Royal Hospital for Neuro-Disability

Royal Hospital for Neuro-Disability

Inspection report

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Date of inspection visit: 14th June 2023 - 16th June 2023
Date of publication: 07/09/2023

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this service went down. We rated it as requires improvement because:

- The service did not always ensure that medicines were managed in a safe way. We found expired medications available for use in ward areas, unsafe storage and use of medical gases, unsupervised dispensing of medications by untrained staff, and an out-of-date medicines management policy.
- The service did not have effective governance systems in place to ensure that actions were taken in response to national patient safety alerts. National Patient Safety Alerts (NatPSAs) are official notices from NHS England giving instructions to providers on how to prevent risks which might cause serious harm or death. We found the service had not taken all actions required from a medical gases alert issued in June 2021, meaning patients remained at risk of serious harm or death.
- The service did not always ensure that all equipment was clean and ready for use, or labelled to show when it had been cleaned.
- The service did not always ensure that equipment used for obtaining laboratory specimens were within their expiration date.
- Leaders did not always have clear oversight of the risks to their patients.

However

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well.
- The service controlled infection risk well. Staff assessed risks to patients, acted on them, and kept good care records.
- The service managed safety incidents well and learned lessons from them.
- Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.
- The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (Including older people's care)	Requires Improvement 	See overall summary above

Summary of findings

Contents

Summary of this inspection

Background to Royal Hospital for Neuro-Disability

The Royal Hospital for Neuro-Disability (RHN) is an independent medical charity which provides neurological services to the entire adult population of England. The hospital specialises in the care and management of adults with a wide range of neurological problems (including those with highly dependent and complex care needs), people in a minimally aware state, people with challenging behaviour, and people needing invasive and non-invasive mechanical ventilation.

The RHN is registered to provide diagnostic and screening activities, treatment of disease, disorder or injury, accommodation for people needing nursing or personal care and transport, triage and medical advice provided remotely.

The service was last inspected in September 2021. This was a focused inspection where we inspected the safe and well-led domains to ensure improvement had been seen following the inspection undertaken in February 2020. The service had improved and was re-rated good overall, with good in safe, effective, caring, responsive and well-led.

The RHN has a total of 237 beds across 12 wards, which are arranged into five service lines; a brain injury service, continuing care service, specialist respiratory services, a specialist behavioural service, and a young adult service. The hospital provides specialist care to patients with a wide range of severe brain injuries, a range of complex neurological disabilities caused by damage to the brain or other parts of the nervous system as a result of brain haemorrhage, traffic accidents or progressive neurological conditions.

How we carried out this inspection

We inspected this service using our focused inspection methodology.

We carried out an unannounced focused onsite inspection on 14th June 2023. We complimented the onsite inspection with a remote off-site interview with the hospital's Chief Executive Officer, Director of Nursing and Director of Governance on the 15th June 2023.

The purpose of this inspection was to check that the service had maintained a good standard in the safe and well-led domains since our previous inspection in September 2021. We used the long-term conditions inspection methodology framework for the inspection.

The team that inspected the service comprised of an operations manager (off site), four inspectors, and an assistant inspector.

To get to the heart of service users' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

We spoke with 15 members of staff including managers, clerical staff and nurses. We also spoke with 8 patients and reviewed 10 patient's records.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Outstanding practice

The service has recently been awarded a Gold Award by the organisation Leaders in Safeguarding for their outstanding safeguarding culture.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure the proper and safe management of medicines. This includes ensuring the service has an up-to-date medicines management policy in place, all medications available for use are within their use by date, the safe management and use of medical gases including medical air and oxygen, and the safe dispensing and administration of medications. (Regulation 12 (2) (g)).

- The service must ensure they assess, monitor and mitigate risks relating to the health, safety and welfare of service users. They must review their governance arrangements to ensure they allow the provider good oversight of the quality and safety of care being delivered in relation to the management of National Patient Safety Alerts. (Regulation 17(2)(b)).

Action the service SHOULD take to improve:

- The service should ensure that all equipment is clean and readily available for use and labelled to show the same. (Regulation 12)
- The service should ensure that all equipment used for obtaining laboratory specimens is within its expiration date. (Regulation 12)
- The service should consider whether the professional responsible for the overseeing of the administration of medications by student nurses should be referred to the Nursing and Midwifery Council. (Regulation 12)
- The service should ensure that it has clear oversight of all risks to their patients. (Regulation 17)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (Including older people's care)	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Requires Improvement

Medical care (Including older people's care)

Safe	Requires Improvement
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Training was provided through e-learning and face-to-face sessions and was tailored to the skill requirement of staff and dependent on their role.

Topics included but were not limited to; basic life support; infection prevention and control; safeguarding children and adults; equality, diversity and human rights; moving and handling; deprivation of liberty standards, and duty of candour. At the time of our inspection, compliance with mandatory training for the various modules was 94% which was above the provider's target of 90%.

Managers monitored mandatory training and staff were alerted when they needed to update their training. Systems in place allowed managers to clearly view staff training files and ensure staff completed training in a timely way. Staff within the service understood their responsibility to complete training and told us training was relevant to their roles.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

There were clear systems, processes and practices to safeguard patients from avoidable harm, abuse and neglect that reflected legislation and local requirements. The safeguarding adults at risk of harm and safeguarding children and young people's policies were in date and accessible to all staff.

Staff received training specific for their role on how to recognise and report abuse. All staff, both clinical and non-clinical were trained to the right level of safeguarding competency for both children and adults, this training was all in date and in accordance with their role. The overall safeguarding training compliance rate for staff over all staff was 94%, which was above the service's target of 90%. Staff told us they received regular training updates in adult safeguarding and safeguarding children, and training was delivered to all new staff at their induction as a mandatory subject.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff we spoke with demonstrated a very high understanding of their responsibilities in relation to safeguarding adults and children in vulnerable circumstances. Safeguarding was at the forefront of all handovers, safety huddles, and team meetings.

Requires Improvement

Medical care (Including older people's care)

All staff of all levels knew who the safeguarding lead was, how to make a safeguarding referral and who to inform if they had concerns. The Head of Safeguarding had external supervision from a national safeguarding system leader. This leader was also a member of the Safeguarding Adults National Network, which had over 500 members from the safeguarding community across health, social care and providers. There was a well-managed system and process for recording the escalation of concerns to external agencies where needed.

The service had recently been awarded a Gold award by the company Leaders in Safeguarding for their outstanding safeguarding culture.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. They did not always keep equipment and the premises visibly clean.

Not all areas were clean and tidy. We found equipment located on different wards to be dusty and visibly dirty. This included trays used for clinical procedures, shower chairs, and hoists. This meant that there was a risk that dirty equipment could be used when delivering care to patients.

Staff did not always clean equipment after patient contact or label equipment to show when it was last cleaned. The service did not always use 'I am clean' stickers to show that equipment had been cleaned and was ready for use. We saw four shower chairs were dirty and did not have any 'I am clean stickers' in place. We saw one shower chair had a sticker, but it was blank and had not been completed to show the date and time it had been cleaned. This meant staff did not know when it had last been cleaned. We saw one hoist that was visibly dirty had an 'I am clean sticker' showing it was last cleaned on the 29th January 2023. When raised with senior staff we were told the hoist was rarely used as the ward used ceiling hoists. However, ceiling hoists were not available in all areas such as reception, hallways, and bathrooms, therefore the hoist would be required for use in these areas if the situation arose.

Cleaning records were up-to-date and stated that all areas were cleaned regularly, however this did not always match what inspectors found. For example, not all equipment was cleaned as demonstrated above.

Since the inspection, senior leaders have told us that staff have been reminded to ensure all equipment is cleaned regularly and 'I am clean' stickers are used to show when the equipment was last cleaned and that it is clean and ready for use.

Staff followed infection control principles of personal protective equipment (PPE), including the use of gloves, aprons, and face masks where required. All staff who had contact with patients were observed to follow bare below the elbow principles and were always wearing the right PPE.

The service carried out monthly infection control audits to ensure all infection, prevention, and control principles were being followed. Results for the 12 months prior to the inspection showed the service was following their own guidelines and were on average over 90% compliant in all environmental and hand hygiene audits, which was above service's target of 90%.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe. Staff were trained to use them. Staff managed clinical waste well. However not all equipment was safe for use.

Requires Improvement

Medical care (Including older people's care)

All areas were clutter free and facilities and equipment were maintained regularly to keep patients safe. Annual service schedules and portable appliance testing was undertaken. And safety checks, such as water safety were undertaken under a service level agreement annually.

Staff carried out daily safety checks of specialist equipment, including resuscitation equipment and equipment used for treating life threatening allergic reactions. A weekly fire alarm test was undertaken within the building. Fire extinguishers were located throughout the service which had been checked and tested in line with professional guidance.

Patients could reach call bells and staff responded quickly when called. Patients who were unable to use call bells were regularly checked by staff to ensure their needs were met.

Staff disposed of clinical waste safely. There were appropriate waste bins in each area which were clearly labelled with what could be disposed of in them. The bins in each room were regularly emptied. Sharps bins were clearly labelled with dates of construction, as well as disposal.

However, not all equipment was safe for use. Inspectors found expired viral swabs, expired pathology bottles and expired blood culture bottles available for use within the service, with some pathology bottles having expired December 2020. This meant that blood tests and viral swabs taken for diagnostic purposes could be contaminated or give an incorrect result.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient within 12 hours of their admission to the hospital. These included but where not limited to infection prevention and control, mobility, skin integrity, falls, behaviour and safeguarding.

The service had a safe and effective escalation process for deteriorating or seriously ill patients. There was an up-to-date deteriorating patient policy in place which included guidance on transferring unwell patients to the NHS. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

National Early Warning Score 2 (NEWS2), was completed twice per day for each patient and when necessary for deteriorating patients. Staff informed the Clinical Response Service (CRS) of patients with NEWS2 scores of 5 and above. The CRS may visit the patient, based on their assessment. Elevated NEWS2 scores were re-checked within an hour and escalated accordingly. Medical staff were informed of the patient's condition by the CRS, and also through the daily safety huddle. Each service line had a daily safety huddle where any patient with a NEWS2 score of 5 were discussed and escalated as required.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. All staff had received training specific to their role.

Requires Improvement

Medical care (Including older people's care)

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants in each areas in accordance with national guidance. Managers could adjust staffing levels daily according to the needs of patients. We saw that the numbers of staff on duty on the day of the inspection matched the planned numbers of staff.

The service had reducing vacancy rates, reducing staff turnover rates, and reducing sickness rates. We saw the service had a marked reduction in their vacancies during the 12 months prior to our inspection. The service had an internal staff bank, and bank staff were used to cover staffing gaps when needed. The service had low use of agency staff. Agency staff received a full induction from the service and managers made sure they understood the service.

The service had enough allied health professionals with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The service used British Society of Rehabilitation Medicine (BSRM) guidelines to benchmark and review allied health professional staffing, in line with patient complexity scores. The department manager could adjust staffing levels daily according to the needs of patients.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

During regular working hours there were enough medical staff present, often with a senior GP from the GP provider supporting the hospital. GPs provided care for patients in the continuing care wards, with at least one consultant on site from 9am to 5pm Monday to Friday. One of the consultants was also contractually responsible for providing specialist support to all GPs.

The consultant led weekly wards rounds, which included a nurse and allied health care professionals. There were also weekly multidisciplinary team meetings, which included doctors, nurses, physiotherapists, neuro-psychologists, occupational therapists and speech and language therapists, as required.

The service hosted visiting consultants who had expertise in different specialisms such as palliative care, respiratory, neuro psychiatry, urology and Huntingdon's disease. During out-of-hours, there was a consultant in rehabilitation and a junior doctor on call. The junior doctor on call reported to the consultant on call as required.

The hospital had a schedule for doctors covering the wards during the day and the on-call rota out-of-hours. The neuropsychiatrist attended the wards weekly, to review medicines and lead the ward round; and was contactable in emergencies.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Patient notes were electronic and staff were able to navigate the electronic system with ease.

We reviewed 10 sets of patient notes. The patient notes we reviewed were clear, concise, and contained appropriate risk assessments.

Communications with other members of the multidisciplinary team such as GPs and allied health services were well documented.

Records were stored securely. We observed that all computers were locked when not in use. This meant patient records were kept secure and confidential.

Medicines

The service did not have effective systems and processes in place to safely administer or store medications. They safely prescribed and recorded medicines.

The service's medicines management policy had expired December 2022, which was 6 months prior to our inspection. This meant the service may not be following the latest guidelines and best practice for managing medicines, including the prescribing, administering, recording and storage of medicines.

Staff did not always safely store or manage medicines in line with the provider's medicines management policy. Staff did not always use 'opened on' stickers to show when liquid medications had been opened. This meant they did not know when the medication had been opened, or the date it needed to be used by after opening. This meant that medications that were no longer safe to use could be administered to patients. Due to the needs of the patients, the service used a high proportion of liquid medications.

The service did not ensure that all medications available for use were in date. Inspectors found expired medications across two wards, which included creams, tablets, and liquid medications. One liquid medication had an expiry date of February 2022, which was over a year before the inspection.

Staff did not always safely store medication keys, which was not in line with the provider's policy. Inspectors found two sets of medication keys laying unattended in a clinical room. Although the room was locked, this meant than anyone who had access to the room could gain unauthorised access to medications.

Staff did not always ensure the safe dispensing and administration of medications. Inspectors saw two student nurses dispensing medications without the direct supervision of a trained professional. The nurse in charge told inspectors that the practice was 'ok' as they were able to tell what each medication was. This was not in line with the provider's policy, or Nursing and Midwifery Council' s (NMC) code for delegating tasks and duties to other people, and put patients at risk as the wrong medication, or wrong dose of medication, could be administered to a patient.

Staff did not always ensure the safe storage and use of oxygen. Inspectors found oxygen cylinders were not always securely stored, and empty cylinders were stored amongst cylinders that contained oxygen on the ventilated unit. This meant that there was a risk that patients who were ventilated and dependent on oxygen for survival could be connected to cylinders that did not contain any oxygen.

The service did not safely manage medical air. The service failed to follow all directives set in the National Patient Safety Alert 'Eliminating the risk of inadvertent connection to medical air via a flowmeter' issued in June 2021. National Patient Safety Alerts (NatPSAs) are official notices issued by NHS England giving instructions to providers on how to prevent risks which might cause serious harm or death. The NatPSA gave direction for airflow meters to be removed from use by the 16th November 2021. Although the service had an agreeance with NHS England that some areas could have air flow meters in use, Inspectors found airflow meters (devices used to administer medical air) available for use across the service, including areas that were not agreed with NHS England. This meant the service failed to remove airflow meters from use as directed in the NatPSA and patients remained at risk of serious harm or death.

Requires Improvement

Medical care (Including older people's care)

Since the inspection, senior leaders have told us the medicines management policy was under review at the time of the inspection, but this had not been updated on the electronic system. Senior leaders told us that the updated policy was presented to the Drugs and Therapeutics Committee the day after the site visit, and had been submitted to be uploaded to the service's internal intranet.

Senior leaders have told us that following the inspection all staff have been reminded to use 'opened on' stickers on all medications, all expired medications have been removed from use, staff have been reminded to ensure medication keys are stored with a registered nurse, and to ensure all student nurses are fully supervised by a registered professional when dispensing and administrating medications.

Senior leaders have told us that since the inspection airflow meters have been removed from use, portable nebuliser have been ordered, and ports capped off as directed in the 2021 NatPSA.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff reported serious incidents clearly and in line with provider's policy. The electronic system used to report and capture information for incidents or adverse events was viewed by inspectors. We saw this was a reliable system to support the oversight and management of incidents.

Incidents reported on the electronic system were escalated to the manager for investigation. Learning was shared at meetings, via email and in huddles.

Staff raised concerns and reported incidents and near misses in line with the provider's policy.

Managers debriefed and supported staff after any serious incident. A recent example was given to us of an adverse event which had happened, and staff confirmed debrief discussion had taken place after this.

The service had no never events in the 12 months prior to inspection. Never events are "Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers".

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Requires Improvement

Medical care (Including older people's care)

There was a clear management structure with lines of responsibility and accountability. The board of trustees had overall responsibility for overseeing the hospital's business. They delegated day to day operations to the chief executive officer. They understood the priorities and issued faced as a specialist service.

Staff we spoke with were very positive about the leadership team and told us that managers were approachable and visible. Staff knew the different managers and their areas of responsibility. Staff said they felt supported and gave examples of when they had received support with personal circumstances.

During the inspection, we observed positive interactions between staff and managers. Staff told us they felt comfortable and able to raise any concerns they had with the management team. Staff told us they were encouraged and supported to develop their skills and take on senior roles. Two senior nursing staff told us how they were supported in developing from a newly qualified nurse to senior leaders at the hospital.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Staff supported the vision for the hospital to become a national centre of excellence for neuro-disability. Patients and their families were at the centre of developing the hospital's vision and strategy. The hospital prides itself on caring for patients as individuals, offering hope, practical and emotional support to them and their families.

The service values were to see the whole person, willingness to learn, delivery on promises, and honesty and integrity.

The service's mission was to provide outstanding care and empowering individuals with neuro-disability, enabling them to live their lives to their fullest potential in accordance with their wishes.

The service had a strategy 2022-2027 titled 'the path to excellence' which highlighted the priorities for the next five years which included patient experience, people/staff, marketing, finance and achieving an outstanding rating with CQC.

Each service line within the hospital had its own strategy for what is wanted to achieve over a five year period. For example, the ventilated service had a strategy in place to increase the capacity for ventilated residents from 24 to 28 beds by 2024, whilst simultaneously enhancing the service user and staff experience.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with felt respected, supported, and valued by their leaders. Staff reported a no bullying culture and felt able to raise any concerns or issues they may have. They told us that equality and diversity was well promoted and that all staff were treated equal. The service had a whistleblowing policy which was available to all staff and information on how to raise concerns was available within this document.

Patients and their families felt able to raise concerns through various means. We saw evidence of them doing this and how the service responded.

Requires Improvement

Medical care (Including older people's care)

When speaking with staff it was clear that their priority was focusing on the needs of the patients they cared for. Staff we spoke with had a strong commitment to their jobs and were proud of the team working within the hospital and the positive impact they had on patient care and experience.

The service's annual staff survey results from 2022 demonstrated staff would recommend the hospital as a good place to work, felt their role made a difference to patients, and would recommend the hospital as a good place to receive care.

Governance

Leaders did not always operate effective governance processes. Staff at all levels were not always clear about their roles and accountabilities. They had regular opportunities to meet, discuss and learn from the performance of the service.

There were structures, processes and systems of accountability in place to support the delivery of good quality and sustainable services, however these were not always effective. The service did not have effective governance systems and processes in place to action national patient safety alerts (NatPSAs).

Inspectors requested the service's action plan in response the NatPSA issued in June 2021 regarding the use of medical air, including the dates the actions were completed. The service provided CQC with actions taken in response to the previous NatPSA for the use of medical air which was issued in 2016. These actions were different from the directive given in 2021 and did not address the concerns highlighted in the 2021 alert.

Inspectors re-requested the action plan in response to the 2021 alert. The action plan provided showed that most actions that were required to be taken by the 21st November 2021 in response to the alert had not been taken until after the inspection, and that some actions were still in progress.

The service did not have clear lines of responsibility or accountability in place to process and action NatPSA's. The service did not have a standard operating procedure or policy in place to respond to NatPSA's. Since the inspection senior leaders have told us that the service has a plan in place to complete a standard operating procedure for actioning NatPSA's, but have not provided a date for which this will be completed.

We saw all other levels of governance and management function interacted with each other appropriately and effectively. The subgroups which included the patient safety and quality committee, audit and risk committee, finance committee, ethics committee, medical committee, research advisory committee, and patient representative committee fed their main points from each of their meetings into the board meeting. We reviewed minutes of the board meeting and saw that the highest risks and concerns were raised and discussed by the service.

Staff we spoke with had a good awareness of local governance arrangements and knew how to escalate their concerns. The service lines held monthly team meetings which were well attended. Minutes for the meeting were circulated to all staff so that those unable to attend were aware of discussions held. Agreed discussion points and issues of concern were escalated to the patient safety and quality committee, which is a Board Committee and reports directly to the Board.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care. However, they did not always identify and escalated relevant risks and issues, or identify actions to reduce their impact.

Requires Improvement

Medical care (Including older people's care)

The service had a risk register which was reviewed quarterly. Each risk was given a score, a set of control measures, and allocated with a risk owner to carry out any mitigations. However, leaders did not always identify and escalate relevant risks, or identify actions needed to be taken to reduce their impact. This included identifying risk highlighted by national patient safety alerts and ensuring that actions were identified and taken in response, to reduce the risk of severe harm or death to patients.

Arrangements for identifying, recording and managing risks, issues and mitigating actions had been devised. There was alignment between the recorded risks and what senior staff said was 'on their worry list'. We saw the risk register was up to date and each risk was reviewed, and a new score allocated that reflected the current risk.

Potential risks were considered when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The service had a business continuity plan to manage specific risks relating to service delivery.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff had electronic access to the information they required to do their jobs, including, incident forms, training, clinical guidelines, and policies. Agency staff also had access to information electronically. During inspection, we observed staff treated patient identifiable information in line with the General Data Protection Regulations (GDPR). The service had a policy in place to guide staff on GDPR requirements and its implications for practice.

Information governance training formed part of the mandatory training programme for the service, and staff we spoke with were able to discuss their responsibilities in relation to information management.

The service had appointed a Caldicott Guardian who understood the Caldicott principles. Caldicott principles are fundamental rules and regulations that guide a patient's confidentiality. They are the basic rules every healthcare personnel must follow to ensure there is no breach of confidentiality.

The service submitted notifications to external organisations such as CQC, and had a good reporting culture for notifying local authorities of safeguarding concerns.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service engaged with patients through patient surveys. The feedback from these surveys was reviewed and themes and trends identified to improve the future service the hospital provided. Feedback was positive and identified the care and support given to all patients using the hospital's services. People's views and experiences were gathered and acted on to shape and improve the services and culture. The service had several ways to engage with the public and service users, including social media feedback forums and a service user suggestion box in the reception.

Requires Improvement

Medical care (Including older people's care)

Staff were engaged in the planning and delivery of the service. Staff told us that they felt able to suggest new ideas to their managers and that they were listened to. There were weekly meetings with staff where they could bring up any concerns or ideas for improvements, including the use of Putney Boards, to flag any ideas they had. There was regular engagement and discussions with the external stakeholders and organisations to ensure patients had a seamless care pathway and good quality care.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff were committed to continuous learning and improvement. Staff told us they were supported by their managers to develop their skills and access development opportunities. Staff told us that no course was 'off limits' if it helped improve their knowledge and skills.

There were clear processes for continual learning and how this was used to improve services. Information was collated and reviewed at every level of the service to ensure that learning was cascaded.

Quality assurance and improvement methodologies were apparent with audits and reviews used to measure quality. There were comprehensive approaches to the management of incidents and complaints with subject specialists undertaking reviews of how these were managed to ensure actions and improvements were appropriate.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure the proper and safe management of medicines. This included having an out of date medicines management policy in place, having expired medications available for use, the unsafe use of medical gases, and the unsafe dispensing and administration of medications.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not always assess, monitor or mitigate risks relating to the health, safety and welfare of service users. They did not always have oversight of the quality and safety of care being delivered. They did not effectively manage National Patient Safety Alerts.