for the specialist work undertaken.
- All National Joint Registry (NJR) metrics for the trust scored as within the national average.
- The trust reported in the GIRFT report that the total orthopaedic and spinal activity was 6,213 episodes. For the majority of the metrics used to assess the performance of the orthopaedic activity in the trust it was within the national average or just above.
- The trust Average Anaesthetic Society of America (ASA) rating was 2.03; the national average rating was 2.13, which would suggest patient's anaesthetic needs were no more complex than the national average.
- The Charlson Co-morbidity Index is used to score patients with contributory health conditions prior to surgery. The average Charlson score for the trust in 2011-12 was 0.53 above the national average of 0.46.
- We saw evidence of a range of metrics to demonstrate the effectiveness of patient outcomes; the 'Sprint' database detailed individual patient outcomes by consultant for spinal patients, and there were examples seen for the treatment of sarcoma.
- We noted that patients having joint replacement surgery were asked to consent for their details to be released to the NJR to contribute to the annual report.

Competent staff

- Appraisals for nursing and medical staff, including consultants, were being undertaken. Staff reported that they were generally happy with process. They confirmed the process included professional development, and staff told us they were funded to attend courses and improve clinical skills.

- Staff reported that they were able to discuss clinical issues arising amongst the nursing team at the handover meetings.
- Junior medical staff we spoke with felt they were well supported by their clinical and educational supervisors. They had protected time every two months to attend audit presentation meetings, clinical updates, and morbidity and mortality meetings.
- The medical director is the revalidation lead for the trust. He confirmed that comparative outcomes by clinician were available, and we saw the spinal surgery data as an example. The trust had received a Green rating for its annual organisational readiness self assessment (ORSA) submission for 2012-13, with high levels of completed appraisals for consultant staff, but low levels for doctors on short-term contracts.

Multidisciplinary working

- We saw very good examples of multidisciplinary team (MDT) working across the adult surgical wards and services.
- The radiology department supported many MDT meetings each week at which large volumes of referrals and cases were discussed.
- Patient notes were multidisciplinary, and there were records of regular MDT meetings.
- Dieticians and physiotherapists attended the meetings.
- There was a service level agreement with a local NHS trust to provide medical support on site for pre-determined sessions, and specialist medical support and out of hours support, and transfer of patients who become unwell.
- An example of external cross-site working was the London Sarcoma Service, which is provided in conjunction with University College London Hospitals (UCLH) and reports the MDT meeting activity as part of its audit to the national commissioning group.

Seven-day services

- We saw evidence of ward rounds by a variety of consultants, registrars and junior doctors. There was a consultant presence during operating hours six days a week, and they provided an on-call presence out of hours and on Sundays.
- Outreach services from the intensive therapy unit (ITU), to support staff to manage a deteriorating patient, were available 24/7.
- The radiology department provided services six days a week, with on-call support for out of hour's requests. This was similar for pharmacy and physiotherapy services.

Are surgery services caring?

Outstanding ☆

Surgery was an extremely caring service that put patients at the centre of the service. The hospital consistently performed higher than the national average in the Friends and Family Test, and the trust patient experience survey achieved very good results. Over the period of our inspection we witnessed many episodes of kind, compassionate and caring interactions from all staff groups, and patients and relatives were universally very positive in their feedback.

Compassionate care

- The overall trust response rate (73%) and score of 78 for the Friends and Family test was above the national average. Individual ward scores were published in the monthly KPI nursing scorecard. We saw that the results were prominently displayed on all wards.
- Patients were asked to complete the trust patient experience survey prior to discharge. The results demonstrated that patients were very satisfied with the care and treatment provided.
- The 2013 inpatient survey results showed that out of a total of 57 questions, the trust performed better than other trusts in 17 questions, and was not rated 'worse than other trusts' in any of the questions.
- Patients all commented favourably about staff working in the trust. We were told staff were "friendly", "kind and caring" and preserved patient's dignity.
- Staff were seen to request permission to enter closed curtains. There was consistent use of red 'do not enter' signs attached to closed curtains when delivering personal care.
- Staff interaction with patients, relatives, and between themselves, was professional, calm and demonstrated a mutual respect.
- Patients were provided with postcards on admission containing details of the ward manager, and advising who was available to talk with about any concerns they may have.

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Patient understanding and involvement

- Patients were very knowledagble about their conditions and treatments.
- Families were involved and well supported.
- Patients were allocated a named nurse on each shift. We witnessed staff introducing themselves to patients, and there was a bedside handover with patient involvement.
- Patients were very knowledgeable about their care and treatment, and were involved in planning their care. We observed the admission of two patients, and at all times they were engaged and participated in the process.
- Ward managers carried out 'rounds' of the patients, and a record was signed every time they occurred. Patients reported that ward managers were visible, and available to discuss issues or concerns.
- The patient-led assessment of the care environment (PLACE) scored the hospital 79.8% for facilities; however, they achieved slightly higher scores above 81% for cleanliness, food and privacy, dignity and wellbeing.

Emotional support

- There were a range of clinical nurse specialists available to support patients. There were MacMillan nurses available to support patients undergoing treatment for cancer.
- The London Sarcoma Service CNS's had developed a supportive pathway for patients from diagnosis to follow up and discharge, to include a holistic needs assessment, the Macmillan HOPE programme (Help Overcoming Problems Effectively), and Wellbeing days with MDT colleagues.
- The trust had arrangements in place to refer patients for psychological support. We witnessed and staff told us they were able to request support from psychiatric specialists when patients had a mental health need. We saw that psychiatric support was provided promptly to an urgent request to review a patient who was unwell.

Are surgery services responsive?

Good

Surgical services were responsive to the needs of patients and others. The trust managed the availability of beds to ensure that patients were admitted as expected. Although there were a significant number of cancellations annually, we noted that the majority were due to the person not being fit for surgery on the day.

Patients were pre-assessed for surgery. This was undertaken at the same time as the outpatient appointment to prevent another visit to the hospital. An admissions lounge was used to process patient's admission into the hospital, and patients were directed to the ward when a bed was available. Admission times were not staggered, and the admissions lounge was too small to accommodate the numbers of people scheduled to arrive at one time.

Care was organised to meet the needs of the patient, translation services were available; however, written information in other languages was only available on request. We found that discharge planning began very early in the patient's pathway of care, and was well organised. There was a multidisciplinary approach involving patients and relatives to ensure the safe, effective discharge of patients. There was a discharge co-ordinator available to co-ordinate complex discharges.

Access and flow

- The hospital provides a national specialist orthopaedic service and accepts referrals from across England in accordance with the NHS England commissioning contract. Other referrals were accepted by the trust from the rest of the UK funded by other agreed contracts.
- The trust's published bed occupancy was reported as 73.2% between September and December 2013. There were arrangements in place to use the private patient ward as a step-down facility to accommodate pre-operative patients and those being discharged if appropriate, to release beds on the adult surgical wards. The bed manager oversaw the utilisation of beds. There was a bed management meeting daily at midday, to ensure the availability of beds and staff across the trust.
- Patients were pre-assessed for their procedure in the outpatient department.
- Patients were admitted through the admissions lounge. Staff told us that admissions were not staggered, and everyone on a morning theatre list reported on the day of admission between 6am and 7am. Patients on an afternoon list were brought in at 11am.
- The lounge comprised of a small room to accommodate a patient waiting area and staff desks, with a small

clinical room attached that was used to admit patients and carry out the nursing risk assessments. People told us they found the environment cramped, and patient experience data from the previous few months confirmed that the admission process 'needed improvement'.

- There were potential confidentiality issues due to the close proximity of the patient sitting area and staff working area.
- The trust had implemented the 'ticket home' system, which identifies the intended date of discharge at the time of activating the process to come into hospital. An A4 'ticket' is generated and displayed on the patient locker with the intended discharge date.
- Staff completing the ward admission process were seen to discuss the expected date of discharge with the patient, relatives or carers, and the need to make arrangements to be collected and leave the ward/bed by 11am.
- Staff told us there was an escalation process to the discharge co-ordinator for complex discharges. Patient records showed there was involvement of carers and relatives in the multidisciplinary planning for discharge. Patients said they were usually kept informed of any changes in the discharge arrangements.
- There was a very low number of cancellations. Information provided by the trust for the previous 12 months showed that there had been 630 patient cancellations. 297 were cancelled by the hospital for clinical reasons, including 156 patients being unfit , 53 operations were not necessary, 68 were for other reasons, and for the remaining 20 reasons included not following pre-op advice, unfit for day surgery, and a pre-existing medical condition. There were 333 cancellations for non-clinical reasons, including 37 patients deeming themselves unfit, 37 did not want the operation, 37 cancelled for an undisclosed reason, 72 cancellations had occurred due to the list overrunning, and 51 patients did not attend for their procedure. We noted 19 cancellations were related to beds not being available and 31 were attributed to equipment failure or equipment not being available; only three patients were cancelled due to emergencies.

Meeting people's individual needs

- The trust had systems in place to meet the needs of patients with complex needs. Staff reported collaborative working across disciplines and external agencies.
- Evidence in patient notes demonstrated detailed communication and liaison with other health care professionals involved in people's care, to facilitate admission, and appropriate care and treatment.
- Translation services were available through a telephone service; however, we found that patient's families were often used to translate information. Leaflets and information available in patient areas was in English; however, all trust leaflets contained details of how to contact the clinical governance department to obtain a translated version.
- Patients with learning disabilities had 'patient passports' detailing key information about the person and how they wished to be cared for. The matron for surgery services told us that a business case was in progress to employ a learning disability trained nurse to support patients during their stay in hospital.
- Staff told us that dementia awareness training formed part of the mandatory training programme. Dementia screening/assessment was undertaken for patients over 75 years, and there was clinical advice and input available from consultant orthogeriatrians, who also attended weekly multidisciplinary meetings.
- There was a 'joint school' for patients on the enhanced recovery programme for joint replacement. Patients living within a 30 mile radius of the hospital were automatically booked to attend, and patients from further away were offered a place if they wished to attend.

Learning from complaints and concerns

- Evidence from the trust showed complaints activity was reported to the board monthly, and was analysed for trends and performance against the response timescales. There were 24 complaints in surgery and theatres for the period October 2013 – March 2014; 17 were closed and seven remained open. Trends included adverse clinical outcomes, cancellation of appointments, and admission and discharge arrangements. The trust complaints log recorded the action taken, which included meeting with patients to resolve issues; all were offered apologies and informed of the actions proposed.

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- Minutes from monthly senior sister meetings showed that incidents and complaints were discussed, and learning from them disseminated through that forum.
- Staff told us they received feedback from patient complaints and comments in ward meetings. Staff told us of initiatives, such as the ward postcards, to address feedback from the patient survey
- Patient comments from the Friends and Family Test were displayed on ward notice boards; these were all positive. Staff told us that they were aware of some negative comments and these were used to identify areas of ward practice to improve the patient experience, such as communication and staff attitude.

Are surgery services well-led?

Good

At ward level the areas were well-led, with motivated senior sisters leading enthusiastic staff. There was an enthusiastic and motivated theatre manager in post; however, we found staff appeared to be less motivated. It was noted that there was no matron in post to provide support to the manager and nursing leadership. The majority of staff told us that they had seen members of the executive team.

Staff morale was generally high on the surgical wards, but in theatres, overrunning lists and working additional hours to cover staff vacancies had affected the morale. Incidents were followed up with an action plan to address the issue, and risks were identified and addressed on the wards. Staff felt that the managers were involved and responded to the action plans and closed them off. The staff told us that areas of the trust worked in silos, so staff didn't always know what was happening in other parts of the hospital.

Vision and strategy for this service

- The vision and strategy for the service was very well understood by staff, and was well described by everyone we spoke with. They all reiterated that they were a centre of excellence, and it was a source of pride for all.
- Staff and patients all spoke of the high standards of care that were delivered and achieved in the substandard buildings. One patient said "if you can get this standard here you should be able to get it anywhere".

Governance, risk management and quality measurement

- We saw information boards containing governance data to inform patients, staff and visitors of the internal audit results, month on month. Where wards had not achieved the benchmark standard, action plans had been developed and another audit arranged to assess progress.
- The trust's risk register included plans for identified risks, with timescales for completion of actions. We saw examples of action being taken promptly, such as arranging the replacement of a ward macerator when the decision was taken that it was unrepairable. Once the actions were completed, the item was removed from the register.
- Staff told us that risks were removed once identified risks had been fully resolved. The risk register contained current issues; premises issues were the longest standing identified risks, and the trust had mitigated the risks to ensure patient and staff safety.

Leadership of service

- There were identified lead professionals in most areas, including a ward manager on all wards who provided local leadership, an identified clinical lead for each of the surgical specialities, and a divisional lead.
- In the operating department there was no identified professional lead for nurses; the senior sisters reported to the theatre manager who was registered with the Health & Care Professions Council as an operations department practitioner.
- The senior sisters and matron were visible in the ward areas, supporting staff, ensuring training and appraisals were completed, and undertaking audits.
- The medical director oversaw the clinical leads, and was seen to be proactive by the trust and consultant colleagues.
- Staff reported that there was a programme of quality visits to the wards by matron and non-executive board members, which were undertaken out of hours.
- Senior staff told us they had been involved in the recruitment of the newly appointed interim director of nursing (DON). Ward staff told us the DON had visited the ward, and appeared interested, supportive and enthusiastic.

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- The majority of staff we spoke with knew the CEO and said he had visited their area of work. Some staff said they had noticed an increase in visits in the lead up to the inspection.
- We spoke with doctors completing their training in anaesthetics who told us their experience in induction and educational supervision was very good. The Trust has variable feedback on GMC Training survey in Anaesthetics; average across nine indicators, above average in two areas, Handover and Local Teaching and below average for one area, induction.
- Junior doctors reported that they did not always have systems in place to support them, particularly out of hours. We found that senior specialist registrar-grade anaesthetic and orthopaedic colleagues were available to provide support out of hours.

Culture within the service

- The trust encouraged any staff member who had a patient safety concern to raise this within the organisation at the earliest opportunity. There was a confidential phone line available for staff to raise concerns. This had been introduced as a direct response of the recent staff survey results. Staff at the trust had continuously reported bullying as an issue in the NHS staff survey since 2008. In theatre, action had been taken to address bullying through mediation and trust disciplinary processes, and the provision of anger management courses.
- Staff we spoke with told us that as a centre of excellence, the priority for everyone was the safety and quality of the patient experience. One person told us "excellence can only be achieved through the contributions of everyone on the team".
- Staff were encouraged to share good practice, and support each other when things went wrong.
- Learning from incidents and complaints was embedded in the wards. Staff told us that they received feedback when they had reported an incident. Staff in theatres did not demonstrate the same awareness, or reporting and learning from incidents, and shared that they did not receive adequate feedback.

Public and staff engagement

- Patients and their family's feedback was universally good. Patients told us that they felt safe and very well looked after.
- There was a trust patient user group. Members served on various committees, to provide the patient perspective and improve the patient experience.
- The trust published a quarterly staff newsletter to update staff on current issues and initiatives. Staff also told us that they were kept up to date with information through the intranet and staff meetings in their ward/ departments.

Innovation, improvement and sustainability

- Staff told us that there was friendly rivalry between wards to achieve high results in standards of care and quality. We saw how certificates were awarded to recognise and celebrate achievements, such as the 'best ward of the month for KPI's' award, and for the highest appraisal rates.
- The trust was in the process of transformation, and encouraged staff to contribute and suggest changes that would streamline processes and improve ways of working.
- Patients were provided with postcards on admission containing details of the ward manager, and advising who was available to talk with about any concerns they may have.
- Ticket home discharge planning assisted the efficient discharge of patients after their treatment
- Staff had the support and encouragement to be involved in pioneering new treatments such as the use of intraosseous transcutaneous amputation prosthesis (ITAP), which is a prosthesis implanted in the remaining part of the amputated limb.

Critical care

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

Information about the service

Critical care services incorporate the intensive therapy unit (ITU) and the high dependency unit (HDU) located within the Alan Bray Ward, the newly refurbished children's high dependency unit (CHDU) and the critical care outreach team. Sixteen beds are available in total to patients who require high level of care and close observation, twelve for adults and four for children in a separate building. The adults' unit is open plan with two single rooms. The critical care outreach team assisted in the management of critically ill patients throughout the hospital. Staff, who mostly worked across critical care services, provided care and treatment for patients who required advanced monitoring and support in the crucial hours after surgery. Patients were mostly received from theatres and wards throughout the hospital. Over 1,200 adults and nearly 400 children used the critical care service between January and December 2013.

During our inspection we spoke with three patients, four relatives and 22 staff members who worked within the unit or in close partnership. This included consultants, doctors, nurses and managers. We observed care and treatment, and reviewed medical records and those related to day-to-day management of the unit.

Summary of findings

Patients received appropriate care and treatment in accordance with national guidelines. There were sufficient numbers of staff on duty, and enough equipment to meet patients' needs. Systems were in place to monitor the quality and safety of patient care provided. Staff were knowledgeable and compassionate. They were aware of the incident reporting systems and told us that they were encouraged by senior staff to report incidents and raise awareness of patient safety issues. Patients were fully informed and satisfied with the outcomes of their treatment. They told us that they were cared for in a supportive way, and found staff very friendly.

Critical care

Are critical care services safe?

Good

Critical care services were safe. There were effective monitoring systems in place, which allowed monitoring actions to be taken in response to incidents. The unit was clean, and staff followed infection control principles. The equipment was easily available, and most was adequately maintained. There were systems in place to ensure the medicines were managed safely. Records were accurate, easily available and reflected individual care and treatment needs. There were clear escalation pathways to support deteriorating patients, and staff were clear on how to obtain specialist support when required. There were a sufficient number of qualified and knowledgeable staff, and they were well supported in their day-to-day jobs.

Incidents

- Clinical incidents were recorded and monitored effectively by the staff.
- Twenty incidents took place between January and March 2014. They were mainly low grade pressure ulcers, which were not incurred on the unit, and three medication administration errors where no patient came to harm.
- The service had a good monitoring system in place, which allowed monitoring actions to be taken in response to incidents.
- Staff we spoke with were aware of incidents which took place on the unit and actions taken in response. We saw that this was discussed during meetings and noted in meeting's minutes. They also told us they felt able to raise concerns, and that if they felt these were unresolved, they could escalate it further.

Safety thermometer

- There was one pressure ulcer reported between January to March 2014, and no falls recorded during the same period of time.
- There were no patients who developed catheter-acquired urinary tract infections (UTI) or venous thromboembolism (VTE - blood clot in a deep vein) while being treated on the unit during the same period of time.

Cleanliness, infection control and hygiene

- The unit appeared clean at the time of the inspection. We observed staff adhering to the infection control principles, using personal protective equipment and hand sanitizers each time they approached a patient.
- Key performance indicators showed that there was no MRSA or C. difficile -acquired bacterial infections on the unit during the last twelve months.
- The infection control policy was up to date and in line with national guidance.
- We saw that there was a cleaning schedule displayed on the wall, and that newly cleaned equipment was correctly labelled to indicate it was clean and ready for use. However, the unit was unable to provide us with cleaning checklists which were to be used to indicate that tasks were completed as detailed by the cleaning schedule. We observed some cleaning activity being undertaken, and a domestic staff member told us that they followed the cleaning schedule displayed on the wall.
- Staff told us that regular hand hygiene and infection control audits were undertaken, and that they mostly achieved the required benchmark. Patient experience reports indicated that the unit had achieved compliance above 95% during the period of twelve months February 2013 to February 2014.
- An audit in the first quarter of 2014 identified that doctors were not always 'bare below the elbows' in clinical areas. Also, doctors did not always decontaminate their hands with gel between patients. Staff were being encouraged to challenge colleagues if they witnessed this behaviour.
- Outside visitors had been identified wearing long sleeves, and staff felt that it was "inappropriate to request visitors to roll sleeves up when they were assisting with feeding patients". This was against the visitors' policy, which required visitors to remove their coats and be 'bare below the elbows'.
- Staff told us that outcomes of the audit were discussed at handover, and this discussion included the specific areas for improvement and the importance of it.

Environment and equipment

- The floor covering was damaged and did not meet infection control standards. We spoke with the matron who informed us that the funds had been allocated to replace the flooring in 2014.

- We saw that personal protection equipment was easily available at each of the patients' bays. However, there were only three hand-washing basins available on the adults' unit for 12 beds. The Health Building Note issued by the Department of Health for critical care services (HBN 04-02) specifies that each bed space should include a clinical wash-hand basin.
- Resuscitation equipment was easily accessible to staff, and it was checked regularly.
- Staff told us that equipment was maintained and easily available; this included mechanical ventilators, cardiac monitors and mattresses used to prevent pressure ulcers. We identified that it was not always clear when the portable electrical equipment had last been tested (PAT test) or calibrated and checked to ensure it was safe to use. Labels on some equipment indicated that PAT tests were overdue. We raised this issue with the trust at the time of the inspection, who showed us the certificates and receipts of the servicing of the equipment.
- Oxygen cylinders and firefighting equipment were checked regularly.

Medicines

- There were correct storage facilities and systems in place to ensure compliance with the requirements of the relevant legislation, which included management of controlled drugs.
- Staff handled medicines safely, securely and appropriately. We saw that staff followed published guidance about how to use medicines safely, and had the competency and skills needed.
- We saw that drug errors were correctly reported and investigated in order to improve the practice and prevent reoccurrences. We also saw evidence that it was discussed during team meetings.

Records

- Personal medical records were accurate, fit for purpose, easily available and reflected individual care and treatment needs. They were accessed by authorised people and remained confidential.
- Computers used on the unit were password protected, and individual medical records were kept near patients' beds.
- Staff told us that they were required to complete information governance training as part of their mandatory training.
- Staff working on the unit were able to access records related to the day-to-day management of the service promptly when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At the time of inspection there were no patients treated on the unit who would be a subject to the Deprivation of Liberty Safeguards.
- Staff we spoke with were aware of the procedures used if patient's capacity to consent was in question. A flow chart displayed in the corridor explained the process which staff should follow.

Safeguarding

- The matron told us that the trust worked in partnership with the local authority to ensure safeguarding procedures reflected best practice, and that staff received training in accordance with the most recent developments.
- Staff knew who the safeguarding leads for adult and children were at the trust, and how to contact them.
- One safeguarding incident was reported by the matron. We noted that appropriate actions had been taken in response, which included informing the local authority's safeguarding team.
- Staff we spoke with were aware of the procedures they would follow if they suspected abuse.
- Staff received mandatory training in safeguarding, which was adequate to their roles and responsibilities. The matron told us that it was a requirement for a member of staff who had completed Level 3 safeguarding adults and children training to be on duty at all times (this training covered detailed knowledge of safeguarding procedures designed for managers working within the Health and Social Care sector).

Mandatory training

- Staff we spoke with were knowledgeable. They told us that their induction to the unit had been very good and they felt well supported. Staff also said that they felt supported with professional development and had access to training, which included infection control, manual handling, conflict resolution, and specialist training related to their role.
- There was an educator nurse allocated to the unit, who oversaw training needs and delivered competency-based training.

Critical care

- We saw that records of training completed by the staff were kept in individual files and monitored centrally. At the time of inspection approximately 83% of all staff working on the unit had completed mandatory training. This was higher than the average mandatory training compliance achieved by all staff groups working at the trust between April 2013 and March 2014 (75.9%).

Management of deteriorating patients

- The unit worked in conjunction with the outreach team in order to provide support to patients of other wards of the hospital during the day and night. There was a clear discharge planning procedure to ensure safe discharge to other wards supported by the outreach team.
- There was a clear escalation pathway, and staff were clear on how to obtain clinical advice and support when required.
- A senior trainee anaesthetist was available day and night, for both adult and child patients.
- A senior anaesthetist consultant was available for immediate recall to the hospital.
- The early warning signs system guide was adapted and continuously improved to reflect the specifics of the service and needs of the people treated in the hospital. Other guides had been used by the unit in the past to determine the degree of illness of a patient. It included national early warning score (NEWS) and modified early warning score (MEWS) systems. We were told that this was a subject of continuous improvement and evaluation to ensure effective operation.
- We participated in the handover where patients' whose conditions had changed, discharges and admissions were discussed. The handover attendance was monitored, and speaking to the trainees involved, a clear record of the problems around the hospital is made and used by the incoming team.

Nursing staffing

- There were sufficient numbers of suitably qualified staff, which were in line with professional guidance. Patients supported on the unit were provided with appropriate support.
- There was one nurse allocated to each of the patients treated at the intensive therapy unit (ITU); one nurse per two patients were allocated to patients treated at the high dependency unit (HDU).
- There was one senior nurse (band 7) present at all times, who was supernumerary.
- The matron told us that the unit aimed to use familiar bank staff when they had to cover a shift at short notice. Rotas indicated that agency staff were used very occasionally.
- Staff told us that they felt there was a sufficient number of staff to meet the needs of the patients.

Medical staffing

- Staff told us that handovers between the on-call anaesthetist and other clinicians were organised twice daily, seven days a week.
- There were six consultants working on the unit, all were registered with the Faculty of Intensive Care Medicine (the professional body responsible for the training, assessment, practice and continuing professional development of intensive care medicine consultants). Each consultant worked four days a week, and they were dedicated to the critical care service.
- Senior trainee registrars were also present and dedicated to the critical care service.
- Out of hours critical care on-call support was provided by each of the 17 anaesthetic consultants working within the hospital. The trust told us that they were in the process of implementing a dedicated intensive care-trained consultant service.

Are critical care services effective?

Good

Critical care services were effective. Although we did not have any specific outcome measures related to critical care overall, outcomes for the whole patient journey were positive. Patients had sufficient access to the pain relief team and to other specialist support accordingly to their individual treatment needs. We observed good examples of multidisciplinary team work. Links with local hospitals had been established to provide specialists support when required. Medical protocols were informed by national guidance and were up to date.

Evidence-based care and treatment

- We saw that medical protocols were informed by national guidance, such as guidance developed by the British Anaesthetic and Recovery Nurses Association, the Association of Anaesthetists of Great Britain and Ireland, the Resuscitation Council or the National

Institute for Health and Care Excellence. We saw that medical protocols were up to date. The medical staff we spoke with were aware of the latest standards and recent development in the field.
- Regular meetings were held in order to update staff on current practices and new protocols, and also to discuss developments within the unit.
- The unit had a clinical nurse training lead allocated, who monitored mandatory training and professional competencies. We saw that staff participated in training relevant to their clinical practice and continuous professional development.
- Staff told us that they were encouraged to develop their clinical practice and participate in courses appropriate to their role, to ensure the care they were delivering was evidenced-based best practice.

Pain relief
- Patients had access to the pain relief team, which included a chronic pain specialist nurse, and consultants specialising in pain management. One of the team had received specialist training in paediatric pain medicine.
- Staff on the unit told us that the pain team was responsive and able to act promptly. However we noted that the team did not work evenings and weekends when support was offered by the medical team and on-call anaesthetist.
- Pain relief team members were involved in providing training to all of the medical staff working on the unit, to support them with providing appropriate treatment out of hours.
- An electronic pain relief team referral system was introduced, with an aim to simplify the process and increase responsiveness. We were told that some of the nursing staff were still not very familiar with this system.

Nutrition and hydration
- We saw that simple meals were prepared in the on-site kitchen, and that patients had sufficient access to fluids. Patients told us that they were happy with the food offered to them on the unit.
- The team were supported by dieticians, one of whom was a diabetes specialist dietician. Staff told us that a dietician visited daily.

Patient outcomes
- We did not have any specific outcome measures related to the critical care unit. The trust was in the process of joining the Intensive Care National Audit & Research Centre (ICNARC) case mix programme, which collects and compares information about the quality of care in ITU and HDU units. Critical care speciality orthopaedics does not have a clear benchmarking criteria dataset in order to assess effectively the treatment received by patients.
- The mortality rate for the hospital was very low. Of the eight deaths that had occurred in 2013/14, five adult deaths occurred in the ITU.
- Overall outcomes for the whole patient journey were positive. We saw that serious cases were reviewed and appropriate lessons were learnt when required.
- On average 3% of patients were readmitted to the unit in January to December 2013 and January to March 2014. Staff told us that they did not feel pressurised to discharge patients, and were able to be driven purely by clinical indicators when deciding on discharges. A follow-up support within the hospital was provided by the outreach team.
- Two consultant ward rounds took place every day to ensure patients' health was suitably monitored and discharges were acted on promptly whenever possible.

Competent staff
- The staff we spoke with were knowledgeable and able to meet patients' treatment needs.
- Appraisals were being undertaken and staff spoke positively about the process. We noted that nursing appraisal on the unit was at 86% in March 2014.

Multidisciplinary working
- We participated in the handover meeting, which was attended by a senior specialist registrar, an outreach team member, and an on-call senior trainee anaesthetist. This meeting was organised twice a day. We noted that information was shared appropriately, and the team worked well together.
- Staff told us that they were supported by other specialists, and that they felt this allowed them to meet patients' needs fully. This included input from specialists in paediatrics, chronic pain management, physiotherapists, occupational therapy, and the resuscitation team, among others.
- Links with local hospitals had been established to provide specialists support when required. Links with

other hospitals included one with the North West London Hospitals NHS Trust accident and emergency department, and with Great Ormond Street Hospital for their specialist paediatrics services.
- Effective local links were established to provide on-site consultant cardiology presence three days per week, to allow the provision of specialist input for pre- and post-surgical support. We were informed of further similar development in other specialities.

Seven-day services
- We noted that in March 2014 there were nine unplanned admissions to the unit. Three of those took place during weekends.
- The unit was staffed seven days a week, and was able to support unplanned admissions and out of hours discharges. However, staff told us that there was limited access to specialists during weekends; the acute pain team worked weekdays only.
- There was on-call consultant support available during the weekend. The on-call consultants were also present during weekend ward rounds.

Are critical care services caring?

Good

Critical care services were caring. We observed numerous episodes of patient and staff interaction when staff demonstrated caring attitudes towards patients. Patients told us that they felt involved in the decision-making and that they were fully informed.

Compassionate care
- We observed that staff interacted with patients in a friendly and professional manner. They were observed to be respectful, and maintained patients' privacy and dignity.
- Patients told us that they were happy with the support and overall care. Some comments provided by friends and family included "genuinely caring and very nice", "staff are brilliant and always there to help" and "really friendly and professional".

Patient understanding and involvement
- Patients told us that they felt involved in the decision-making and that they were informed of "short and long term plans". We asked people if they knew who their allocated consultant, nurse or physiotherapist was, and most of them were able to tell us their name. They also knew what the next stage in their treatment was, and when they were going to be discharged to another ward.

Emotional support
- There was a psychology and psychiatrist available to both children and adults who required emotional support throughout their treatment.
- Bereavement services were provided by members of the Patient Advice and Liaison Services.
- Chaplaincy services were provided to patients and visitors of any denomination, any faith or none. This included an Anglican chaplain who visited three days a week and was available on-call for emergencies. Representatives of other faiths offered visits by request.

Are critical care services responsive?

Good

Critical care services were responsive. We noted that the bed occupancy rate and readmission rate were low. There were systems in place which allowed safe discharges to other hospitals in the event of additional specialist medical support being required. There were a sufficient number of staff to provide assistance to people who required additional assistance. Staff concerns were accurately recorded, and improvements were discussed at staff meetings. There were no complaints noted for the past twelve months prior to the inspection.

Service planning and delivery to meet the needs of local people
- Visiting times were clearly indicated for friends and family members. There was a small waiting room with two recliner chairs and hot drinks available. In the children's' high dependency unit each of the patients rooms had a foldable settee, which could be used by a relative if they wished to stay overnight.
- Admission, discharge and transfer criteria policy had not been updated since 2009, and staff told us that it did not fully reflect their current practice. Staff told us that they were not exposed to external pressures, linked to how

the service was planned and delivered, and which would compromise patient outcomes. This meant that they could be flexible on their admission, discharge and transfer criteria in order to provide personalised care.
- Between January and December 2013 the trust reported 16 discharges out of hospital. These were cases where specialist medical support was required, such as for patients with cardiac issues, or for endoscopy and colonoscopy procedures. There were systems in place which allowed safe discharges to other hospitals.

Access and flow

- The average bed occupancy in the unit was at 61% during January to March 2014; this was lower than the national average of 83%. The majority of patients were admitted to the unit after elective surgeries, or from other areas of the hospital if their health deteriorated.
- The matron told us that most of the patients were discharged after a one night stay on the unit. Patients we spoke with told us that they knew when they were due to be discharged, and if they were going to another ward or home.

Meeting people's individual needs

- There were two single rooms available for patients who required additional privacy, or were at the greater risk of acquiring or transmitting a dangerous infectious disease. Staff told us that they would benefit from additional single rooms in order to respond to patients' individual needs. We saw that one of the rooms was being used by a person who had speech and hearing impairment, and who was being supported by a family member who was helping with communication issues.
- Staff had access to the telephone interpreter services. There was some written information on services offered, and support available to patients and their families. This was mostly written in English.
- There was no policy which would provide staff with guidance and support on how to care for patients at the end of their life. Staff told us that no end of life training was provided to them, and that they felt they would benefit from attending such training.
- There were a sufficient number of staff to provide assistance to people who were confused.

Learning from complaints and concerns

- There were no complaints reported, for the twelve months prior to our inspection, which would relate to critical care services. We noted that staff concerns were accurately recorded and improvements were discussed at staff meetings.

Are critical care services well-led?

Good

The leadership at the critical care unit was visible, and senior team members were knowledgeable and aware of constraints, and areas where service improvement was required. There was a clear allocation of responsibilities within the unit and a clear accountability structure. Staff shared objectives and were able to communicate with each other effectively in order to achieve them. Staff told us that they felt they contributed to creating a positive work environment.

Vision and strategy for this service

- Most of the staff participating in the unit's staff survey, published in January 2014, were able to identify themselves with the trust's values, and said that they understood them. Over 80% of staff working on the unit said that they felt proud working for the trust; nearly the same number stated that they supported the direction that the trust was moving towards.

Governance, risk management and quality measurement

- We noted that the management team had taken actions to reduce the risks and improve the service. Risks related to sharps containers had been highlighted in the clinical audit report produced in October 2013. We noted that additional sharps containers had been installed near patients' beds in order to manage or reduce that risk.
- We saw from the minutes of the senior nurse meeting that complaints, incidents, audits and quality improvement projects were discussed.

Critical care

Leadership of service

- Staff told us that they felt that the leadership was strong and visible on the unit level. We noted that senior team members were knowledgeable, aware of constraints and areas where service improvement was required, and were taking action to address these.
- There was a clear allocation of responsibilities within the unit and a clear accountability structure. Most of the staff said that they felt able to openly discuss issues and challenge one another.

Culture within the service

- Staff told us that they were happy working on the unit, and felt that they contributed to creating a positive work environment. We observed effective team work and good communication among staff members working on the unit.
- The unit staff survey published in January 2014 indicated that people felt that they shared objectives, and were able to communicate with each other to achieve them. Staff we spoke to also said that they were clear on what their responsibilities were, and that there were opportunities to develop their careers in the organisation.
- We noted that the staff retention was high, and many of the staff working on the unit had been there for a number of years.
- Staff sickness levels reported for the year 2013/14 on the unit were at 4.46%, and were slightly higher than the national average for NHS organisations in England. It was also higher when compared with other wards in the hospital (2.45%). The matron told us that this did not affect patients care and treatment, and was managed within the ward.

Public and staff engagement

- The service was for specific patients from across the country; therefore it was difficult to get public engagement, as it was not primarily local people who used the service.
- The unit had been inspected by members of the patient group in 2013. This group was made up of patients and people interested in improving the patient experience. Findings of this patient-led assessment of the care environment (PLACE) inspection were shared with the trust's board. The patient group noted some positive feedback received from the patients interviewed, and improvements made to the food served on the unit. They had also made some recommendations, which included reorganising equipment storage facilities, replacing the floor tiling in the sluice room and reorganising some of the staff rooms, which "were very cramped".
- The feedback provided through the Friends and Family Test was positive. Comments included: "nurses very friendly and helpful", "[I have experienced] attentive care and I felt that nurses understood patient's concerns" and "the team was fantastic and I was kept informed at all times".
- Staff told us that they participated in the unit meetings which were organised approximately every six weeks. There were separate meetings organised for middle and senior grade nurses. We saw that those meetings were recorded.
- The trust organised an annual staff survey, findings of which were summarised for each of the wards. We saw that staff felt involved, and the feedback from this survey was mostly positive. Outcomes of this survey were discussed during the unit meeting.

Innovation, improvement and sustainability

- The treatment offered was personalised. Clinicians worked on adaptation of non-invasive respiratory support for patient with complicated congenital and traumatic complications. Doctors we spoke with told us that tracheostomy (surgical procedure to create an opening through the neck into the 'windpipe') was avoided were possible, and methods were modified to facilitate it.

Services for children and young people

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

Information about the service

The children and young people's department provides a highly specialised surgical service. There were over 20,000 outpatient appointments and 2,300 inpatient stays within the service from April 2013 to March 2014. Children and young people with complex conditions, often where previous treatments have been unsuccessful, or with serious or multiple co-morbidities and requiring a second opinion, are assessed and treated. Since 2011, the lower age limit for operations is three months of age.

Children and young people are referred to the department, usually by their GP or other paediatric services, to have planned specialised operations to their muscles, joints or bones. They are seen before and after their operations, at outpatient clinics at either of the trust's locations. Specialist reconstructive surgery for children and young people with complex needs is regularly carried out.

On the day of their operation, most patients arrive on the specialist children and young people's ward, Coxen Ward. There are 17 beds are for adolescents aged 13 years and over and 12 beds for children under 12 years old. The ward has a further three side rooms which are allocated for the use of paying patients.

The children's side of Coxen Ward is an open bay with two single cubicles used for patients who require isolation or who have longer-term needs. The young people's side of Coxen Ward has three single cubicles and four bays that are for single sex use. There are no individual rooms for babies and young children.

Children and young people are taken to theatre to have their operation. After their operations they share a recovery area with adults. For those children and young people that require more clinical support, there is a newly-built dedicated high dependency unit (HDU) equipped for infants, children and adolescents who weigh over 10 kilograms.

There are no intensive care facilities available for children who require advanced respiratory support alone or basic respiratory support together with support of at least two organ systems.

There are no intensive care facilities available for children who require Level 4 care and those requiring Level 3 care with multi organ failure or with acute renal failure needing renal support will be identified within 24 hours and contact will be made with the Children's Acute Transport Service (CATS). If CATS are unavailable within a reasonable time frame the on call consultant paediatric anaesthetist can undertake the transfer.

Paediatric medical cover is provided by four consultants, three of whom work at North West London Hospitals NHS Trust, and provide cover through a formal arrangement with the trust.

We spoke with ten children and young people, and their parents, and 22 members of staff.

Services for children and young people

Summary of findings

The Chief Operating Officer commissioned a review of the services in April 2014 by Sir Alan Craft and shared with us the draft findings. Previous reviews had been carried out and there had been slow progress with implementing the recommendations. The short review concluded there were assurances the service was effective and safe however there remained some concerns.

We found the service was not sufficiently safe. Only 42% of medical staff had completed their required level of child safeguarding training. Equipment was found to be out of date and not clean. Records of checks on resuscitation equipment were incomplete and assurances could not be given.

The service was providing treatments that other hospitals could not do. Patients came from all over the country to have their surgery and their outcomes were good. Surgeons worked with the British Society for Child Orthopaedic Services (BSCOS) to identify methods to benchmark outcomes nationally. Patients and their families were involved in their care and told us staff were caring.

The main ward, Coxen, was small, with limited space and facilities for patients, many of whom had complex conditions, and their families. Due to the location of the ward, children and young people have to be taken outside in order to access theatres and on return from theatres, and we saw a number of children and young people covered in blankets and coats for protection during transfer to and from theatre.

The trust response to the patient journey for children and young people was inadequate. The use of the trust estate and layout meant that the service was not responsive to children and young people's needs. Scheduling of planned operations was inflexible, and not arranged to suit the needs of children and young people with complex conditions. Theatres were not following good practice guidance to ensure that the environment was child-friendly, which impacted on the overall patient journey. Translation services, though available, were not always used.

Leadership within the children and young people's service was fragmented. Progress of some of the actions following the external review carried out in 2005 and 2009 were not seen. Although the presence of a paediatrician as the 'voice of children and young people' on the board is a positive factor, at the time of the inspection there was a lack of ownership of the issues faced by the department.

Services for children and young people

Are services for children and young people safe?

Requires improvement

Although incident reporting is acknowledged as a requirement amongst all staff groups, lessons did not appear to be sufficiently recognised or understood. Equipment was found to be out of date and not clean. Records of checks on resuscitation equipment were incomplete, and assurances could not be given to establish why this had occurred.

The arrangements for the safeguarding of children are not sufficiently robust and do not meet the requirements of national guidelines. Only 42% of medical staff had completed their required level of child safeguarding training. In addition, there was not a sufficient number of staff with specialist training in caring for children, to ensure that there was always someone, with appropriate skills to care for the number of children, working across the departments which children used, and which included outpatients.

The main ward, Coxen, was cramped with limited space and facilities for patients, many of whom had complex conditions, and their families. Due to the location of the ward, children and young people have to be taken outside in order to access theatres and on return from theatres, and we saw a number of children and young people covered in blankets and coats for protection during transfer to and from theatre. This environment was not sterile, and also meant that children who were recovering from surgery were at risk of experiencing unsuitable temperatures and inclement weather.

Incidents

- Three serious incidents reported December 2012 and April 2014 related to children and young people. Each incident had been subject to a root cause analysis, and subsequent actions for staff were monitored.
- In addition, the trust provided us with the incident listing reports related to children and young people from April 2013 to March 2014. In total, 62 incidents were reported, all of which were rated as being of low to moderate harm. The incidents graded as moderate harms were falls and pressure ulcers.
- We asked a range of staff if they reported incidents and how they learned from them. They reported that they were aware of the need to and how to report incidents. Lead nursing staff shared information on themes of incidents with their staff.
- Incidents related to surgical or medical issues were investigated at directorate level, whereas incidents related to nursing care were investigated by senior nursing staff. Therefore, not all common themes that impacted on children's care were shared amongst staff that worked with children and young people.
- There was evidence, in staff meeting minutes, of incident reports being shared. These meetings occurred at irregular intervals, and not all staff were present. Minutes were shared with staff through email; nursing staff told us that many of them did not have regular time to access their emails.
- The last nurse ward meeting was in March 2014; there were plans to develop a newsletter to support the sharing of information more widely but this was not in place at the time of our inspection.

Safety thermometer

- We saw the trust's safety thermometer (a tool designed for frontline healthcare professionals to measure harm, such as falls, pressure ulcers, blood clots, and catheter and urinary infections in adults). Results reported for October to December 2013 were publicised in the main entrance area to the ward.
- The ward showed 100% compliance, which indicates that no harms of the four listed were caused, according to the safety thermometer, between January and March 2014.
- However, in April 2014 compliance stood at 94%. The ward had scored 90% compliance for hospital-acquired pressure ulcers.
- All children and young people admitted to the ward from January 2014 underwent a nutrition assessment.

Cleanliness, infection control and hygiene

- There was one case of C. difficile, specifically in the children's and young people's service, reported in 2013.
- During our inspection, we observed that drip stands that were labelled clean had visible dried blood on them, and infusion pumps used for pain medication were dirty in the theatre recovery areas, although they were marked as clean and ready for use.
- The last infection control audit, with data collected July to October 2013, was displayed as being from April 2014.

Overall, the unit scored over 90% in many areas audited, including for hand hygiene, which was below the trust target. We were not provided with details of subsequent follow-up audits and actions taken.

- There was clear MRSA guidance relating to admission and pre-assessment, and the trust used a swabs system, which reported results in six hours, allowing for a quick response to results.
- We noted evidence that the ward staff had regular feedback, relating to infection prevention and control, at the senior nurses meeting, but hand hygiene compliance rates were not discussed.
- On the patient journey to theatres, from Coxen Ward to the main building where theatres are located, there was a plastic PVC strip door which had visible layers of dirt on it.

Environment and equipment

- Overall, the environment in Coxen Ward, and across the children and young people's pathway of care, was not suitable for the patients and families. We reviewed the inpatient journey and found a number of safety concerns related to the position of the ward, for children and young people requiring surgical intervention.
- The children and young people's ward is the only ward in the trust where patients have go outside of hospital buildings in order to access all the other services provided at the hospital.
- We asked for evidence that the hoists had been checked by the equipment team, although we were not provided with evidence to demonstrate these checks had taken place.
- The recently opened and purposely-built four bedded high dependency unit (HDU) for children and young people was clean, tidy, well stocked and well organised.
- All four rooms had suitable equipment so that young children, who weighed above 10kg, could receive artificial ventilation if required
- All equipment and resuscitation trolley checks were up to date on the HDU.
- We were shown the medical devices register; it contained details of maintenance for all the equipment used on the children and young people's ward, and included details of servicing requirements and frequency. However, on inspection, we found a plaster cutter which was part of the resuscitation equipment, was due to be portable appliance tested (PAT tested) in 2011. We raised this during the inspection; we were told this item had been tested, but that the sticker which indicated the testing dates had yet to be changed.
- The resuscitation trolley contained appropriate equipment for children, as required by the Resuscitation Council UK (2012) guidance. However, one resuscitation trolley on Coxen Ward and two paediatric equipment trolleys in theatres had not been checked every day or every week from January to May, and in some cases, whole months passed without regular checks, which was the case in February. Senior ward staff told us that this was because they were busy during that month. We found checks had not been undertaken daily during the week of our inspection. One trolley that had been labelled as checked in the week of our inspection contained a pedi blue resuscitator, which had a hole in the dust cover for which contained the bag mask.
- The flowchart for managing children resuscitation was not displayed within direct eye line and view of the recovery areas, and therefore, could not be seen in an emergency situation.

Medicines

- A pharmacist attended the ward daily, and reviewed prescriptions and made recommendations.
- There was a member of staff nominated to complete a daily check of controlled drugs.
- We found medicines loose and out of their original containers, including a controlled drug. We alerted staff who were not aware of why this medicine was loose, or why the checks had not been completed that day.
- The medicines in the controlled drugs cupboard had not been subject to a pharmacy check (to ensure they had not expired) since March 2014.

Records

- A number of staff we spoke with told us that notes retrieval worked well; required reports were processed easily, and there were no backlogs or delays in acquiring notes.
- We looked at ten sets of notes during our inspection.
- Most notes contained relevant nursing and medical documentation, including routinely undertaken risk assessments, with times and dates of review documented.

Services for children and young people

Consent

- Parents, and those responsible, were given information to consent for procedures for children and young people under the age of 18, before operations took place.
- The consent policy had recently been updated, and featured some specific information concerning the law regarding consent and children.

Safeguarding

- The named doctor and named nurse had received level 4 training.
- We had significant concerns that safeguarding children procedures were not sufficiently safe. The named nurse for safeguarding had an allocated one day per week to undertake their role, which included providing mandatory safeguarding training for all staff at levels 1 to 3, and ensuring compliance with the Working Together 2013 guidelines.
- A recent focus for safeguarding children within the trust was to improve uptake of Level 1 safeguarding training, though it was not clear why this decision was taken, as there was lower than required uptake of training across all levels, and particular concerns with identified staff groups.
- We saw from minutes that the named nurse for safeguarding children was covered by an interim member of staff between August 2013 and March 2014, and was not routinely present on the safeguarding committee in 2013.
- We saw a safeguarding folder on the wards, which was used to support staff to make safeguarding alerts. Concerns about safeguarding of a child were also reported on the trust's electronic record keeping system. An audit of the use of alerts in 2012 found that these were not being done routinely, and we could not establish whether sufficient progress had been made since.
- However, we were told that other departments across the trust had their own systems for raising safeguarding alerts, which meant that the safeguarding folder was not routinely used. This meant that some departments were not following the trust's own policy.
- The trust had recently dated published guidelines, for children who failed to attend their appointments, which contained a pathway for safeguarding children. This included guidance that children or young people, who have not attended two appointments, are referred to the child protection team, as well as for groups who were more vulnerable, such as 'looked after children'. This guideline had not yet been audited.
- Some staff attended external training on safeguarding children which was not contained on the trusts electronic system for recording training. Further, intercollegiate training to bring safeguarding training up to the required level across the trust was in place, but senior staff acknowledged they were unable to evidence this.
- Amendments to the topics covered in safeguarding training were being made, as it had been recognised by the director of nursing that some subjects were not sufficiently covered, such as domestic violence.
- An audit in April 2013 found that all staff interviewed knew how to correctly raise a safeguarding concern about a child. A recommendation from this audit was to ensure that safeguarding training is part of annual appraisal checklist for clinical and non-clinical staff; we were not assured on inspection that these recommendations had been fully met.
- Minutes of safeguarding committees contained less than one paragraph of detail, and therefore we could not track, or be assured how actions had been progressed.
- Additional administrative resource was being appointed for the named nurse, as there was insufficient capacity to undertake the work required.

Mandatory training

- There was a lack of accurate information regarding completion of mandatory training. Figures provided centrally by the trust, and those reported to the trust board, differed from those provided by senior staff locally.
- In March 2014, the trust reported compliance rate with mandatory training was 82.75% overall. However, we were not assured of the accuracy of this data, as it did not show a breakdown into staff groups or at individual department level.
- We were told that all theatre nursing staff had received Paediatric Immediate Life Support (pILS) training, though we were not provided with evidence of this.
- Nursing staff in HDU were either dual trained as adult and paediatric nurses, or had completed specific

paediatric qualifications to ensure that they were skilled to care for children and young people. The staffing ratio was one nurse to one patient in line with national guidance.

- Staff we spoke with during the inspection told us there were no regular resuscitation scenario training sessions for staff. The trust held told us that regular cardiac arrest simulations happen throughout the hospital and the performance and results of these regularly monitored by the Trust's resuscitation committee.

Management of deteriorating patients

- The paediatric early warning score (PEWS) was used throughout the department. Whilst an escalation procedure was printed on the front of the observation booklet, the triggers for escalation to the outreach team, alerted by a child or young person's vital signs did not included in the tool, such as respiratory effort, and the tool layout and scoring system did not follow recommended best practice.
- Some concerns were shared with us by staff regarding the ability of junior doctors to recognise deteriorating children and young people. Some nursing staff told us that the request for more sensitive and improved tools had been escalated within the last year, but there had been no change. An audit of PEWS use by the medical team was carried out in April 2014 and had identified the need to develop a Stanmore PEWS tool which will be calculated from heart rate, respiratory rate and temperature, and parental or staff concern, to increase sensitivity for early detection of the deteriorating child. However, actions underway were not seen on inspection and no mitigation for the interim period, while a new tool was being developed, was in place.
- Staff told us that data was being gathered to support information in measures regarding blood stream infections to meet the Department of Health's 'Saving Lives' guidance. This data was not been made available to us. However, this data collection had recently stopped and staff were not sure why.
- We saw that appropriate observations were taken, recorded and acted on in the children's HDU.

Nursing staffing

- Staffing levels met expected standards for the care of young people. Information provided by the trust indicated that the registered nursing establishment was 29.21 Whole Time Equivalents (WTE). The recommended establishment for the department was documented as 28.62, which accorded with the paediatric services operational updated paper for April 2014, which stated that the service was fully established.
- The sickness rate was 3.7% in March 2014, which was slightly higher than the trust average. Causes of this elevated sickness had been monitored by senior nursing staff on Coxen Ward in order to support staff.
- The Royal College of Nursing guidelines for acuity were used, which recommend a minimum average of one nurse to four children or young people. The general establishment was listed visibly on a whiteboard near to the adolescent part of the ward. The required minimum staffing level on the unit was eight trained nurses and one health care assistant during the day, and five trained nurses and one health care assistant during the night, which is within the levels recommended by the Royal College of Nursing.
- We were told that most nursing staff working on Coxen Ward were paediatric-trained nurses.
- Senior nurses were supernumerary and not included on the daily rota.
- The ward did use bank and agency if and when required; however, we could not determine the frequency with the staff we spoke to; from the information provided we were unable to ascertain whether all bank and agency received a local induction prior to their shift.
- In the HDU for children one nurse was allocated to each patient.
- There were eight paediatric trained nurses working on the HDU, to ensure there was one working at all times throughout the week. The matron told us that 40 out of 67 nurses undertook specialist paediatric modules (HDU).

Medical staffing

- Patients were admitted under the operating surgeon, and the surgical team were present daily during week day ward rounds.
- The department also had four whole time equivalent paediatric consultants, one of whom was employed by the trust, and three of whom were employed by North West London Hospitals NHS Trust, and provided cross-site cover.

Services for children and young people

- There were four medical grade paediatric doctors, who were present on the unit from 8am until 8pm, Monday to Friday, and 9am until 2pm, on Saturdays and Sundays.
- Overnight medical cover was provided by an anaesthetic registrar on site, and a consultant paediatrician was on-call from home.
- In addition to a lead paediatrician surgeon, there was a lead paediatrician for children and young people's services.
- There were five paediatric specialist surgeons. The lead paediatric surgeon attended six weekly strategy meetings, and had regular meetings with the paediatric services manager.
- There was low use of locum doctors, and patients told us they regularly saw the same doctors.
- At the time of the inspection we were told by staff that three specialist paediatric anaesthetists provided day time cover on the HDU. The trust has since said a consultant intensivist and paediatric consultant provide day time cover on the HDU.

Major incident awareness and training

- The trust provided regular fire safety and evacuation training. Nursing staff we spoke with confirmed this. Evidence of attendance by staff at this training was not maintained at ward level, and therefore we were not able to verify if all staff, who provided care to children on the ward and in HDU, had received the required training.

- We asked to see the ward business continuity plans, but these were not made available to us.

Are services for children and young people effective?

Outstanding ☆

The department was not eligible to routinely provide evidence of outcomes, due to the complexities of care required by children and young people accessing the service. Despite this, there were routine efforts to identify methods to proactively audit care, and surgeons worked with the British Society for Child Orthopaedic Services (BSCOS) to identify methods to benchmark outcomes nationally.

Evidence-based care and treatment

- Surgeons regularly presented cases to the British Society for Child Orthopaedic Services (BSCOS) to benchmark their practice, and were proactive in doing so. Our inspection noted this was best practice.
- Surgical outcomes were scrutinised, and change in practice was evidenced by the surgical teams.
- Paediatric surgeons had led and contributed to five medical journals in 2013, and many had presented cases to peers internationally.
- The lead paediatric surgeon was the audit lead for the hospital, and co-ordinated participation in national audits.
- Staff continuously worked towards establishing compliance with nationally-recognised best practice on the treatment for spasticity in children.
- Standardised paediatric tools were only in use for nutrition and hydration; these included the screening tool for the assessment of malnutrition in paediatrics (STAMP), and the VTE risk assessment for adolescents aged over 12.
- The trust regularly reviewed compliance with guidance from the National Institute for Health and Care Excellent (NICE) and other bodies. Recent guidance which the trust complied with, included social and emotional wellbeing in early years, conduct disorders in children and young people, feverish illness in children, and the management and support of children and young people on the autism spectrum.
- We were shown an audit of the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER, 2000) guideline, and reported satisfactory adherence to standards.
- The child death and consent policies had been recently reviewed to include information specific to the care of children and young people.

Pain relief

- A paediatric pain team was established to provide direct support to staff caring for children and young people.
- A pain chart was included in the paediatric observation tool, but it did not include any paediatric pain assessment tools, and therefore was not suitable. The tool was recommended for use for adults, and it was not based on guidelines recommended by the Royal College of Nursing for recognition and assessment of post-operative pain in children and young people.

Services for children and young people

Nutrition and hydration

- The trust had scored 100%, indicating no harms on their monitoring tool for Coxen Ward regarding nutrition and hydration in April 2014.

Patient outcomes

- There was consensus from the inspection team that the trust had the best outcomes for transformational spinal surgery for children.
- The children's scoliosis unit is one of few services in the country, and was well supported by an integrated multidisciplinary team. New surgical techniques were pioneered and used within the scoliosis department, and a recent example was the magnetic rod treatment or MAGC spinal bracing system to lengthen the spine.
- Some patients received treatment that could not be offered elsewhere such as the services offered by the sarcoma team.
- Many children have rare conditions which meant outcomes could not be benchmarked easily. Despite this, there were routine efforts to identify methods to proactively audit care, and surgeons worked with the BSCOS to identify methods to benchmark outcomes nationally.
- Less than 0.1% of children and young people were readmitted to the hospital after having their procedure, and there was only one emergency readmission to hospital between April 2013 and March 2014.

Competent staff

- Overall appraisal rate for nursing staff who worked with children and young people was 95% in March 2014.
- A training needs analysis for nursing staff had been undertaken to identify further specific requirements, such as care for patients with spinal injuries. Some staff had commenced the required training courses, whilst others were awaiting approval.
- Two recovery nurses had paediatric qualifications, and when these staff members were not on duty, recovery nurses were supported by paediatric nurses from HDU.
- Nursing staff on HDU had undertaken a foundation course on paediatric critical care.

Multidisciplinary working

- We observed multidisciplinary team (MDT) working throughout our inspection.
- Although nursing, medical and therapy handovers were undertaken separately, there were weekly MDT meetings represented by a range of staffing groups, including education and social services.
- There were frequent multidisciplinary outpatient clinics amongst the surgical specialties, such as orthotics and rehabilitation, which involved nursing, therapy, medical and support staff.
- Nursing and medical staff we spoke with told us that there were very good physiotherapy and occupational therapy services available.
- The physiotherapy outpatient musculoskeletal service and the occupational therapy service carried out inpatient and outpatient work for the consultant doctors. Therapies staff spoke of regular MDT working, with senior staff meeting the divisional lead for paediatrics on a weekly basis, and MDT meetings incorporating teaching on a weekly basis.
- The paediatric spinal rehabilitation, amputee and shoulder teams had their own multidisciplinary teams, which included therapists.
- There was involvement from paediatric speech and language specialists.
- Transition to adult services was integral, as a number of children and young people continued to access specialist services into adulthood; the 'Young Adult Hip supported discharge' provided a service to a number of patients, from transition and throughout their adult lives. A business plan for recruitment of a transition co-ordinator had recently been approved, to improve the transition services offered.
- There was a formal agreement with a nearby hospital to provide psychiatric input to children accessing services within the trust.
- There was a clear and agreed pathway for the teenage and young people age group with support from a designated clinical specialist nurse.
- We saw the hospital play specialists engaged in activities with the children. The trust employed two play specialists who were based on the ward. They did not visit children in the outpatients department or in theatres.

Seven-day services

- Paediatricians were not available on site at night, but were available on-call from home. Staff escalated any immediate issues to the adult specialist doctors.

Services for children and young people

- We were told by junior medical staff that consultants on-call were quick to respond, and that they arrived on site within 30 minutes.
- The therapy services available provided a weekday-only service between 9am and 5pm. We were told that plans were in place to extend the services offered to seven days a week.

Are services for children and young people caring?

Good

Evidence provided, from both prior to our inspection, and from speaking to children, young people and their families, gave assurance that they were providing a consistently caring service. The department had worked hard to increase the Friends and Family Test response rate, and recently introduced a 'child-friendly' form, which was now achieving returns above the national response rate. As a result, scores were at or above the national average. In addition, we witnessed many episodes of caring interaction during our visit, and feedback from individual patients and relatives was almost universally positive.

Compassionate care

- Throughout our inspection we saw staff interacting positively and in a friendly manner with patients and families, in person and in telephone interactions.
- Feedback from parents, family members, children and adolescents, was unanimously positive. One young person told us their stay was "5* care". Another said, "they are helping me to get better, it's great".
- Parents and family members told us how staff often went "out of their way to help" and the hospital "provides an excellent, specialist service".
- Parents told us that they had received sufficient written information about the operations for which their child was scheduled. However, more up-to-date Friends and Family Test results were not displayed on the ward. We saw results for December to October 2013 were displayed at the ward entrance in May 2014, showing a score 84%.

Patient understanding and involvement

- We reviewed care records in order to assess if care was planned and provided in a manner that indicated the involvement of parents or advocates. We saw that information was recorded by clinical staff that indicated an initial assessment of immediate and on-going care and treatment needs. Information was personalised, as far as possible, in respect to age and included, where relevant, information about the child or young person's preferences.
- Parents who spoke with us said that they had been involved in discussions about the needs of their child. They felt they had been suitably informed about investigations, and updated with regard to their child's progress. One parent said they were told "what we can expect to see in their progress". Another told us "we were given specialist advice to manage their pain".
- We saw that details of named nurses were accurately displayed on walls behind the beds of children and young people.
- Several parents and relatives spoken to, commented that they understood and were confident about what was happening to their child, regarding their diagnosis, investigations and treatment.

Emotional support

- Referrals for assessments for anxiety and depression were made to the clinical psychologist.
- Families we spoke with in HDU spoke highly of the level of support provided to them and their children by the ward staff.

Are services for children and young people responsive?

Inadequate

The trust response to the patient journey for children and young people was inadequate. The use of the trust estate and layout meant that the service was not responsive to children and young people's needs. Scheduling of planned operations was inflexible, and not arranged to suit needs of children and young people with complex conditions. Theatres were not following good practice guidance to ensure that the environment was child-friendly, which impacted on the overall patient journey. Translation services, though available, were not always used. Complaints were answered promptly, although we could not find evidence that previous concerns had been learned from. Patient stories, or complaints regarding children and young people, were not regularly reviewed by the board.

Services for children and young people

Education was well integrated into the service, and inclusive and innovative teaching methods meant that children and young people could continue to access learning throughout their hospital stays.

Service planning and delivery to meet the needs of local people

- Some actions from external reviews, to improve the children and young people's service, conducted in 2005 and 2009, had not been followed through to completion. A further external review had taken place in April 2014, and the report was presented to the board in May 2014. The 2014 review also identified that some recommendations remained outstanding. These included increasing the number of nursing staff with mental health and learning disability experience, policies incorporating the care of children being based on best practice, undertaking an audit against the children and young people's national service framework, and implementing enhanced recovery programmes.
- Children and young people were taken outside of the building for approximately 150 metres, not all of which is covered by a roof or shelter, in order to access theatres, and then to return from theatres back to the ward. We saw a number of children and young people covered in blankets and coats for protection during transfer to and from theatre. We observed children being carried to theatres by their parents, and families were wearing outdoor clothes, as it was wet and cold.
- The quiet room, which was particularly small and could not accommodate more than two people at any one time, it had multiple uses, as a breastfeeding room, a room for breaking bad news to people, and a room for parents to have quiet time away from their child.
- There were two chairs in the room and no other facilities. Those with physical or more complex needs could not access the space.
- Coxen Ward had limited facilities to cater for children with complex needs, in respect of toileting and showering. In the children's wing, there were portable hoists available, which were suitable for children aged three to nine, as the bathrooms were not purpose-built. It was not clear what facilities were available for children aged one to two.
- Parts of the children's wing on Coxen Ward were small. There were toys and other items stored on the floor of the corridor, between washing facilities and the main part of the ward, which reduced the space available. This meant it was difficult for wheelchair users to use the corridor. On two occasions, members of the inspection team had to move trolleys that had been left in the corridor, out of the way, to ensure families could walk past.
- A large number of children, young people and their families were not local, and some had travelled great distances, due to the specialist nature of the services provided. Accommodation was available on site, but there were limited facilities for parents to stay with their children on the ward. Planning for this was inflexible, as all patients had to arrive at 7am for their planned procedure.
- The facilities were not improved despite increased inpatient activity. There had been an increase of over 5,000 episodes since 2008-09.
- Similarly, outpatient paediatric activity in had grown by over 40,000 episodes since 2008-09. A paediatric nurse from Coxen Ward, and parents, accompanied the child or young person to theatre. After the operations, parents could join the child or young person in the recovery suite.
- Where possible, children were routinely scheduled to be operated on first. Nurse's shifts commenced at 7am, rather than at 7:30am in keeping with adult wards, to cope with the additional workload. The management team had restricted the number of new admissions on Coxen Ward to a maximum of 10 admissions on Thursday and Friday, which was when many paediatric surgeons were available to operate. However, some complex surgical operations were undertaken on these days, which meant that a small number of children and young people needed to stay in hospital over the weekend. We were told by staff that nursing staffing levels were increased if required, based on the needs of the child or young person. However, it is notable that therapy services were not available over the weekend.
- There were no dedicated facilities for children in outpatients, and children were seen in the same clinic facilities as adults.
- Trust figures showed that 121 (3%) of children and young people had to wait longer than 18 weeks for the planned operations due to a range of clinical and non-clinical reasons.
- 2% of children and young people had to wait longer than 18 weeks for their outpatient appointments due to a range of clinical and non-clinical reasons.

Services for children and young people

Access and flow

- Children and young people were operated on throughout the week. Data provided to us for March 2014 showed that 142 children were admitted to the ward, with 75 more complex surgical procedures, which meant that children stayed on the ward for at least one day following the procedure.
- Although there were no dedicated paediatric lists, most operations were scheduled to take place on Thursdays and Fridays due to theatre availability. This has been recognised and we were told that the general management team had identified that plans were in progress to increase activity on alternate days. However, these plans were neither established nor in practice during our inspection.
- There were plans to progress the role out of the 'Ticket Home' programme to the children's departments, to reduce the length of stay and support MDT discharge planning; this had not commenced at the time of our inspection.
- We observed handover, and were told that the week of our inspection was quieter than usual, as two surgeons were not working.
- Children and young people with complex healthcare needs were brought into hospital for a 24 hour assessment prior to surgical intervention.
- The pre-assessment process did not identify individual requirements, such as allowing extra time or flexible arrangements. Children and young people were brought in at 7am and, on the days of our inspections, the first patients did not go to theatre until 11:30am.
- We were told that recovery room 9 and 10 were usually used for children and young people, but that all recovery rooms could be utilised if required. This meant that it was possible that children and adults could be recovering in the same bays.
- Bed occupancy varied, from 32% to 68% between 2013 and 2014, and at 52% in March 2014, which was flagged as being a risk on the nursing key performance indicators for the trust, indicating that bed spaces were not utilised sufficiently. However, this contradicted reports from staff who told us that the ward was almost always busy, with most or all beds occupied.

Meeting people's individual needs

- Daily nursing handovers took place, and historical issues for each child were mentioned in detail. However, we found that some current significant information was not shared. We witnessed that a handover failed to cover requirements for an interpreter, the need for a falls assessment for a child who had been identified as at risk of falling, and for a pressure prevention and management assessment for children and young people at risk of or who had developed pressure ulcers, whilst the risk to children or young people who were expressing suicidal thoughts was not discussed.
- Staff we spoke with told us they undertook 'intentional rounding' every four hours. Intentional rounding is an initiative which requires nursing staff to check every patient regularly to ensure they are safe, comfortable, have access to food and fluids, and to monitor pain and take appropriate action if required. It was not clear how four hourly rounds met the needs of the children.
- A family shared with us that their baby of 16 months, who had recently had surgery, had not been provided with food. The mother was staying with the child and commented that the food provided for her was fine, but that there was none provided for her child. This had been the case for two days. When we raised this immediately with a nurse, we were told they were not looking after this child, and that the family hadn't raised the issue directly with staff, so they were not aware of the situation. We raised the situation immediately and it was looked into by the executive team.
- One parent spoke limited English. Information leaflets and a detailed letter explaining requirements of the procedure were provided only in English. The child and their siblings interpreted for the parent. An interpreter was not offered to the family.
- One young person's nursing notes identified that they had expressed suicidal thoughts and an intent to self-harm. There were no follow-up actions indicated and we saw this issue was not discussed during the morning handover. We raised this with senior nursing staff, who assured us that appropriate responses had been taken, though these actions had not been documented.
- There were no children's toys, displays or other distractions in theatres. We were told that anaesthetic masks, with different smells, were sometimes used to help distract children or young people who were anxious, and there was a dividing screen with animations used in a recovery bay.
- The trust told us that coloured fabrics were available for children's prosthesis.

Services for children and young people

- The private ward had three beds, which were predominantly staffed by nurses directly employed for this ward. There were three cubicles within the general ward which were designated as cubicles for private patients; they were staffed with dedicated nursing staff and domestic staff; parents and their children shared the majority of facilities with NHS patients.
- The arrangements for private patients meant that private nursing staff and food for private patients had to be delivered through Coxen Ward, visible and often different to NHS patients and visitors.
- There were no children's trained nurses designated to work in the paediatric outpatients department, and therefore we were not clear as to whether nurses in this department had up-to-date skills in order to care for children and young people.
- We asked whether there were any paediatric trained nurses in pre-assessment. and this is the case but we did not receive evidence of this at the time of the inspection.

Education

- The Children's Education Service is managed by Harrow Council, London. The service is part of Harrow Tuition Service and provides full time education for all patients between the ages of five and sixteen. Children are able to participate in school as and when their treatment and medical conditions allow.
- Ofsted rated the service as 'outstanding' in its 2009 inspection report.
- We saw a flexible attitude toward curriculum, and to child and personalised learning, which meant that children and young people could be taught in a place they chose, including at their bed, in the ward, or on HDU.
- Teaching sessions were provided at the bedside, on the ward, and in the high dependency unit.
- We spoke with young people who were undertaking their GCSE's with support from the hospital teachers and their school. One said "I am getting help to take this exam so I don't fall behind. That's important."
- There was liaison with schools and home schooling for handover when children and young people were ready to leave hospital.
- There was a daily handover from the ward regarding which children and young people needed education and why. They also worked with a dietician on the subject of healthy eating, as part of the school development programme and food technology.

Learning from complaints and concerns

- Some recommendations remain outstanding, including increasing the number of nursing staff with mental health and learning disability experience, policies incorporating the care of children being based on best practice, and audit against the children and young people's national service framework.
- We were told by management that when a complaint was received, contact was made with the complainant to agree timescales to respond, even if these were before the times published within the complaints policy. Complaints were only closed following full investigation.
- Any actions arising from compliant investigation were shared with staff appropriately. The complainant was made aware of the outcome of the investigation, and any action the trust needed to take. An overview was maintained of complaints progress and reported to the board. Feedback was sought from complainants when the complaint investigation process was complete.
- People we spoke with said they knew how to make complaints, most saying they would raise it with a member of staff first. We spoke to one person who had raised a complaint with the Patient Advice and Liaison Service (PALS).
- Complaints regarding nursing, therapies and the medical team were responded to within the separate departments. This meant that there was a risk that shared learning opportunities were missed for children's services as a unit.
- The division for direct care operations department, under which the paediatricians and paediatric surgeons were managed, was meeting its 25 day turnaround time for complaints. Four complaints regarding the medical team involved in the care of children and young people were received in 2013-14, and evidence was received to demonstrate progress and learning from complaints.
- We saw there were 25 Patient Advice and Liaison Service issues reported regarding the medical team in 2013/14. Themes and trends of these issues were not stated in the minutes of the paediatric services meetings, and it was therefore not clear whether trends were being monitored and actioned.

Services for children and young people

- The operations manager who was responsible for co-ordinating the investigations for complaints and serious incidents had undertaken a comprehensive root cause analysis investigation training course in 2014.
- Patient stories or complaints regarding children and young people were not regularly reviewed by the board.

Are services for children and young people well-led?

Requires improvement

Leadership within the children and young people's service was fragmented. Some of the identified actions following the external reviews carried out in 2005 and 2009 had not been completed. Although the presence of a paediatrician as the 'voice of children and young people' on the board is a positive factor, at the time of the inspection there was a lack of ownership of the issues faced by the department. The nursing structure did not have a matron level post. Prospective plans for change and improvement came from the belief that the proposed hospital rebuild would provide a solution to the current inadequacies in the provision of care; however, this building work was not due to be completed for at least five years. Some long standing concerns about the capacity of the department to provide safe and good quality care to children and young people had not been addressed. Staff worked in often challenging circumstances, and though recognised, were offered limited ways in which to effect change to the quality of care they were providing.

Vision and strategy for this service

- There was no overarching vision or strategy for the service. The trust board minutes from April 2014 acknowledged the requirement of a formal strategy for paediatrics.

Governance, risk management and quality measurement

- The governance structures for the children's service were aligned to the overall governance structure. The remit of the children's services strategy committee was to provide assurance to the trust board on the current safety, and to improve safety and excellence in paediatric patient care.
- Six out of sixteen recommendations from external reviews remained partially or fully outstanding. This included the appointment of a non-executive director for children and young people, ensuring staff who worked with young people had undertaken specific training in caring for adolescents, having an appropriately-skilled and experienced nurse based in the outpatients department, and ensuring that all policies incorporated best practice in the care of children.
- Risks registers were not appropriately maintained at ward level, and did not describe risks to the service as described separately by the staff. An action plan, resulting from the risk management audit dated 15 May 2012, was provided as the most up-to-date risk register. Risks described included the requirements to carry out assessments of slips, trips and falls, stress, fire and security, none of which had been completed two years later
- We were shown an issues log which was kept at ward level. We were told by senior staff that it was recently introduced, as staff were reporting issues that could have been addressed more swiftly by other routes, such as escalating concerns regarding broken doors directly to the estates department.
- The trust's risk management policy did not describe the use of an issues log to escalate risk and support them to be managed in a timely manner.
- Administrative and support staff we spoke with told us that health and safety risk assessments in the work place were not completed as required and in line with the trust's own policy.
- The risks relating to the children's service regarding referral to treatment time targets were escalated to the board. Staff we spoke with were not aware of risks on the children and young people's risk register.
- We asked for and reviewed all root cause analysis investigations carried out within the last two years. Although root cause analysis investigations were undertaken, actions stated did not demonstrate how required improvements could be made. Actions from one root cause analysis, investigating a child's fall, described how the child was correctly assisted, rather than focusing on the changes required to reduce a similar incident. An incident form was not completed at the time of the fall, and the incident was not investigated until it was received as a complaint. There were issues raised regarding the medical staff record entries not containing times and dates. There was no

clear evidence of how this requirement was communicated, and how improvements in this area would be made and monitored. Neither local nor organisationally learning was clear.
- The paediatric inpatient admission/discharge booklet, the admission checklist, patient handling assessment and care plan, bed rail assessment, slips, trips and falls assessment and pressure ulcer risk assessment were tools developed for use with adults, and not with children.
- Concerns regarding the safeguarding of children had not been escalated to the trust committees or board by any committee or subcommittee in the past. Staff were now clear of the Local Children's Safeguarding Board they reported too and partnership working had commenced.
- Some concerns identified by internal and external reviews regarding the suitability of post-operative care provision for the deteriorating infant had not been addressed. We were told that children could be transferred to a Paediatric Intensive Care Unit (PICU) if required, and that there had been no requirements to transfer children to PICU within the last five years.
- We were informed that the vast majority of infants operated on at RNOH of less than one year of age are admitted for developmental dysplasia of the hip, surgery for birth related brachial plexus injury or the Ponseti technique under local anaesthetic.
- Some actions have not been progressed sufficiently in order to assure that the practice of operating on babies is safe in relation to having appropriately skilled staff and equipment. Whilst senior medical staff acknowledged our concerns, we were told that they had been addressed by the anaesthetics team. Some actions from a review of surgery on infants undertaken by the anaesthetic team in April 2014 stated that the risk to infants remains a concern.
- We were told of challenges in meeting the training requirements for safeguarding children in the trust. Only 42% of medical staff had undergone the level of required child safeguarding training. Some staff undertook training in other organisations; however, as certificates and evidence were not provided, it was difficult to be assured of competence. These issues had not been reported to the committee or the board, as the figures showed overall compliance across clinical and non clinical staffing groups.
- The issue was identified in April 2014, by the named nurse for safeguarding children, and was detailed within the trust board meeting minutes; no assurance was detailed in the minutes of how this issue would be addressed.

Leadership of service

- Although the presence of a paediatrician as the 'voice of children and young people' on the board is a positive factor, at the time of the inspection, there was a lack of ownership of the issues faced by the department.
- All other divisions within the trust had a matron role; however there was no equivalent role for the children and young people's service.
- The lead nurse for paediatrics reported to the matron for adult intensive care. A decision had been taken at trust level to remove the matron for children's services.
- Clinical protocols we reviewed, including those for the deteriorating child, did not reflect evidence-based practice. There was recognition of this at ward level, but when escalated, it was not clear to us or to the staff whether action was being taken and protocols were being updated.

Culture within the service

- Almost all staff we spoke with would recommend the trust as a good place to work, and spoke in high regard of the team work. Many praised the senior nursing staff for the support they offered.
- Staff told us that support was very high within teams, with regular clinical supervision, and there was good morale at ward and service level.
- There was an employee assistance programme available for all staff. The total number of employees using the service over the year May 13 to April 14 was 49, a utilisation rate of 4.34%. Staff we spoke with were not aware of other mechanisms for support, despite the often-challenging and highly specialised nature of the service provided.
- A small number of nursing staff told us that they had been shouted at by consultants and felt bullied. When we asked to see reports of this behaviour we were told that it had been acknowledged, but not documented. We were therefore not assured if and how this bullying had been addressed.

Public and staff engagement

- The views of children and young people had been sought at a trust-wide level recently. Coxen Ward had

created a Friends and Family Test survey, designed specifically for children, which had been approved by a multidisciplinary committee. This child-friendly survey had been recently piloted, although results for the adult survey were being collected. The national target response rate was 15%, and actual responses were regularly 30% or higher between April 2013 and March 2014.

Innovation, improvement and sustainability

- The physiotherapy service offered a two week residential pilot programme for young people with long-term musculoskeletal conditions, offering individual clinical psychology, occupational therapy, physiotherapy and dietetic input.
- Surgeons were involved in a number of pioneering academic research studies including presenting research on the effect of vitamin D, and publications included the genetic influences on hip development for developmental dysplasia of the hip.

Outpatients

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

Information about the service

The Royal National Orthopaedic Hospital NHS Trust provides outpatient services at two locations; a Central London outpatients facility in Bolsover Street and at the main hospital site in Stanmore, Middlesex.

Outpatient services at Stanmore are provided from 19 dedicated clinic rooms, five days a week, between the hours of 8am and 5pm. There is a separate entrance and seated waiting areas leading off from the clinic rooms. All services are located on the ground floor, and are accessible by wheelchair.

The outpatients' service sees approximately 90,000 patients a year (7,500 a month). Approximately two thirds of these patients are seen at Stanmore.

Patients present to the department, either by walking into the reception area or arriving by patient transport. All patients report to reception and are booked in for their appointment. There is a café located next to the main waiting area providing tea, coffee and snacks.

We spoke with 22 patients, and a further 51 completed our 'tell us about your care' forms that were available in the outpatient departments' waiting areas throughout our inspection. We also spoke to a range of staff at all levels of the trust, observed waiting areas of the clinics, and interactions between staff and patients. We received feedback from our listening event and staff focus groups. We also reviewed performance information about the trust.

Summary of findings

The outpatients department was safely managed. There had been no major incidents or instances of hospital-acquired infection. The department was adequately staffed.

The service ensured that assessments followed trust assessment and treatment guidelines. There were good examples of multidisciplinary working. Services were provided five days a week.

Staff were caring. Almost every patient we spoke to felt that they received a kind and caring service. We were also told that staff were helpful and polite most of the time. We found only a small number of instances where patients felt that staff attitude was not satisfactory.

Patients told us that the service was responsive to their clinical needs, however some clinics ran late most of the time. 26% of the clinics started late. There was no key performance indicator for sending out clinic letters following consultation to patients and their GPs. A significant proportion of letters were not sent out for over one month. There was an exception within the trust that letters regarding patients who had cancer would be sent out within 48 hours.

There were clear lines of accountability and management for front line services within the outpatients department. However, some clinics routinely started late and over ran. This had been identified through leadership meetings and also through comments and complaints that the service

received. Waiting times were the responsibility of individual clinical divisions, not the outpatient department itself. This meant that neither the head of outpatients, nor the head of operations for clinical support services could influence and effectively improve this aspect of the service.

Are outpatients services safe?

Good

The service had a good system for reporting and investigating incidents. There had been no serious incidents in the outpatients department. Aspects of safety were suitably monitored. The environment was clean, although hygiene issues were dealt with in a reactive manner rather than in a systematic way. Medicines were checked and stored securely, although the medication case for emergency use was not secured. Patient records were stored securely and were accessible when required. Records for staff training showed they were up to date, although staff lacked a working knowledge of consent, capacity and safeguarding. The department was adequately staffed.

Incidents

- Staff had access to an online reporting form and were trained in using it.
- The outpatients department demonstrated a good culture of reporting incidents.
- There had been no 'never events' or serious untoward incidents reported in the outpatients department.
- Reported incidents were assigned to an appropriate service lead for investigation. Risk ratings and outcomes were decided by the trust's 'risk team', who reviewed every incident report to ensure that what had been initially reported had been responded to.
- The completed report was automatically sent back to the person who reported the incident, so that they received feedback.
- The quality and risk support services meeting (the medical division to which outpatients belonged and the formal structure to monitor quality in outpatients) reviewed incidents that occurred within outpatients, to identify possible themes and review specific issues.
- We were given examples of learning from incidents. Wider learning was cascaded through lead nurses, and issues were also discussed at monthly outpatient team meetings. However, we also found an example where staff who reported a less serious incident, had to escalate it themselves because the process in place had not brought about the appropriate change.

Outpatients

- Incident reports demonstrated the department responded swiftly and effectively to incidents requiring instant responses, such as a cardiac arrest and a hypoglycaemic attack.

Safety thermometer

- The safety thermometer was not used in the outpatients' department although we recognise this is not a national requirement.
- Monthly staff meetings monitored a number of safety aspects relevant to outpatient areas. There had been three falls in the last year, and there were no rates of infection. Understaffing was monitored and was mitigated when it occurred.
- There was a risk folder, and all areas had environmental risk assessments. Some aspects being monitored and acted on included: adding fans in some rooms that get very warm, and new note trolleys having raisers added because they were too low.

Cleanliness, infection control and hygiene

- Contractors cleaned the clinic rooms each evening. Staff reported to us that this needed constant monitoring, but when issues were raised, overall the contractors were responsive.
- Nurses and healthcare assistants had a protocol for cleaning items in clinic rooms between patients. Outpatient nurses checked that clinic rooms and equipment were clean each morning before appointments began.
- There were hand-washing facilities in every room. We observed that some hand gel dispensers were empty, although alternatives were available nearby.
- A matron's update at the quality and risk support services meeting in April 2014 described hand hygiene as an issue, with plans in place to improve, but no further details were available.
- A clinic support worker was the department's hand hygiene champion. They had recently held a monitoring day where the quality of staff's hand washing was tested.
- The service was not undertaking infection control audits as they used the patient-led assessment of the care environment (PLACE) audit that took place on a monthly basis. There had not been any incidents of infection in the department
- Cleaning was outsourced to a private company who monitored their own performance against the contract they held with the trust, and carried out monthly cleanliness assessments to assure this.
- Staff felt the cleaners offered a reactive service which some staff told us caused issues. For instance, one nurse told us that they were not always happy with the cleanliness checks done by the private contractors, while another told us that they had reported the cleanliness of toilets as an incident, which then had to be escalated because action was not taken.
- There was also a deep clean programme in place for all clinic rooms. Curtains were replaced as soon as they were marked.

Environment and equipment

- The outpatients' department at Stanmore had 19 clinic rooms and its own separate entrance to the main hospital. Patient transport was able to pull up close to the entrance to enable patients with limited mobility easier access to the department.
- Overall staff told us there was enough of the right equipment and facilities. If additional equipment was needed then it was provided.
- Medical engineers were responsible for the maintenance of equipment. There was an allocated budget to cover the maintenance.
- Nurses we spoke with said that they would ideally like more electrocardiography machines.
- There were good systems in place for equipment cleaning in hydrotherapy. All water hygiene checks were up to date. However, there was no print outs to demonstrate that equipment had been washed at the appropriate temperatures which should be standard procedure.

Medicines

- Medicines were stored securely. They were stored in locked medicine cabinets to which nurses had access.
- Monthly medicines audits took place.
- All medication and equipment was in place and up to date on the emergency / resuscitation trolley and was checked daily.

Records

- Patient files were stored securely within the records department at the main hospital site.

Outpatients

- Clinical records kept were a combination of electronic records and paper files. When records were in the outpatients department, they were stored securely; locked away or on password-protected computers.
- Nurses told us that many patients had multiple conditions, so notes were essential for their appointment. They told us they rarely could not locate patient records, and were well served by the records department.
- The medical records manager told us they had a 'key performance indicator' target of 99% for a patient's file to be with the patient by the time of their appointment. If a file could not be found a temporary file was produced from the most recent electronic data, such as clinic letters, basic details and test/blood test results.
- Records showed that the 'key performance indicator' target of 99% had been achieved month on month for the whole of the 2013/14 year. Approximately 7,500 files were retrieved for outpatients per month.
- The records department was a well-managed department, with staff who were confident and competent in their roles. They spoke highly of the team they worked within, and praised the manager they reported to.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The lead outpatient nurse told us that there had been a drive in the last two years to improve staff awareness and knowledge of safeguarding, consent and capacity, which were all part of mandatory training. The safeguarding lead for the trust was raising the profile and awareness, and was featured in the trusts' staff magazine for spring 2014.
- The head of outpatients told us that they had not had any safeguarding issues or referrals. We spoke with four nurses and found that all four lacked an understanding of recognising a safeguarding issue or how to report it. We also found that staff lacked an understanding of what to do if patients lacked capacity and how then to support consent.
- Staff told us that if they had identified a safeguarding or capacity issue they would call the safeguarding lead nurse practitioner to assist. The safeguarding lead verified that this practice occurred.
- The safeguarding lead told us that they had identified a gap in staff knowledge, and had been supported to roll out further safeguarding awareness and Mental Capacity Act (MCA) training.
- We were shown laminated posters designed by the safeguarding lead. They provided clear step-by-step guidance for staff when dealing with any safeguarding issue, or where they perceived a patient to lack capacity. At the time of our inspection they had not yet been displayed.
- Outpatients had introduced a 'This is me' booklet, which can be filled out and given to staff when a person with dementia goes into hospital. It provides a snapshot of the person behind the dementia, and helps hospital staff be aware of a person's habits, hobbies, likes and dislikes. This was in the process of being implemented.
- Patients told us that staff always spoke to them about any procedure before carrying it out.

Mandatory training

- Staff felt training was beneficial to their role, which took place away from normal duties. Staff cover was provided so they could go on training days. Some modules were delivered through an e-learning format, while others were face-to-face.
- Staff felt training was beneficial to their role, which took place away from normal duties. Staff cover was provided so they could go on training days. Some modules were delivered through an e-learning format, while others were face-to-face.
- Online training records showed that 90% of outpatient staff were up to date with their training. Those not at 100% compliance could be accounted for by maternity leave, sick leave and training arranged for future dates.
- Core training topics included information governance, infection control, moving and handling, fire safety, child protection (levels 1,2 &3, although who had completed what level was not verified), safeguarding, health and safety, conflict resolution, equality and diversity, blood transfusion, dementia awareness, Deprivation of Liberty Safeguards (DoLS) and MCA.
- Staff told us that basic life support training was given, which had been used successfully on a couple of occasions.

Outpatients

- Reception staff told us that they had not received any customer care or conflict resolution training. Trust managers told us it had not previously been considered applicable for all staff, although reception staff were now included and would receive future training.
- All new staff had a four day, face-to-face induction prior to beginning duties in a supervised capacity.

Nursing staffing

- There was a good level of retention of nursing staff within outpatients. We were told there was one vacancy, which was currently going to advert.
- There was a paediatric nurse who was the outpatient link to the wards. Staff were also supported by the lead nurse for safeguarding, who assisted staff with consent and capacity issues.
- The senior sister was responsible for overseeing the staffing rota. We reviewed the staffing establishment in relation to the number of qualified nurses, clinic support workers and administrative staff. We found the outpatients departments on both sites to be adequately staffed.
- The nurse lead for outpatients was in addition to nursing numbers, so was able to supervise and assist staff.
- There was a shift co-ordinator whose role was to identify any issues as they arose, such as patients who might be in need of assistance in the waiting area.

Medical staffing

- The head of outpatients told us there were individual service managers for sarcoma, paediatric and upper limb, pain and rheumatology, nerve injury and spinal, who were responsible for the management of doctors and the staffing of their own clinics.
- The medical staffing manager attended the quality and risk support service meeting (the medical division to which outpatients belonged, and the formal structure to monitor quality in outpatients). It was reported in April 2014 that there were five junior doctor vacancies, all were being filled by locum doctors awaiting substantive appointments.

Major incident awareness and training

- The head of outpatients told us about the overall trust plan from a practical perspective and that major incident planning was the responsibility of senior trust managers.

Are outpatients services effective?

Not sufficient evidence to rate

The service ensured that assessments followed trust assessment and treatment guidelines through integrated booklets for different patient pathways. Patients had access to pain relief. Appraisals were taking place for all staff, and we found good examples of multidisciplinary working. Services were provided five days a week.

Evidence-based care and treatment

- The service had integrated booklets to support patient pathways that were based on evidenced-based best practice. These included: elective hip, elective knee, short stay (day case), general, foot and ankle, and paediatric. We found these covered all aspects of care and treatment.

Pain relief

- Nurses were able to give pain relief in the outpatient department. They worked closely with pharmacy, and described the correct procedure for prescribing and administering.
- One patient we spoke with told us that they were able to make appointments when their pain increased. The service aimed to see patients within an 11 week treatment target.
- There was a dedicated consultant-led pain therapy service.
- A business plan for a new consultant and two nurses specific to pain management had been submitted to the board and awaited confirmation for approval.

Competent staff

- All annual appraisals were completed by the appropriate level of staff. Most staff had had an appraisal in the last 12 months, and those who had not were accounted for; this was due to issues such as maternity leave, sick leave and 'completed but record not updated'.
- Regular supervision or one-to-one operational meetings were less fixed, and took place within the same structure as appraisals. The lead outpatient nurse had one-to-one meetings with the senior sisters.
- There was a competency framework for new staff to the service, completed within the first three to six months.

Outpatients

- There was a teaching programme for staff development. Staff told us that the trust supported training, including training for degrees and qualifications, such as in health promotion, management of chronic illness and advanced assessment.
- Clinic support workers had a competency book and worked to its core values.
- Appraisal rates for administrative and clerical staff detailed evidence of this being managed.

Multidisciplinary working

- Multidisciplinary team meetings and multidisciplinary complex care meetings took place and typically consisted of occupational therapists, physiotherapists, geriatricians, lead pre-assessment nurses and bed managers.
- We saw good multidisciplinary working and co-operation from ward staff. One example of this was when a patient arrived in outpatients having a hypoglycaemic attack.
- The lead outpatient nurse told us that they worked with volunteers who had a good relationship with the patient group.
- Consultant anaesthetists met with pre-assessment teams formally and informally. These meetings were recorded. Outpatient staff told us there was good input from anaesthetics, but that they did not see much of surgeons.

Seven-day services

- Outpatient clinics ran from Monday to Friday. Clinics were scheduled to run from 8am to 5pm.
- The head of outpatients and the lead outpatient nurse both told us that there were nursing resources to run weekend clinics, although this did not happen. The reasons for not providing on the weekend were unclear.

Are outpatients services caring?

Good

The outpatients service was caring. Almost every patient we spoke to felt that they received a kind and caring service. We were also told that staff were helpful and polite most of the time. We found only a small number of instances where patients felt that staff attitude was not satisfactory. This was the overall message from every aspect of the outpatients' service.

Compassionate care

- We spoke with and received feedback from approximately 55 patients during our visit. An overwhelming majority told us that staff were caring and kind.
- Four patients fed back about poor staff attitudes; all related to one consultant and administrative staff.
- Privacy and dignity were maintained in private consultation in rooms with the door closed.
- We observed medical staff coming out and greeting patients in the waiting areas to collect them for appointments.
- Patients were given contact cards at the end of their appointment, with the phone number and email address of who to contact if they needed to.
- Patients told us that reception staff were caring and dedicated.
- Reception staff we spoke with gave us examples of how they had helped patients who were in need. They were also confident that they had nursing support they could call upon when they had identified patients who needed extra assistance.
- Patients told us that radiology staff were very committed and caring, and stayed late if needed.
- Patients told us that patient transport services were friendly and helpful.
- There were three methods for patients to provide feedback: patient satisfaction (real time feedback), via the Friends and Family Test, and 'say so' which was a comments card. The real time feedback will eventually be replaced completely by the Friends and Family Test.
- If negative comments could be attributed to an individual because they had attached their contact details, they would receive a call or an email from the head of outpatients. We were also shown examples of resolving issues reported through this process, such as coat hooks being placed in the disabled toilet.
- Figures for the previous year showed over 500 responses to the outpatients department through the Friends and Family Test, with an overwhelming majority being positive about the care and treatment they had received.

Outpatients

- Recurring themes and issues arising from patient feedback were waiting times in clinics, and some specific clinics, such as sarcoma and joint replacement.
- The 'patient experience improvement committee' met quarterly. Minutes show patients, the Patient Advice and Liaison Service (PALS), the director of nursing, consultants and heads of departments attend. Where issues had arisen through patient satisfaction feedback, action had been identified.

Patient understanding and involvement

- Patient understanding of conditions and services was enhanced by patient information leaflets that were readily available throughout the department. There was also a list of online information leaflets and paper leaflets available.
- Patients told us that they felt that both medical and nursing staff were good at explaining what was happening and what different treatments involved.
- Patients and family members we spoke with told us they felt included in care and treatment. We observed patients' family members and carers being included in consultations.

Emotional support

- Patients told us they felt emotionally supported when this was needed, through the kind and compassionate care they had experienced.
- There was a designated room available to speak to patients in private about confidential or sensitive issues.
- There was a duty nurse whose role was to walk around the waiting areas, and identify and offer support to those who were in need of extra help.

Are outpatients services responsive?

Requires improvement

We found that outpatient services were not always responsive to the needs of patients. For instance, care pathways were monitored to ensure they were responsive to patient need and there was a shift co-ordinator who walked the floor and identified patients who needed extra support or assistance. We also found that the outpatients department reviewed complaints about the service.

Patients told us that the service was responsive to their clinical needs, however, 26% of clinics started late. DNA rates at this site were 6.1% in April. There was no key performance indicator for sending out clinic letters following consultation to patients and their GPs. A significant proportion of letters were not sent out for over one month. There was an exception within the trust that letters regarding patients who had cancer would be sent out within 48 hours.

Service planning and delivery to meet the needs of local people

- A new centralised booking process had been introduced in the last six months which made it easier for patients to make appointments.
- Waiting areas had comfortable seating, although at Stanmore they were, at times, overcrowded and on occasions there was nowhere for some patients to sit.
- There were tea, coffee and snacks available from a café located next to the main waiting area in outpatients. Toilet facilities were easy for all to access.
- Nursing and therapy services were able to access interpreters when required. Telephone and face-to-face interpreting services were available, and were booked through the Patient Advice and Liaison Service (PALS).
- There was a dedicated transport service for outpatients, run by a private contractor. The system for booking transport was responsive to patients' needs and was monitored for quality. Patients we spoke with told us their transport generally arrived on time and was reliable. We observed that transport was suited to the different mobility and health needs of patients.
- Car parking was free.

Access and flow

- Overall 74% of clinics started on time or within 15 minutes allowing time for the first patient to visit x-ray. Overall DNA rates were 7.9%.
- The DNA rates were monitored by specialty. Patients not attending their appointments for spinal clinics were the highest, PHI the lowest. DNA rates were worse at Stanmore than the outpatients facility at Bolsover Street.
- The Outpatients' Transformation Board meeting minutes from March 2014 described the DNA rates as 'appalling', and ' a bad month for cancelled clinics' when reviewing specific clinics.
- The Outpatients' Transformation Board meeting minutes from March 2014 stated 'serious overruns adversely affecting patient experience and complaints data supports this '.

Outpatients

- Waiting times were the responsibility of individual clinical divisions, not the outpatient department itself. This meant that neither the head of outpatients, nor the head of operations for clinical support services could influence and effectively improve this aspect of the service.
- Steps were taken to mitigate this by blocking out spaces in booking diaries. One example of this is in the spinal sarcoma service, where it has had a positive impact on capacity. However, services did not have the capacity to deliver on waiting times consistently.
- Patients consistently told us that they felt they received a good service, but their appointments regularly ran late. No one was managing clinic waiting times. Patients told us that the service was quite good in keeping them informed about late running appointments, but they were not told why their clinic appointment was late.
- One patient we spoke with had travelled a 60 mile journey in patient transport. It was not communicated to them that their consultant was away, and the registrar they saw was not able to make a decision based on their test results. This meant that the patient had to rebook his appointment and had a wasted journey on this occasion.
- We spoke with another patient who had travelled from Scotland by aeroplane at great personal expense, as they felt it was worth it given the effectiveness of the service they received. Their clinic was running late, to the extent that they were very anxious that they would miss their flight home. Their appointment was fast-tracked once they alerted the nurses.
- There was a supported discharge for patients, which allowed for patients to come back if they needed to after being formally discharged from the trust, although the lead outpatient nurse told us that it remained difficult to encourage patients to be discharged.

Meeting people's individual needs

- A shift co-ordinator walked the floor and identified patients with additional needs and in need of some assistance. We observed that this role was although helpful, not that visible. This was verified by outpatient staff, who told us they would like the role to be more visible.
- Patient notes and screening documentation were checked by a senior nurse to determine the most appropriate pre-assessment format, such as by telephone or face-to-face, and the anaesthetic assessment. This was then input into the centralised booking system, where an appointment was booked based on individual patient need.
- A comprehensive pre-assessment took place, which was carried out by nurses. A pre-assessment booklet was completed. 84% of patients visiting outpatients were pre-assessed by either telephone or face-to-face.
- Depending on the assessment's outcome, senior advice might be sought from the multidisciplinary complex care meeting.
- A one-stop paediatric outpatient clinic with a pre-assessment sister was currently being piloted. If successful, the approach would be rolled out to adults.
- We were told that the outpatients department ran a fast-track service for those who needed it. One patient we spoke with told us that they had had an operation at the hospital last year and were attending outpatients' appointments at the Bolsover Street site. They were told by their doctor to get in touch if they had any problems. They had come in to the outpatients department at Stanmore because of a relapse, but without an appointment. Reception contacted their consultant's secretary, who arranged for him to be seen by the nurse therapist consultant.
- As a national organisation, most patients were not local. Clinical information was shared with patients' local GPs and other hospital consultants. However, records showed there were severe delays in sharing this information following treatment. Transcripts of the consultants were contracted out, and were typically returned after 30 days. We saw that there was then a further delay of up to 52 days for the letters to be approved before being sent out to GPs, consultants and patients.

Learning from complaints and concerns

- There had been only two formal complaints in the last 12 months. The trust target was for all complaints to be fully responded to within a 25 day period. People were notified if this was not possible. All complaint responses were reviewed following their investigation, by an executive team member.
- The complaints and the Patient Advice and Liaison Service (PALS) officer attended the quality and risk

support services meeting (the medical division to which outpatients belonged and where quality was monitored) to give brief detail of complaints and timeframes.
- We were given examples of where the department had acted on comments made in formal complaints.
- We were told by the head of outpatients that all negative patient feedback received with the patient's contact details attached was responded to. One patient we spoke with told us how they had used 'the yellow form' (a form of patient feedback not classified as a complaint) to make what they thought was a complaint four weeks ago. They had included their contact details, but had not heard back.
- A variety of staff told us that they had not had many complaints recently, but waiting times were a source of patient frustration. We were also told how they would try to locally resolve comments and complaints first.
- Patients were offered free drinks and biscuits whilst waiting for their appointment. This was in response to continued comments and complaints regarding the length of waiting times.

Are outpatients services well-led?

Requires improvement

There were clear lines of accountability and management for front line services within the outpatients department. There was a senior sister at Bolsover Street who reported to the head of outpatients, who reported to the Head of Operations – Clinical Support Services Division.

Some clinics started late and over ran. Patients told us appointments were regularly late. The do not attend (DNA) rate for the trust was 6.2% for April 2014 having been 7.9% for 2013/14 overall. These had been identified through leadership meetings and were being considered within a transformation project, and also through the comments and complaints the service received. Waiting times were the responsibility of individual clinical divisions, not the outpatient department itself. This meant that neither the head of outpatients, nor the head of operations for clinical support services could influence and effectively improve this aspect of the service.

Vision and strategy for this service

- The outpatient transformation programme meeting oversaw the vision and development of the department and was attended by the medical director, the director for integrated services, the head of outpatients and the lead nurses from both sites.

Governance, risk management and quality measurement

- There was a formal structure to monitor quality in outpatients through the quality and risk support services meeting, the medical division to which outpatients belonged and which quality was monitored. The April 2014 minutes showed that although matrons attended, there were no doctors or allied health professionals from outpatients involved in this meeting.
- The risk register was monitored through the quality and risk support services meeting. The April 2014 minutes showed that from April the deputy head of nursing attended the meeting. Minutes showed that the trust risk register had been reviewed by the trust, and as a result there were now three risk registers, one for each medical division. A newly devised issue logging process is awaiting approval .The intention is that issues will be discussed at this meeting to decide their level of risk.
- The outpatients' transformation board meeting minutes from March 2014 showed that the improvement of clinic times and the efficiency of the outpatients' department was a work in progress. The meeting minutes evidenced that this was being discussed, but that it needed further work to effect the desired improvements.
- The patient experience improvement committee met quarterly. Minutes showed that patient representatives, the Patient Advice and Liaison Service (PALS), the director of nursing, consultants and heads of departments attended.
- There were clear lines of management in outpatients, up to the chief operating officer.

Leadership of service

- The outpatients department was managed under the integrated services directorate. The director for integrated services line managed the head of outpatients. There was a lead nurse in outpatients and sub leads for areas such as reception, records and administration. There were monthly outpatient staff meetings on each site.

Outpatients

- There was a yearly executive walkabout through the department. We were given the example of IT being improved as a result of this. However, a number of staff told us they had never seen any senior managers in the department.
- The pre-assessment sister met with the lead nurse for outpatients three times a week, and the head of outpatients was always available if needed. We observed a high level of contact with their staff.
- There were weekly visible leadership days, where lead nurses and matrons did patient-based work, and looked at sets of notes to check the quality of records.
- Clinics started late and over ran. Patients told us that appointments were regularly late. The do not attend (DNA) rate for the trust was 6.2% for April 2014 having been 7.9% for 2013/14 overall. These had been identified through leadership meetings and were being considered within a transformation project, and also through the comments and complaints the service received.
- Waiting times were the responsibility of individual clinical divisions, not the outpatient department itself. This meant that neither the head of outpatients, nor the head of operations for clinical support services could influence and effectively improve this aspect of the service.

Culture within the service

- There was an open door policy for staff to come and speak about issues. We were also told that they let people get on with their work rather than micro manage, but always wanted to be the first to know if anything was a concern.
- Staff felt there were pockets of very good culture. We were also told by staff that there were examples of bullying and that they had no faith in the leadership rooting this out.
- Other staff felt the leadership were managing instances of bullying as a direct result of responding to the staff survey, and that the culture had changed for the better.
- One member of staff told us “it’s a funny place you either love or hate, where people either stayed for ages or left quickly”. Some staff felt that because staff stayed for a long time, promotion and development opportunities were limited.
- Other staff were happy with staff development opportunities, and we were given examples of educational trips and promotion opportunities.
- A recent initiative meant nursing staff within the outpatients department now had the opportunity to rotate with ward staff, to give them wider experience and develop their promotional opportunities.

Public and staff engagement

- Staff told us that through staff engagement, the leadership had recognised the stress involved in turning patients around between appointments quickly, especially bone tumour patients. There were now plans to improve this with the appointment of a new nurse.
- The human resources (HR) department presented the results of the staff survey to the outpatients department. Outpatient sub leads also met with HR to discuss the survey outcomes.
- The head of outpatients told us that all staff were asked if they were willing to express more about experiencing violence, which some did. This was reported to HR anonymously, along with actions taken to address issues raised in the staff survey.
- We were told that in relation to bullying, some staff were spoken to about how to be a less oppressive manager.
- We were told there was some interpretation needed to understand this, as staff were reporting confrontational situations they had experienced as physical violence, when physical violence had not occurred.

Innovation, improvement and sustainability

- New initiatives were discussed in monthly outpatient staff meetings. We were given an example of where a new practice, developed by the foot and ankle nurse, was presented, and staff were supported to deliver this new procedure.
- We were given examples of where there had been initiatives to improve the service. There was, for example, now a dressing clinic.
- There was an innovation fund which had funded the development of a video, for staff about the patient pathway through the hospital, which was accessed through staff computers.

Outstanding practice and areas for improvement

Outstanding practice

- Outstanding clinical outcomes for patients.
- Innovative surgery was being carried out to improve patients' quality of life. For example limb lengthening for patients with skeletal malformation.
- The Executive board demonstrated leadership and vision for the hospital.
- Staffing levels and the skill mix of staff met patients' needs.
- Effective multi-disciplinary working putting the patient first.
- A hotel based rehabilitation programme supporting patients to recover from surgery and have a normal daily life.
- A ward dedicated to providing wound care to patients with appropriately skilled staff.
- Some wards had started to use a drink container that attached to equipment and could be kept with patients at all times to ensure patients were kept hydrated, especially during rehabilitation sessions.
- The training for surgical trainees was excellent
- The education for children and young people's was well integrated into the service, and inclusive and innovative teaching methods meant that children and young people could continue to access learning throughout their hospital stays.

Areas for improvement

Action the hospital MUST take to improve

- The design and layout of the premises is suitable for all service users.
- Continue to focus significantly on culture, values and behaviours of all staff.
- The paediatric resuscitation equipment in the theatre recovery area is checked regularly to assure it is ready for use if required.
- The World Health Organisation (WHO) surgical safety checklist is used and completed at each stage of surgery.
- Staff that treat children and young people are up-to-date with the appropriate level of safeguarding training.
- The needs of children and young people are considered in scheduling operations.
- The learning from incidents is widely shared.

Action the hospital SHOULD take to improve

- Develop the services across seven days.
- Review its use of opioids prescribed for pain relief for older people as it is recognised as a contributory factor in falls and increased confusion.
- Consider the mechanisms in place for identifying if equipment including mechanical ventilators, cardiac monitors and mattresses used to prevent pressure ulcers are clear to all when testing is needed.
- Ensure all staff are aware of support mechanisms such as the employee assistance programme. The RCN recommends there should be formal support mechanism available challenging and highly specialised nature of the service provided, particularly with children and young people.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable premises by means of suitable design and layout.

Regulated activity	Regulation
Surgical procedures	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment How the regulation was not being met: People who use services and others were not protected against risks from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity was properly maintained to ensure it was suitable for its purpose. The paediatric resuscitation equipment was not regularly checked to ensure it was ready for use if required.

Regulated activity	Regulation
Surgical procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The registered person had not taken proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the planning and delivery of care and, where

Compliance actions

appropriate, treatment in such a way as to ensure the welfare and safety of the service user. The WHO surgical safety checklist was not always used and completed for all patients.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers How the regulation was not being met: The provider did not identify, assess and manage risks relating to the health, welfare and safety of service users and others. Some ward and service meetings did not discuss complaints, incidents and audits, or the discussion only focused on their own service and did not share learning from other areas of the trust. External reviews to improve the safety of children's and young people's services had been carried out five and nine years ago and many of actions remained outstanding.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services How the regulation was not being met: The needs of children and young people were not considered in scheduling operations.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff How the regulation was not being met: The registered person did not have suitable arrangements in place in order to ensure that persons employed for the purposes

This section is primarily information for the provider

Compliance actions

of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal. Only 42% of medical staff had completed their required level of child safeguarding training. In addition, there was not a sufficient number of staff with specialist training in caring for children, to ensure that there was always someone with appropriate skills to care for the number of children working across the departments that children used, which included outpatients.