

Imperial College Healthcare NHS Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Acute services

Facts and data about this service

Imperial College Healthcare NHS Trust provides acute and specialist health care in north west London for around a million and a half people every year. Formed in 2007, it is one of the largest NHS providers, with over 11,000 staff.

There are five hospitals: Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye. The trust runs the sector's major trauma centre, hyper acute stroke unit and heart attack centre. It also has a growing range of community and primary care-based services, and offers private healthcare in dedicated facilities at all sites.

With their partners, Imperial College, The Royal Marsden NHS Foundation Trust and Royal Brompton & Harefield NHS Foundation Trust, it forms Imperial College Academic Health Science Centre, one of 11 academic health science centres in the UK. With Imperial College, the trust also hosts one of 20 National Institute for Health Research biomedical research centres, and leads one of NHS England's 13 genomic medicine centres.

In 2017, the trust was recognised as a leader in the adoption of digital technologies to improve patient care by being selected by NHS England as one of 16 global exemplars of acute care in partnership with Chelsea and Westminster Hospital NHS Foundation Trust.

The trust's chief executive was appointed in December 2017, and they have recently added three new roles, director of transformation, director of operational performance and director of corporate governance.

A list of the acute hospitals at Imperial College Healthcare NHS Trust is below.

Name of acute hospital site	Address
Charing Cross Hospital	Fulham Palace Road, London, W6 8RF
Hammersmith Hospital	Du Cane Road, London, W12 0HS
Queen Charlotte's and Chelsea Hospital	Du Cane Road, London, W12 0HS
St Mary's Hospital	Praed Street, London, W2 1NY
Western Eye Hospital	Marylebone Road, London, NW1 6QH

(Source: Trust website / Routine Provider Information Request (RPIR) – AC1. Context acute tab)

Well led

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

The trust board had the appropriate range of skills, knowledge and experience to perform its role. The trust board of directors comprised seven non-executive directors, including the chairperson and four executives: chief executive, medical director, director of nursing and chief financial officer. The trust board members were a group of individuals with a wide range of experience, knowledge and skills:

- Paula Vennells CBE Chair (start date 1 April 2019)
- Sir Gerald Archer, Non-Executive director (start date 1 April 2012)
- Professor Andrew Bush, Non-Executive director (start date 1 September 2016)
- Peter Goldsbrough, Non-Executive director (start date 1 September 2016)
- Dr Andreas Raffel, Non-Executive director (start date 1 July 2013)
- Victoria Russell, Non-Executive director (start date 1 July 2017)
- Sarika Patel, Non-Executive director (start date 1 January 2013)
- Professor Tim Orchard, Chief Executive (start date 7 June 2018)
- Professor Julian Redhead, Medical Director (start date 1 February 2016)
- Richard Alexander, Chief Financial Officer (start date 3 August 2015)
- Professor Janice Sigsworth, Director of Nursing (start date 20 October 2008)

There have been several changes in senior leadership since the last inspection. Following his appointment as CEO at NHS Improvement, Ian Dalton was replaced by Professor Julian Redhead, acting as the interim chief executive officer, from 4 December 2018. Professor Tim Orchard was appointed as chief executive officer from 7 June 2018. Professor Orchard was formerly the trust's interim medical director and divisional director of medicine and integrated care.

Former chair Sir Richard Sykes (start date 1 January 2012) stepped down in December 2019, after completing a seven-year tenure at the trust. Sir Gerald Acher for took on the role of interim chairman from January 2019, helping to ensure a smooth transition between leadership arrangements.

Paula Vennells CBE joins the trust from the Post Office, where she is group chief executive. She took up her position on 1 April 2019. Ms Vennells is an experienced leader in business. She is a non-executive director at the Cabinet Office and sits on the board of Morrisons PLC. Prior to the Post Office, she held senior positions at Whitbread and Argos, beginning her career with Unilever and L’Oreal. In our interview with Ms Vennells she demonstrated a comprehensive knowledge of the trust’s vision and strategic objectives along with current priorities and challenges despite only recently joining the trust.

The board had overall responsibility for monitoring performance, finance and maximising the efficiency of the trust’s services.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience. The executive team sat directly below the trust board in the organisational structure and comprised seven roles: director of communications, chief information officer, director of people and organisational development, director of transformation, divisional director of medicine and integrated care, divisional director of surgery, cardiovascular and cancer and divisional director of women’s children’s and clinical support.

Services were organised into three clinical divisions, each with its own clinical divisional director who reported directly to the chief executive: medicine and integrated care; surgery, cardiovascular and cancer; and women’s children’s and clinical support. Each divisional director was supported by a divisional director of operations, divisional director of nursing, finance business partner and HR business partner.

The trust reviewed leadership capacity and capability on an ongoing basis. The divisional structure across the trust provides specialty, directorate and divisional management and leadership bringing these together across the trust’s hospital sites. The trust recognised that on-site leadership and cross divisional ownership for the daily issues faced on our sites can sometimes be more difficult. In response to feedback both internally and externally new posts are being set up to strengthen the trust’s approach to site and trust wide leadership and management. These include:

- Director of transformation (appointed in November 2018) to respond to the need for better co-ordination and strategic leadership of change within the trust in order to achieve the improvements that will have most benefit for patients, local community and staff.
- Director of operational performance (appointed in November 2016). The role is responsible for co-ordinating trust-wide efforts to make sure that care pathways work as effectively and smoothly as possible for patients and staff, ensuring that key operational and performance targets are met consistently.
- Three new associate medical director posts are proposed, (one for each of the large acute hospital sites) who will be responsible for providing clinical leadership for their site. This will involve providing expert clinical judgement in a number of areas, particularly when there are risks and a trust level decision is required to be made.

The trust is committed to developing leaders across the organisation and has leadership development activity in place to support leaders at all levels. These include five core programmes for each level of manager or leader: ‘Foundations’, ‘Springboard’, ‘Headstart’, ‘Aspire’ and ‘Horizons’ as well as a programme run in conjunction with AHSC partners at Imperial College Business School for the trust’s most senior strategic leaders. Over 150 leaders participate in these programmes each year, focusing on leadership behaviours, culture and engagement. The trust has a ‘Coaching and Mentoring’ register and a leadership alumni masterclass series as part of on-going development. The trust provides a range of management skills training to support new and emerging leaders.

The trust launched a new Leadership programme for our very senior leaders run by Imperial College Business School, and in 2019 will be launching “Frontier” a new programme for newly appointed consultants.

The trust uses a talent management system to identify and develop senior leaders and create succession plans for all Divisional and Executive roles. This uses both ratings of performance and potential to identify successors to senior Divisional and Executive roles, both as emergency cover and future substantive roles.

To support continued improvement in leadership, which was highlighted as an area for improvement in the first year of the trust’s internal annual ward accreditation programme (WAP) was, a bespoke Band 5 and 6 nursing and midwifery leadership programme has been launched.

The trust conducts an equality analysis of all succession plan nominees to ensure that the diversity of succession plans is appropriate. To promote equality and diversity of staff who want to progress, the trust ensures that all recruitment managers are trained in best practice and is currently reviewing the internal promotion processes. The trust has introduced career clinics for nurses and ensure that all BME delegates on leadership programme are offered support from a coach or mentor.

During 2017/2018 the trust launched their recruitment and retention plan for nursing and midwifery staff (bands 2-6). A number of initiatives were introduced including:

- Creating a new brand for recruitment;
- Launching career clinics;
- Automatic offers for students;
- Extending the Preceptorship to one-year;
- Introducing a new leavers survey;
- Implementing a new leadership programme for band 5/6 nurses;
- Creating a retention toolkit.

The trust told us 150 staff overall have participated in a leadership development programme in 2018/19. These were all local programmes but does not include staff who have attended an external or national NHS programme as central records are not kept for these.

The chief pharmacist was supported by a senior leadership team. Pharmacy was well integrated into the governance structure of the trust, having reviewed the composition and reporting lines of medicines related committees in the previous year. The pharmacy team demonstrated a commitment to involvement in research, and we saw that learning from this was published in peer reviewed journals.

The trust board and senior leadership team displayed integrity on an ongoing basis. There was evidence from our conversations with senior people, including the non-executive directors, of constructive challenge among the leadership team; we also observed this at a board meeting on 27 March 2019. Directors and senior staff we spoke with all confirmed the board members were open and challenged each other professionally and openly.

There was a programme of board visits to services and staff fed back that leaders were approachable. Staff we spoke with on the core service inspections told us local leaders were visible and approachable. While staff did not expect to see the executive team regularly, we noted that staff told us the new chief executive was visible and approachable. The director of nursing participated in a ‘back to the floor’ day each week to ensure she had an oversight of frontline issues.

Fit and Proper Person checks were in place. The trust had a current fit and proper persons policy to comply with the Fit and Proper Persons Requirement (FPPR) (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 5). There was a defined process for undertaking FPPR checks that is applicable to both Executive and Non-Executive Directors; however, we found the process was well applied to the NED's but not to the Eds. There were separate named persons/roles responsible for ensuring all checks are completed; The executive assistant to the Chair is responsible for NEDs FPPR checks/monitoring records and the executive assistant to the chief executive is responsible for executive members.

We looked at the files of seven non-executive board members. The files were well organised and easy to navigate. All files contained a comprehensive FPPR checklist based on Regulation 5. the most recent checks were undertaken in March 2019

We looked at the files of four executive board members. There was an index sheet at the front of the file, but none contained the FPPR checklist. None of the files contained any evidence of regular checks; for example: none of the files contained evidence of up to date professional registration such as GMC, NMC; three of the four files checked did not have current DBS checks (all were outside 3 years), there was an email on file from occupational health, however this did not provide evidence of fitness, and there was no evidence that annual self-declaration forms had been completed. We raised this with the trust at the time and were told: professional registration is checked on a monthly basis. The HR teams download professional registration status from ESR and sends reports monthly to divisions about forthcoming expiry dates. Expiry dates are checked and staff are suspended if their registration has expired as per policy. This tracking and reporting is not stored on individual exec files as it is a 'business as usual' activity. DBS checks are updated at time of appointment or change in role. The trust does not refresh DBS checks.

Of the executive board members at the trust, none were Black and Minority Ethnic (BME) and 25.0% were female. Of the non-executive board members 14.3% were BME and 28.6% were female.

The leadership at board level had a good understanding of the financial position of the trust. A consistent position was described by both executive and non-executive directors.

While the trust has a number of risks and challenges to its financial position, all the key board members of the trust were able to articulate the excellent progress made over the past 12 to 18 months, which included stabilising and improving the financial position from a deficit position to a surplus including incentive payments, improving grip and control particularly around agency spend, and articulating credible plans for future improvement.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust's vision of 'better health, for life,' and is supported by a strategy is based on three overarching strategic goals:

1. To help create a high-quality integrated care system with the population of north west London
2. To develop a sustainable portfolio of outstanding services
3. To build learning, improvement and innovation into everything we do

The trust strategy is underpinned by the values: to be kind, collaborative, expert and aspirational. Alongside the strategy and annual plan, the trust developed a new 'behaviours framework' which sets out clear examples of behaviours that show when staff are, or are not, living the values. This followed feedback that whilst 95% staff were aware of the values and behaviours, not all felt they were able to embrace them in their daily work. Co-designed with staff, the new framework is designed to strengthen the link between the trust vision and values. The trust published an infographic poster to share this information with staff, patients, partners and public.

The trust has a set of core strategies, which were developed in 2016. The trust's organisational strategy brings together a summary of the core trust strategies. These include the clinical strategy, quality strategy, redevelopment and estates strategy, finance plans, people and organisational development strategy, digital strategy and education strategy. Each of these strategies are supported by implementation plans that are monitored through the executive committees and board or board committees as appropriate.

The development of each strategy was informed by engagement with patients, public and key stakeholders, including the needs of the local community and those of the wider NW London sector. The clinical strategy was developed through a large-scale engagement process. The quality strategy was designed using best practice principles from national reports and inquiries, coupled with local learning from surveys, data analysis, adverse events and feedback from key stakeholders.

The trust launched a programme of work in January 2019 to refresh their core strategies, strategic aims and to agree corporate objectives for 2019/20. This programme of work is supported by an engagement plan. The strategy refresh programme includes core strategies: Organisational, Clinical, Improving quality, People and organisational development, Estates, Research and education strategies.

The trust's 'Improving Quality Strategy' is being drafted and will set out the trust ambitions for quality over the next five years with the aim to be rated as outstanding. The trust told us the strategy will align to the CQC domains as well as to the National Quality Board's Shared Commitment to Quality as part of the Five Year Forward View. It has been developed following an extensive listening campaign with over 1,000 members of staff, patients and members of the public. The draft was shared with the executives in December 2018 for review with their teams with a view to it being finalised for launch in April 2019.

The Hospital Pharmacy Transformation Plan (HPTP) is in place and the next iteration was being reviewed. There was a workforce strategy in place and structured training opportunities were in place for pharmacy staff to develop their knowledge and skills.

The trust has undertaken a comprehensive and consistent approach to quality improvement through the Speciality Review Programme (SRP). This programme has brought together costing data, Patient Level Information and Costing System (PLICS) data, income expertise, 'Get It Right First Time' (GIRFT) reviews and Model Hospital data to work with each specialty to create plans to optimise performance. This has meant that there has been a systematic approach to Cost Improvement Programmes (CIPs), job planning, electronic rostering and a number of other operational areas. In turn, this approach resulted in improvements in operational performance, efficiency and underlying financial performance.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff we spoke with during our core service inspections and in focus groups held before the inspection reported feeling supported respected and valued.

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.



(Source: NHS Staff Survey 2018)

The specific areas which showed positive results across both national and local surveys were:

- National: KF2: Staff satisfaction with the quality of work and care they can deliver (also high scoring in 2016).
- National: KF12/13: Quality of appraisals/Quality of non-mandatory training, learning or development
- Local: Staff clear about the values and behaviours expect of them at work (95%)
- Local: Staff clear about their own objectives (93%)

The areas of concern that were highlighted in the national staff survey included:

- Staff experiencing discrimination
- Staff experiencing bullying and harassment
- Staff working extra hours
- Staff witnessing potentially harmful errors, near misses or incidents. However, a new question in the local survey showed that 92% of staff felt they knew the processes to report any concerns they had on errors or incidents.

From the quantitative results, the question areas which gave cause for concern trust-wide in the local survey were:

- Senior leadership communication and visibility
- Poor behaviour is addressed effectively in this organisation
- Enough time to complete work
- Ability to influence/feel empowered to make change happen at work as well as having views and ideas encouraged
- Receiving praise when people do a good job as well as regular feedback on team performance
- Celebrating successes and small wins
- Health and wellbeing suffering because of work
- Sufficient opportunities for career progression

Over 150 wards and departments have access to results at ward level which enabled local action plans for the factors that were of concern locally.

There was a range of workstreams underway to address concerns raised both at corporate level and local level.

The trust provided the following breakdowns of four staff groups by ethnic group.

Ethnic group	Medical and dental staff (%)	Qualified nursing and health visiting staff (%)	Qualified nursing midwifery staff (%)	Qualified allied health professionals (%)
White	43%	39%	57%	67%
BME - British	18%	44%	29%	23%
BME – Non-British	10%	14%	9%	7%
Unknown / Not stated	29%	4%	5%	3%

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

(Comparing to London population using 2011 Census, 40% of the London population is of BME backgrounds and 60% is white.)

The annual equality and diversity report and workforce race equality standard were both ratified by the board and published in September 2018. This annual report focuses on workforce and will provide the Trust with valuable insights into our workforce equality performance and identifies priority areas for improvement. In addition, this report has incorporated information required by the Workforce Race Equality Standard (WRES) which is mandated in the NHS standard contract.

An action plan is in place to deliver improvement. For the coming year the trust will continue focusing on the following priority areas from last year that remain as some of the key challenges in this year's reports:

- Improve workforce representation of BME people and female staff on Band 7 and above
- Improve disproportionate representation of BME people receiving D or E rating (PDR)
- Mitigate disproportionate representation of BME people entering formal workforce procedures
- Address the concerns about harassment and bullying reflected in the 2017-18 NHS staff survey
- Develop broad Equality and Diversity objectives for 2018/19

An Equality and Diversity Steering Committee was established in 2018.

The trust provided information about their approach to and grading against each of the 18 outcomes of EDS2 quality system.

The Equality Delivery System (EDS) for the NHS was made available to the NHS in June 2011 and formally launched in November 2011. Following an evaluation of the implementation of the EDS in 2012, and subsequent consultation with a spread of NHS organisations, a refreshed EDS is now available, known as EDS2.

The main purpose of the EDS is to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010.

The EDS2 framework outlines 9 steps for implementation. NHS Trusts are advised to assess and grade their performance each year across all of the EDS2 outcomes; however it notes NHS Trusts should make EDS2 work for them and 'adapt its processes and content to suit their local needs and circumstances'.

An updated version of the EDS toolkit, EDS2, was launched in 2014. At the heart of the EDS are four goals:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and included staff
4. Inclusive leadership at all levels

At the trust, goals 3 and 4 are monitored and assessed by the workforce directorate and goals 1 and 2 by the patient experience function in the nursing directorate. The trust has held grading events in the past, inviting an extensive audience including external stakeholders. Engagement to date has been poor. The current EDS2 outcomes that the trust has been working on are due to be reviewed. An internal review of these outcomes has been undertaken.

Since 2014/15 the trust has assessed six outcomes. Each patient experience outcome (goals 1 and 2) was graded as 'achieving' based on eight protected groups faring well. In all outcomes it

was felt that patients with disabilities, notably learning disabilities (LD), fared less well; therefore in 2016/17 it was agreed that the trust should focus on patients with learning disabilities.

The workforce related outcomes were graded as achieving and developing.

In 2016/17 the trust assessed five outcomes; these and their associated grading are shown appendix 3. The patient experience outcome (goals 1 and 2) focused on patients with learning disabilities. The workforce outcome (goal 3) focused on flexible working options.

Since our last inspection the trust has supported staff to form a BME network and a women's network as well as the Lesbian, Gay, Bi-sexual and Trans (LGBT) staff network.

Progress is being made on raising awareness on equality and diversity agenda which is supported by various local initiatives, such as E&D drop-in sessions for staff, flying a Pride flag cross three sites to support participation in London Pride and women's network.

During the inspection we met with members of the trust's Women's Network. The network was established 12 months ago and has 150 members on its 'mailing list'. Members we spoke with described a positive and supportive relationship with executive leaders. The network has held several events since its inception; these included a consultation event, a leadership event and a return to work event (how staff returning from maternity leave or long-term sickness could be supported).

We also met with members of the trust's Black, Asian and Minority Ethnicity (BAME) network which was set up nine months ago. The network is still in development; members told us it was taking time to ensure it is meaningful and provides what staff want/need. Members expressed challenges in accessing senior positions and believe there is significant under-representation of BAME staff in senior positions (less than 1%). Members were enthusiastic to develop a meaningful network/group. Members told us There is a reverse mentoring scheme Schwartz round for BAME staff. The BAME group is chaired by the Director of Nursing; staff present felt this provided a good opportunity and exposure to senior staff. The chief executive has also attended one of the meetings.

The chief executive discusses BME data in monthly open-door sessions, his podcast ('Tim's take away'), his blog and has attended BME network events.

Staff Side representatives we spoke with told us they had a positive relationship with senior managers and have six weekly meetings with the HR Director. They described how they represented staff in the running of the trust; for example, staff side sat on the interview panel for the post of Trust Chair and newly appointed directors meet with them as part of their trust induction.

The trust's multi-faith chaplaincy team comprises 6.1 whole time equivalent (WTE) substantive staff from the Anglican, Muslim, Roman Catholic and Jewish faiths who work across all trust sites.

Christian chapels, Muslim prayer rooms and multi-faith rooms are provided on each of the three main trust sites (St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital). Christian services and Muslim Friday Prayers are held weekly. Major religious festivals from the Christian, Muslim and Jewish faiths are observed or promoted throughout the year. Trained and experienced volunteers help to facilitate services and visit patients.

Chaplaincy staff participate in weekly palliative care and ICU multi-disciplinary teams across all sites. A 24:7 on-call facility is available across the trust for emergency and end of life situations.

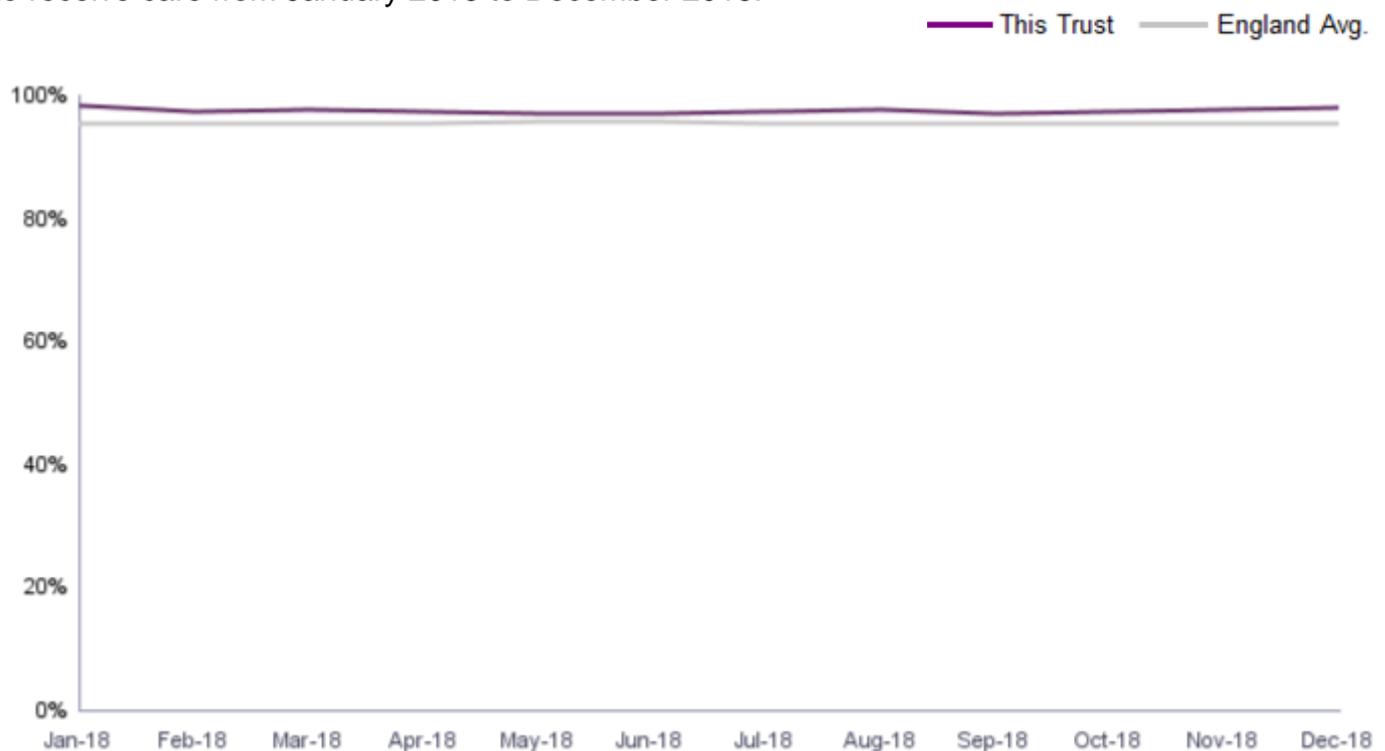
The Gender Recognition Policy (2017) highlights that people should be nursed in an environment according to their gender identity and presentation indicating they are living permanently as that

gender. The trust offers patients the choice of a cubicle (when available) or people are nursed as above in accordance with their gender identity and presentation.

The trust's 'Learning Disability and Autism Policy and Procedure', advocates that reasonable adjustments are considered for each person this applies to. As part of this, people may be nursed in a side room if, after assessing all of their clinical and safety needs, this is considered to be the safest environment for them. The trust has a 'Carer's charter' and use carer's passports to promote the role of the carer, giving them access to visit out of hours and to stay.

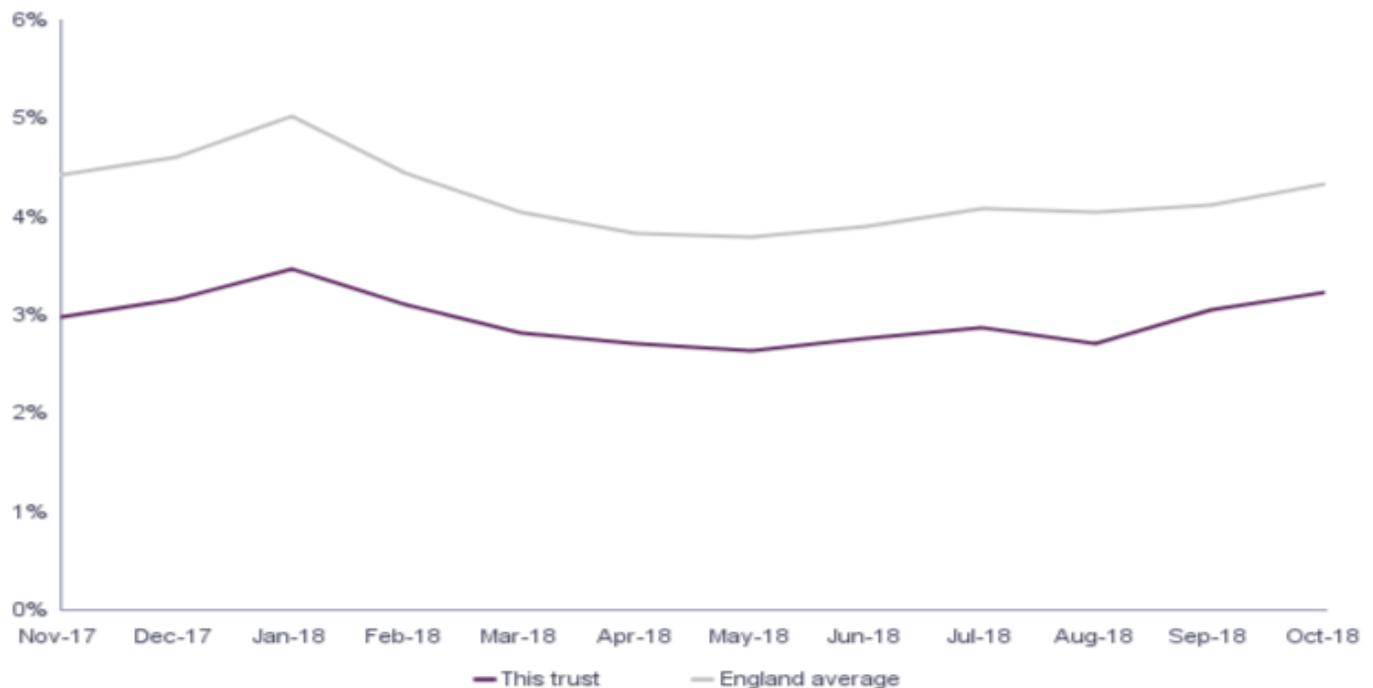
The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored consistently above the England average for recommending the trust as a place to receive care from January 2018 to December 2018.



(Source: Friends and Family Test)

The trust's sickness absence levels from November 2017 to October 2018 followed a similar trend but was consistently below the England average.



(Source: NHS Digital)

In the 2018 General Medical Council Survey the trust performed the same as expected for all 13 indicators.

(Source: General Medical Council National Training Scheme Survey 2018)

The results of GMC National training survey, published in July 2018, showed deterioration when compared to the previous year, with an increase in red flags and a decrease in green flags. In response, the trust developed a number of actions to support improvement:

- A task and finish group is in place to work on improving junior doctor facilities, engagement and well-being.
- A faculty development programme is in place, with new content developed in line with HEE priorities.
- A transparency exercise aimed at indicating the proportion of total education income notionally allocated to each specialty has concluded and is being taken forward by the divisions.
- Revised education governance was implemented, with five specialties identified as requiring additional support and assurance meetings with the medical director. Two out of five of these reviews have taken place, with actions agreed which include the requirement for a comprehensive workforce review in Haematology and confirmation of actions relating to expanded consultant staffing and enhanced supervision in Clinical Radiology. Progress against these agreed actions is being monitored via divisional committees. Assurance meetings for Cardiology, Oncology and Vascular Surgery will be completed by the end of 2018.
- The revised governance process also includes a regular focus on medical education at divisional committees, with the discussion of a scorecard for key education metrics and relevant division specific education risks.

- An improvement programme is in progress to refine all elements of on-boarding. This includes completion of statutory and mandatory training, Cerner training and provision of information prior to arrival.
- The Trust has a guardian of safe working in post. Plans to report rota gaps to the board, as per the new requirements set out by the secretary of state, are in progress.

Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak up Guardian (FTSUG). The trust appointed two Freedom to Speak up Guardians in 2016 and increased the number to five in July 2017, across a variety of departments, with representation on each of the main sites. The trust provided them with sufficient resources and support to help staff to raise concerns including mobile phones and a dedicated number and email address. All FTSU guardians were appointed following informal recruitment processes, overseen by a Non-Executive Director. They come from a broad range of backgrounds in profession, personal characteristics, banding and location and so are representative of the workforce.

The FTSUGs are promoted through the intranet and staff are encouraged to make contact in the event they have concerns. The primary aim of the FTSU guardians is to support staff to raise concerns, facilitate escalation and increase the profile of the raising concerns process and feedback from the trust is that this does appear to be making a difference.

The NHSI/National guardians office self-assessment tool has been completed. A freedom to speak up strategy is being developed and will be rolled out next year.

The whistleblowing policy outlines the steps available to people in order to make a qualifying disclosure by raising with: immediate management, executive director, Employee Relations team (ERAS), Freedom to Speak Up (FTSU) Guardian.

The ERAS team collate details of whistleblowing cases and report twice annually on these cases to the Audit Risk and Governance Committee.

There were eight whistleblowing incidents between 1 August 2017 - 31 March 2018. In the previous year (April 2016 - March 2017) there were 10 whistleblowing cases and during the year April 2015-March 2016, 18 cases were reported.

Of the eight cases raised, seven were raised anonymously making it difficult to draw themes from the cases raised as most cases were about specific instances rather than being recurrent themes.

Concerns were raised in February 2017 about compliance with the duty of candour (DoC) for SIs. A full review of processes across the trust was completed and compliance is now monitored through the weekly medical director's incident review panel. The duty of candour policy was refreshed in 2018, and a mandatory online training module for consultants and appropriate nurses was implemented.

The Associate Medical Director for Safety is the trust lead for duty of candour (DoC), reporting to the Medical Director who is the executive lead. The trust's duty of candour policy was implemented in 2016 and subsequently reviewed and published in 2016 and 2018.

The trust policy states that the DoC must be applied to all incidents causing moderate and above harm and to all incidents when a serious incident or internal (level 1 incident) is declared irrespective of harm. The patient must be informed verbally as soon as possible, but within 10 working days, of the incident being reported on the trust's electronic reporting system. This should be followed up by a letter. Both should include an apology and a clear explanation. The process must be completed by the consultant responsible for the care of patient (the exception is for

pressure ulcers where ward manager/senior nurse can undertake it). If the incident is subject to an SI investigation, the medical director also writes to the patient/family to explain and to ask if they would like to receive a copy of the investigation. The SI panel only proceeds if complete evidence of DoC compliance is included. All stages of DoC are recorded on the trust's electronic reporting system, full compliance is achieved when documented evidence of the conversation and copies of the correspondence sent by the trust are uploaded onto the trust's electronic reporting system.

Completion of duty of candour for SIs has been monitored weekly through the medical director's incident review panel since April 2017. This commenced in July 2017 for incidents graded moderate and above.

The trust applied duty of candour 270 times between 1 Nov 2017 and 31 October 2018.

The percentage of incidents reported between October 2017 – September 2018 that have had stage 1 and stage 2 of the duty of candour process completed is 91% for SIs, 90% for internal investigations and 97% for moderate and above incidents. This is reported in the trust's integrated quality and performance report to the executive committee, board quality committee and to the trust Board. The report is also shared with commissioners through the trust's Clinical Quality Group. Duty of candour is included as part of the trust's annual audit cycle; the outcome of the 2018 audit has informed the changes made to the policy during 2018.

To support implementation of the original policy, training was provided to all staffing groups by the trust's legal team. An on-line e-learning module was launched in June 2017 and has been mandated for all consultants, who are required to complete the training. The same training module is recommended for band 7 nursing staff and above (who might be responsible for DoC for pressure ulcer cases), this is being rolled out.

All staff had the opportunity to discuss their learning and career development needs at appraisal. Between 1 April 2017 and 31 March 2018 appraisal/PDR was completed for 6947 of 7930 staff eligible (87%).

Managers addressed poor staff performance where needed. Between 1 April 2017 – 31 March 2018, 13 staff were suspended and three staff were supervised.

There was a clear focus from the executive team, which was shared by finance staff, that the delivery of CIPs sits firmly within the divisions and the operational staff, with appropriate support and challenge from the key functions of finance and HR.

Interviewees noted the process by which financial, operational and clinical staff have worked together to ensure the financial constraints the trust operates in are well understood. The finance teams ran workshops on workforce, quality and financial sustainability as part of the business planning rounds over the past two years. In addition, the trust board focused on improvements delivered through clinicians; this was through focused and consistent messages from the GIRFT programme. While the cost of this approach was time, the board stresses that this is more sustainable in the longer term.

Governance

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior

managers. Leaders regularly reviewed these structures. The trust board had five board committees providing oversight:

- Quality committee
- Finance and investment committee
- Audit, risk and governance committee
- Remuneration and appointments committee and the
- Re-development committee

Below the board committees are several executive committees (ExCo) which meet on a weekly basis. These committees have been themed to ensure that the executive team has oversight of the trust objectives across the all domains and that work and performance is triangulated. The committees are:

- Executive quality committee
- Executive people and organisational development committee
- Executive digital, strategy and transformation committee
- Executive finance committee
- Executive operational performance committee

There is one action log in place for all ExCo meetings to ensure that actions are tracked and not missed when items are discussed at more than one committee.

Sub-groups to a number of the executive committees meet monthly to ensure that there is sufficient time and detailed work being undertaken to deliver improvements.

The governance arrangements for clinical quality and safety in the organisation are led by the medical director who has executive responsibility. Trust progress with quality priorities is reported through this framework, to enable monitoring from ward to board. Mechanisms for ensuring this include the directorate and divisional scorecards and the 'harm free care report' which monitors specific safety indicators at ward level. Exception reporting from directorate teams to divisional committees is in place which contributes towards the trust's integrated quality and performance report (IQPR) which is presented to the executive committee, CCG clinical quality group and trust board.

There is a trust-wide framework to support regulatory compliance. Key components of the framework include statutory notifications, responding to concerns and complaints raised about the trust with the CQC and a ward accreditation programme (nursing peer review programme) which has been in place for 3 years.

The trust has recently established an improving care programme group chaired by the Director of Nursing which focuses on driving improvement in core services and in key trust-wide work streams such as; hand hygiene, medicines management, statutory and mandatory training and medical devices. The trust-wide assurance framework is being refreshed to align with the improving quality strategy which is currently in development.

The trust board met six times between 1 April 2017 and 31 March 2018. We attended a board meeting on 27 March 2019 as part of our routine trust monitoring and engagement. Papers for board meetings and other committees were of a reasonable standard and contained appropriate information. Non-executive and executive directors were clear about their areas of responsibility.

We reviewed the trust's Board Assurance Framework (BAF) which was revised in November 2018 (v4.1 - ARG December 2018), and which detailed 25 risks and gaps in the risk controls which could impact upon the five strategic corporate objectives (summarised below) and accompanying risks within each.

1. To achieve excellent patient experience and outcomes, delivered efficiently and with compassion
2. To educate and engage skilled and diverse people committed to continual learning and improvement
3. As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care
4. To pioneer integrated models of care with our partners to improve the health of the communities we serve
5. To realise the organisation's potential through excellent leadership, efficient use of resources and effective governance

(Source: Trust Board Assurance Framework – P106b - November 2018)

There has been up front investment in senior operational, Finance and Human Resources (HR) resource, and in a Quality Improvement (QI) methodology to support team working and change to enhance staff training, pathway and engagement. Accordingly, while functions such as Finance benchmark as being more costly than national median, the trust can evidence the outcomes from this investment."

The trust increased investment in these functions as they sought to improve support to clinical and operational teams to design and implement the SRP. Given the reduction in the underlying deficit and the operational outcomes noted above, the level of investment appears to be reasonable.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements.

There were 137 Serious Incidents (SI) reported between and 1 November 2017 and 31 October 2018.

- 1 Adverse media coverage or public concern about the organisation or the wider NHS
- 1 Apparent/actual/suspected self-inflicted harm meeting SI criteria
- 2 Confidential Information Leak/Information Governance Breach meeting SI Criteria
- 19 Diagnostic incident including delay meeting SI criteria (including failure to act on test results)
- 1 Environmental incident meeting SI criteria
- 8 HCA/infection control incident meeting SI criteria
- 7 Maternity/Obstetric incident meeting SI criteria: baby only (this includes foetus, neonate and infant)

- 3 Maternity/Obstetric incident meeting SI criteria: mother and baby (this includes foetus, neonate and infant)
- 2 Maternity/Obstetric incident meeting SI criteria: mother only
- 6 Medication incident meeting SI criteria
- 1 Operation/treatment given without valid consent
- 2 Pending review (a category must be selected before incident is closed)
- 1 Pressure ulcer meeting SI criteria
- 1 Radiation incident (including exposure when scanning) meeting SI criteria
- 1 Retained foreign object post-procedure
- 11 Slips/trips/falls meeting SI criteria
- 20 Sub-optimal care of a deteriorating patient meeting SI criteria
- 7 Surgical/invasive procedure incident meeting SI criteria
- 16 Treatment delay meeting SI criteria
- 26 Treatment delay meeting SI criteria (Availability of Mental Health beds)
- 1 Wrong Site Surgery

All patient safety incidents which are reported on the trust's electronic reporting system are reviewed and investigated locally, with actions developed in response. Incidents are reviewed locally at risk meetings during and after the investigation process to ensure any learning is embedded. Themes from incidents are reviewed at the directorate quality and safety committees and fed through into the divisional quality and safety committees. The minutes of these meetings are reviewed at the trust quality and safety sub-group, chaired by the medical director to allow trust-wide themes to be identified, monitored and included in safety improvement priorities as appropriate. Trust-wide issues are monitored every month at executive level through the incident monitoring report which includes actions to support improvement.

All patient safety incidents graded moderate and above are reviewed weekly by the divisional management teams and then at the weekly panel chaired by the medical director. This allows timely declaration of SIs as well as executive oversight of emerging safety risks and their mitigations.

Processes were in place to record and learn from medicines incidents. In some areas of the trust, medicines reconciliation was reported as being lower than the national target. As a result, a plan had been formulated to improve data collection for this, to ensure that an appropriate strategy could be put in place to make improvements.

Nine key safety improvement work streams were identified and approved by the board as safety priority areas for 2018/19 to address the most frequently occurring clinical risks reported by staff:

- Abnormal results
- Optimising hand hygiene
- Recognising and Responding to the Very Sick Patient
- Safer Surgery

- Foetal Monitoring
- Safer Medicines
- Positive Patient Confirmation
- Reducing Falls with Harm
- Treatment delays to mental health patients in the Emergency Department

Each safety stream is underpinned by a service improvement methodology and is chaired by a senior leader in the trust. Common themes across all safety streams include reviewing and refreshing trust policies, undertaking audit and developing a robust communications strategy in support of improvement work. Progress is reported quarterly to the trust's quality and safety sub-group and includes:

- A reduction in incidents and complaints relating to CTG misinterpretation through investment in a new monitoring systems and training
- An improvement in hand hygiene compliance in focus wards
- A reduction in falls with harm declared as a serious incident
- A programme of simulation & human factors training to improve safety culture in theatres and improvement in Trust wide observational audit compliance with WHO safer surgery checklist
- Planned roll-out of NEWS2

Additional themes were identified by the divisions through local reviews of incidents. These include the following, which have been taken forward as trust-wide pieces of work. Progress is reviewed regularly through the quality and safety sub-group:

- Delayed blood components in a major haemorrhage – diagnostic undertaken by improvement team to determine reasons for the delays. Major haemorrhage protocol due for approval at quality and safety sub-group in January in response.
- Wrong blood in tubes - action plan delivered leading to a 50% reduction in these types of incidents.
- Anti-coagulation issues including duplication - action plan in development through Thrombosis and Anticoagulation committee.
- Delays for patients in theatre recovery at St Mary's Hospital. A standard operational procedure (SOP) was developed and agreed including daily metrics to monitor implemented and all incidents (regardless of grade) reviewed at incident panel. Success was evidenced by the reduced number of patient delays.

An SI was declared in May 2016 following the death of a baby at St Mary's Hospital. An internal review and an external review by the Royal College of Obstetricians and Gynaecologists undertaken in March and April 2017. A number of the recommendations from these reviews informed the trust's SI improvement programme to improve the investigation and learning from SIs.

The trust improved their process to better align them to the national framework and made the process more responsive to patients and supportive of staff. This included:

A new 72-hour template and SI report template designed with staff was introduced in November 2017. A composite investigation toolkit is also in development.

- Education and training programme for SI investigators and those responsible for quality assuring reports was introduced in December 2017. Over 140 members of staff are trained.
- SI operational tracker which supports divisional oversight and management of the key milestones was implemented in December 2017. KPIs are being monitored to ensure timeliness in completing high quality investigations.
- NHSI's 'Just Culture' guide has been appended to the latest version of the trust's SI policy and is being actively used to guide decision making in the weekly medical director's incident review panel.
- Incident monitoring reports were redesigned to include KPIs, level 1 incidents as well as SIs, and statistical analysis and mapping of data to allow for identification of trends.

In May 2017, the trust launched an incident reporting improvement work-stream to plan, develop and oversee improvements to reporting and management processes. Plans were developed using feedback from engagement events where staff expressed the need to make reporting as simple and efficient as possible and shared their fears of the consequences of reporting incidents. In response the trust has:

- Simplified the trust's electronic reporting system reporting fields to minimise time taken to complete.
- Launched range of communication tools to widen learning for safety improvement messages including monthly safety briefing.
- Supported a number of areas with low reporting rates to understand the barriers and explore their local "trigger lists".
- Amended incident management workflow to provide more timely feedback to reporters by removing an unnecessary management approval step.
- Introduced anonymous reporting.
- Developing an app-based reporting tool with the PSTRC with a pilot planned in 2019.
- Positive reporting programme 'Learning from excellence' introduced.

The trust's 'safety alert' (including never event alerts) has been distributed on fourteen occasions since it was launched and for both the monthly safety briefing and the alerts.

Learning from incidents is also shared through local newsletters and at 'safety huddles' which have been introduced in specific specialties. If there is immediate trust-wide learning required as a result of a specific incident or theme, communications are sent to all relevant staff through the divisional cascade system or through monthly 'safety briefings'.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

In 2016/17 the trust reported four never events related to practice in surgery. In response the medical director established a safer surgery task and finish group which undertook a number of actions including: a baseline information collection, audit and observation process; review of all policies to ensure compliance with national guidance; introduction of 'no brief, no start' (both the senior surgeon and anaesthetist must be present for the team brief) and the establishment of an annual, comprehensive trust-wide audit programme.

The task and finish group completed its work in summer 2018 and oversight returned to business as usual governance in the divisions. The longer-term culture change related actions were included in the Safer Surgery improvement stream work, led by the trust lead surgeon.

In response to this work, there were no invasive procedure related never events in 2017/18, however one 'wrong route medication' never event was reported, where an epidural line was connected to a peripheral cannula. A national patient safety alert (NPSA) was issued outlining the actions trusts should take including introducing a standardised product to prevent epidural lines from being connected to the inappropriate access device. In August 2018 an audit led by the pain service collected compliance data for a number of areas including storage, labelling, equipment and staff training. The report highlighted that 50% of cases audited complied with the NPSA guidance for the epidural line to be labelled. A number of immediate actions were agreed including the addition of label checking to the epidural observation chart and changes to storage. A second audit was carried out in October 2018, and showed improved results, with 95% of patients being compliant with NPSA guidance for labelling epidural infusions.

The trust's clinical audit plan for 2018/19 incorporated audits against never event criteria to provide assurance that appropriate processes and systems are in place to prevent such incidents occurring. However, another five never events were reported in 2018/19: one wrong route medication incident in May 2018, one retained swab in July 2018, one retained foreign object incident in September 2018, one wrong site surgery in urology at Charing Cross in October 2018 and one wrong site block in November 2018. The four most recent never events were all related to invasive procedures.

In response to these incidents, the trust took additional actions led by the office of the medical director:

- Interventional procedures task and finish group convened to review compliance with training, LocSSips, count policy, WHO checklist, 'Don't interrupt the anaesthetist when the patient is in the anaesthetic room', displaying the intended site of surgery on the wipe board in theatre, use of radiopaque markers during surgery (where appropriate) and 'Stop before you block'.
- Governance confirmed with divisional directors:
- A trust-wide audit showed improved performance overall with areas of issue in specific areas e.g. when staff change over (in theatres), and poorer performance in out of theatre areas.
- Divisions reviewing data with local action plans required.
- Safer surgery improvement stream.
- Dates for medical director and divisional director to attend all theatres suites being confirmed to discuss the never events and immediate actions.
- Review of directorate scorecards to ensure relevant safer invasive procedure metrics are included.
- An update of the invasive procedures policy and count policy and a review of all other policies relating to invasive procedures.

Patient safety alerts are issued via the Central Alerting System (CAS), a web-based cascading system for issuing alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations, including independent providers of health and social care. The trust has a Central Alerting System (CAS) Policy dated June 2017 covering the

Procedure for the Dissemination and Implementation of Medical Devices, Patient Safety and other Safety Alerts. The trust must have a named person to act as the CAS Liaison Officer (CASLO), who is responsible for receiving and recording CAS alerts, disseminating them for assessment and closing the alerts on the CAS system when they have been signed off as compliant. The CASLO for the trust is the Medical Devices Safety Officer in the Clinical Technical Services (CTS) Department.

The trust maintained an electronic risk register. All staff had access to the risk register and were able to effectively escalate concerns as needed. Service risks fed into operational risks, which fed into divisional risk, which in turn fed into the corporate risks. Staff concerns matched those on the risk register. The trust board had sight of the most significant risks and mitigating actions were clear. Divisional risk registers were monitored monthly.

The trust provided a document detailing their 12 highest profile risks under the well led domain. Each of these have a current risk score of 12 or higher.

ID	Title	Description	Risk score (current)	Risk level (target)	Target date
2473	Failure to maintain financial sustainability.	Failure to maintain financial sustainability.	20	15	March 2021
1660	Risk of delayed treatment to patients and loss of trust reputation due to poor data quality.	Risk of inaccurate data, which can result in delayed treatment to patients, inaccurate data sets being published externally and therefore breach of contractual and regulatory requirements and loss of trust reputation.	20	12	March 2019
2681	Loss of system availability due to Windows 7 end of life.	The trust currently has 10,300 desktop computers that currently run on Windows 7. Microsoft support for Windows 7 ends on the 14th of January 2020. As a result of the above, Microsoft will no longer provide security patches for known vulnerabilities to Windows 7 PCs after this date. Running windows 7 after this date there is a probability of a major cyber security incident resulting in loss of access to systems and/or loss of trust or patient data. Clinical and corporate application suppliers are no longer designing applications for windows 7 - the Trust will not be able to leverage benefits of new functionality in applications with Windows 7 moving forwards.	20	10	November 2019

ID	Title	Description	Risk score (current)	Risk level (target)	Target date
2680	Increased risk of PC failure due to delay in PC Replacement Programme.	<p>ICHT are currently running a desktop estate of 10,300 devices. Due to a lack of capital investment the programme is now seriously behind schedule and as things stand the trust has over 3,567 desktop PCs which are over five years old in April 2018.</p> <p>By March 2019 this figure will reach up to 6,000 PC devices. This figure includes 800 "computers on wheels" (COW) which are now beyond their recommended production life and now display persistent and frequent problems.</p>	20	6	December 2020
2677	Risk of failure of network core devices as they reach end of life.	<p>Risk of failure due to age of Network Core devices - Cisco Nexus7K eight years old for SMH and CXH, and at HH Cisco Catalyst 6,509 13 years old. The core devices are also running software/firmware five years old. Additionally, the devices will come to end of life in November 2019. The network core devices provide the network backbone to all the primary sites within Imperial: CXH, HH and SMH. End of life indicates the manufacturer of the hardware will no longer provide support or software updates to their devices.</p>	20	10	November 2019
2472	Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.	<p>Failure to comply with the Care Quality Commission (CQC) regulatory requirements and standards could lead to a poor outcome from a CQC inspection and / or enforcement action being taken against the trust by the CQC.</p>	16	8	April 2019
2498	Failure to gain funding approval from key stakeholders for the redevelopment	<p>Failure to gain funding approval from key stakeholders for the redevelopment programme resulting in continuing to deliver services from sub-optimal</p>	16	8	December 2020

ID	Title	Description	Risk score (current)	Risk level (target)	Target date
	programme resulting in continuing to deliver services from sub-optimal estates and clinical configuration.	estates and clinical configuration, including Paediatric Intensive Care Unit (PICU) and Western Eye Hospital (WEH).			
2593	Delays in payment of suppliers impacting trust's ability to operate and provide services.	Delays in payment of suppliers resulting in supplier accounts going on stop, creating a risk to the trust's ability to continue to provide its operational services.	16	4	Under review
2482	Risk of cyber security threats to trust data and infrastructure.	Risk to Data: A cyber security incident can result in data being stolen, destroyed, altered or ransomed. Risk to Infrastructure: A cyber security incident can result in all or part of trust ICT infrastructure being disabled, or destroyed. There would be a prolonged period of recover.	16	8	December 2018
2613	Compliance with General Data Protection Regulation (GDPR).	Risk of financial and reputational damage to the Trust resulting from failure to fully comply to the General Data Protection Regulation (GDPR), which became effective in May 2018. The GDPR is a directive for the European Union that has been enacted in UK legislation.	16	8	March 2021
2714	Failure to successfully implement the 2017/18 NHS e-Referral Service within timeframe.	Failure to successfully implement the 2017/18 NHS e-Referral Service CQUIN: 'Paper Switch Off' (PSO) project within timeframe, which will result in inefficient capacity management and subsequent increased ASIs, increased costs and potential loss of income.	16	4	January 2019
2557	Increased risk of legal challenges to procurements.	Risk of using medical devices that have not been tested due to lack of scheduled maintenance.	12	9	December 2018

(Source: Trust Corporate Risk Register – P106a)

Senior leaders we interviewed fed back that the quality of risk reporting had improved, there was an acceptance that more needed to be done to educate divisions on both risk reporting and risk appetite.

The main risk fed back by all senior leaders we interviewed during the inspection was around the trust's estate. The trust has previously been part of strategic estates programmes which have not been approved and/or implemented, most recently North West London's Shaping a Healthier Future (SaHF). NEDs stressed that the trust is working up their own business cases for redevelopments and is engaging with the appropriate stakeholders (regulators, DHSC and HMT) in order to progress these. At the same time, the trust has made considerable progress in managing with their existing (often older) estate including improving flow such that older parts of the estate can be decanted and refurbished.

The trust had a clinical audit programme incorporating expected national and local clinical audit studies. A new post of clinical audit lead was created in the last 12 months and a clinical audit and effectiveness group (CAEG) was established by the clinical audit lead providing direction and leadership for the programme, as well as reporting to the trust's executive committee.

There were plans in place for emergencies. The trust had a Business Continuity Plan V2.1 18th June 2018) to ensure the trust is capable of responding to business continuity incidents and is able to continue its critical services at an acceptable pre-defined and agreed level. There were current Major Incident plans for each of the three large acute hospital sites. The plans identified key members of staff and detailed their roles and responsibilities.

NHSI's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. As at 30/03/2019, the trust has been placed in segment 3: Mandated and targeted support: support needs identified in Quality of care, Operational performance and Finance & use of resources.

Financial metrics	Historical data		Projections	
	Previous Financial Year (2016/17)	Last Financial Year (2017/18)	This Financial Year (2018/19)	Next Financial Year (2019/20)
Income	£1.1bn	£1.1bn	£1.2bn	£1.1bn
Surplus (deficit)	(£40.8m)	(£22.5m)	(£22.6m)	(£31.5m)
Full Costs	(£1.1bn)	(£1.2bn)	(£1.2bn)	(£1.2bn)
Budget (or budget deficit)	(£41.0m)	(£25.2m)	(£20.6m)	(£31.5m)

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

For 2016/17 after participating in a PwC supported Financial Improvement Programme (FIP) to identify and support performance improvement initiatives, a control total of £41m deficit was agreed with NHS Improvement which gave the trust access to £24m STF funding (i.e. a net deficit of £16.8m).

For 2017/18 a control total of £25m deficit was agreed in August 2017 with £20.6m available in STF funding. The trust met its control total and received bonus funding taking it into a reported surplus position for the year.

For 2018/19 a control total of £20.56m deficit was agreed which would see the trust receive £34.2m of STF. The CIP target for the year is £48m. CIP schemes continue to follow a robust process of risk assessment against the CQC domains.

After deducting funding and one-off adjustments the trust is improving its underlying income and expenditure position year on year; from an underlying deficit of £50m in 2016/17, to a forecast underlying deficit of £35m for 2018/19. The trust has recently met a commitment to NHSI to prepared and submit a 4-year recovery plan which sees the underlying position continue to improve by £5m each year.

Following the Financial Improvement Programme (FIP) undertaken by the trust in 2016/17, the trust initiated a comprehensive Specialty Review Programme, reviewing each of its 31 specialties. The reviews covered the market position for each of the specialties, looking at areas such as cost, profitability, productivity, strategic fit, experience and outcomes, as well as peer comparison. The programme is moving into its next phase which will see action plans developed to deliver financial improvement opportunities.

The trust is also involved in a number of developments that will impact on income and the trust's sustainability over the medium term. These include:

- As part of the NWL STP, the trust is working on several workstreams to align approaches and create efficiencies across the sector. One such work stream relates to Outpatients services.
- The trust are active participants in a number of Integrated Care programmes across North West London, notably in Hammersmith & Fulham. The trust are working in partnership with Commissioners and other providers through a signed Alliance Agreement with clinical teams developing pathways of care across the entirety of CCG commissioned services.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust was aware of its performance through the use of KPIs and other metrics. This data fed into a board assurance framework. The board received holistic information on service quality and sustainability. Information was in an accessible format, timely, accurate and identified areas for improvement. The trust has an integrated quality performance framework in place. As part of this an annual review of the metrics for all domains of quality is undertaken with the executives, their teams and the trust board. This feeds the metrics that are included in the integrated quality performance reports (IQPR). The trust report provides oversight of over 110 core indicators at each of the four levels of the organisation (board, division, directorate and where relevant ward / clinic).

The framework is split into the CQC's five quality domains, with a further domain on use of resources. Each indicator in the IQPR is mapped to an executive committee which has the responsibility to monitor that indicator and consider exception reports and interdependencies. The indicators are reviewed by the executive team annually, to align with national priorities and trust quality account targets. It was last refreshed April 2018. Quality, workforce and financial indicators are all included, e.g. patient safety incidents and incident reporting rate, staffing fill rates, infection prevention and control, medical devices management, mortality, sickness absence, bank and agency spend, FFT, national operational standards, in month variance to plan and cost improvement programme delivery.

Monthly scorecard reports give an integrated view of ward to board performance and are reviewed at each level to inform decisions about delivery of services. The board review includes scrutiny and discussion of issues, trends (with gradual introduction of SPC), learning and action plans for areas that need to improve or return to trajectory.

The trust has a data quality framework overseen by a Data Quality Steering Group led by the CIO. Priority Data Quality Indicators (DQIs) are agreed annually and included in the trust's Integrated Quality & Performance Framework and are measured at all levels of the organisation.

The trust undertakes its own routine audits of patient waiting times, the results of which inform a data quality rating which is included in the Integrated Quality & Performance Report (IQPR) to the trust board. The Data Quality Framework provides the Trust with a clear picture of its data quality and, based on this, the trust invested in 2018/19 in a training team to undertake 'deep dives' into waiting times data quality issues at speciality level and deliver targeted training to address root causes.

The trust rated the quality of its data for the national waiting times standards for Cancer and A&E as Green whereas the waiting times standards for diagnostics and RTT were rated Red for data quality. The independent review of Elective Care waiting times at the Trust which was undertaken by MBI during 2018/19 also flagged that there was work required to improve data quality for RTT and diagnostics waiting times. Assurance is provided for the other domains in the Integrated Quality & Performance Framework via audits undertaken by the trust's Internal Auditors.

The Data Quality Framework includes 150 indicators across 32 datasets. A key component of the framework is also a quality assurance and audit process for every waiting times dataset to inform training, learning and development. Random samples from datasets are audited to ascertain whether the error rate is below 5% and an escalation process is in place if results are adverse.

Prior to submission to national bodies waiting times datasets are validated according to Standard Operating Procedures. Assurance is provided for activity and income datasets via audits undertaken by the trust's internal auditors. In addition, the trust audits around 800 admitted spells per month where the clinical coding is most likely to require change (as identified through sophisticated algorithms).

The trust has had a major investment programme over the past few years to implement an Electronic Patient Record (EPR) including use of electronic prescribing.

An Electronic Prescribing and Administration (EPMA) system was used in the trust alongside paper prescription charts and an additional electronic system in some of the critical care units. This had been recognised as a risk, reviewed and processes put in place to mitigate the risk. Additionally, the pharmacy team provided clinical staff with regular information and learning opportunities in relation to other risks and previous incidents associated with EPMA.

The trust was announced as a Global Digital Exemplar by NHSE in 2016/17 and was awarded £10m over two years to make further advances and we are now in the process of going paperless across our hospitals. The trust is working in partnership with a neighbouring NHS trust to implement the existing system across both organisations to better serve the population of NW London. Recently the trust started using the system across the organisation to identify and manage deteriorating patients with a particular focus on Sepsis. Current developments and investment include a focus on clinical analytics to reduce variation in clinical practice. In addition, over 10,000 of trust patients have signed up to access their own electronic records through the trust's Care Information exchange.

On average (over the last year) 1% patients were seen as outpatients without the full medical record being available.

The digital 'big room' identified seven priority areas for 2018/2019. These act as important enablers across 'improvement priorities' for trust wide digital transformation. The digital priority areas overlap with GDE priorities and comprise:

- Optimal use of existing digital features
- Going paperless

- Introducing voice recognition
- Device and system integration; to develop systems that connect and share information safely and securely
- Developing a mobile App interface
- Care Information Exchange (CIE)
- Analytics: to ensure provision of access to data to develop real time feedback mechanisms to collect and act upon data.

Work is progressing and being monitored through the executive digital transformation committee.

The Information Governance Toolkit for acute trusts consists of 45 individual requirements, each assessed between level 0 and level 3. The trust's information governance toolkit submission in March 2018 achieved a 'Satisfactory' grade (all requirements met at level 2 or better). The trust had an overall score of 66% for 2017/18.

As at 31 March 2018, the trust achieved 96% compliance rate for information governance training for eligible staff.

The quality of the data and reporting which informs decision making was also easy to understand and appropriately signposted key risks to both the executive team and the NEDs.

A good level of financial information is available at board level, with a clear statement of the financial position of the trust. Interviewees felt that the financial and CIP reporting highlighted key risks and appropriately set out the current position, which allowed a good conversation at board and sub-committees on mitigations and future delivery.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

In 2016, the trust developed a trust-wide approach to increasing and improving patient and public involvement in every aspect of our work. Progress with the strategy has included:

- A new digital patient reference group providing input and feedback on the development of apps, the use of digital patient records and other online opportunities to help ensure the digital strategy meets the needs and preferences of trust patients and communities
- The establishment of an additional 22 lay partner roles. This enables patients and local people to play a full part in the trust's key projects and programmes, bringing the total to 44 and influencing major developments such as waiting list improvements, estates redevelopment and a new patient transport tender.
- The creation of a new volunteer role to support improvement projects. This is focusing on gathering feedback directly from patients, carers, family and friends in clinical environments.
- The trust published its first involvement toolkit for staff offering advice and practical support to involve patients and the public in services and improvement work.

The trust provided a report from the strategic lay forum 'Patient and public involvement: review and priorities for 2018/19' which identified the following priorities:

- To expand and embed the strategic lay forum and lay partner programme

- To determine how best to increase involvement with seldom-heard groups
- To create and launch a 'keep in-touch' offer for all patients and local residents
- To develop an organisation-wide staff campaign to raise awareness and understanding of the value of – and opportunities for – involvement
- To develop an integrated approach to understanding and acting on feedback
- To develop and test self-care and prevention approaches as part of an overall integrated care model
- To ensure involvement is a key element of our strategic change and improvement programme – both in terms of developing the programme and to embed within the programme.

Patient stories are included at each bi-monthly public board meetings to learn from the experiences of patients.

The trust's Friends and Family Test (FFT) scores remain above the sector average (3.84 compared to a sector average of 3.76).

The trust encouraged membership, which is free and open to all patients and carers as well as local residents, staff and partners. Members receive the trust's bi-monthly membership e-newsletter and invitations to events, including the annual general meeting, as well as involvement opportunities.

The trust's Friends groups are independent voluntary organisations that provide support to the trust's hospitals, including running shops and cafes, raising funds for local improvements and helping out at events.

Overall staff engagement has improved in the NHS Staff Survey for the last three years. The overall engagement score has increased from a position of 'lowest 20 per cent' in 2015, to 'Average' in 2016, to 'Above Average' in 2017 (an increase of 3.71 to 3.84).

The trust runs a local 'Our Voice' engagement survey on an annual basis. The 2018 survey was responded to by 3164 staff (an increase of 357 on 2017).

The trust's local survey results indicate relative consistency in levels of engagement across the trust; (77% in 2016, 80% in 2017 and 78% in 2018).

The chief executive holds monthly open-door sessions and issues regular podcasts ('Tim's take away')

As a result of previous inspections, where medicines management was highlighted as an issue, the pharmacy team had started a "medicines matters" programme, which aimed to improve medicines management compliance across the trust. This included initial and ongoing engagement with a range of different staff groups, as well as re-designing processes and guides for staff, in both clinical and non-clinical areas.

Senior managers we interviewed during the inspection were able to articulate a detailed understanding of how the trust engages with patients and triangulates financial information with patient feedback, patient stories, staff survey results and other softer information. This was equally the case for both executives and NEDs

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

There were organisational systems to support improvement and innovation work and staff had training in improvement methodologies and used standard tools and methods. The improvement team was established in 2017 to bring together all the quality improvement functions in the medical director's office into a single team with the aim of creating a culture of continuous improvement in the trust that was fully aligned to the trust strategic objectives. The core programme focuses on increasing capacity and capability through the provision of education, training and coaching. In addition, the team supports both strategic and service led projects ensuring that improvements are delivered using a robust improvement methodology. The improvement team have supported teams to deliver a wide range of quality improvement which is reported bi-monthly to the executive.

The team supports both strategic and service led projects and programmes, either directly or via the trust's improvement coaches, ensuring that improvements are delivered using a chosen methodology (the IHI's Model for Improvement).

The core programme focuses on increasing improvement capacity and capability through the provision of education, training and coaching. There have been around 4,000 training attendances and there are 134 trained improvement coaches across the trust.

The improvement team was developing a process for organisational oversight including a registration process for QI projects which can then be shared with divisions, through their Quality & Safety Committees, to support alignment with improvement priorities at a trust, division and local ward level. Staff had time and support to consider opportunities for improvements and innovation and this led to changes.

Staff were aware of their contribution to cost improvement objectives. The trust noted that the SRP is by its nature is multi-factorial and has to cover a huge range of processes and areas and these elements are co-dependent and aim to deliver a transformed pathway. For example, the trust has made improvements in its theatre productivity. This has been the result of a planned and comprehensive programme that encompasses: surgical orders (through the Cerner system), pre-operative preparation, scheduling, theatre planning, in-theatre efficiency, recovery pathway and enhanced discharge.

The trust had a planned approach to take part in national audits and accreditation schemes and shared learning.

The trust receives and reviews outcome data from multiple sources including Dr Foster, national audits and the Copeland Risk Adjusted Barometer on a regular basis. A number of trust specialties are demonstrating clinical outcomes consistently better than national averages/similar trusts

Trust results in the national audit programme show performance in line with national standards. There are some examples of excellent practice, including:

- SSNAP which shows continued improvement and excellent outcomes for the HASU at Charing Cross Hospital, which is the second best performing in the country.
- TARN – the major trauma network has had the best survival rates nationally for the last two years.

- UK Renal Registry: for prevalent dialysis patients, renal services is ranked 5th for survival out of 71 submitting centres in the UK for patients < 65years, and 8th for survival for patients >65 years, and is the leading London Renal Centre.
- Endocrinology: The trust is a European Centre of Excellence for the management of Endocrine tumours (reviewed by ENETS).
- Oncology: excellent standardised mortality rates and cancer survival rates in all areas. Second highest network recruiter in UK for cancer clinical trials.
- Neurosurgery: Best 1, 3 and 5 year survival rates in the UK according to the National Cancer Intelligence Network
- Hepatology: the trust achieves SVR (sustained virological response) rates at 12 weeks consistently above published standards. Current run rates are filled at 99 -100%. Mortality figures for patients with decompensated chronic liver disease are significantly better than the published standards (Kockerling et al, 2017).

Some of the areas reporting excellent outcomes through the NHSE Specialised services quality dashboards (SSQD) include:

- HIV and Sexual Health: CD4 count <350 in late HIV diagnosis and CD4 count <200 in very late HIV diagnosis
- NICU Level Three and Two: retinopathy screening (L3), admission temperature <36 degrees (L2/3), low rates of positive blood cultures with lines present
- PICU: low rates of emergency readmission
- Cardiology: low post-intervention complication rates for ICD, CRT-D, CRT-P implants and low readmission and complication rates pre-discharger for elective first-time catheter ablation of AVNRT, AVRT, typical atrial flutter, paroxysmal AF and persistent AF
- Renal Dialysis: low rates of peritonitis amongst patients receiving peritoneal dialysis

Trust mortality rates are consistently amongst the lowest in the country. At trust level there has been significantly low mortality rates since 2009. The trust has shown a continued improvement in mortality from low-risk diagnosis groups to bring us well below the national average (Dr Foster). Some examples where data shows much better outcomes include in-hospital mortality rates for acute cerebrovascular disease and acute renal failure.

For the period April 2017 - March 2018, the trust's HSMR was lower than expected with a value of 69.42 and 1,355 deaths compared to an expected 1,952 deaths. Weekend HSMR is lower than expected for this time period.

Effective systems were in place to identify and learn from unanticipated deaths. Over the last 12 months of data, the trust had the lowest HSMR rate when compared nationally. HSMR has remained within the lower than expected banding since 2009. In October 2018 the Trust's HSMR was 69, which is statistically significantly low.

The most recent full year data for SHMI (Q1 17/18 to Q4 17/18) shows the trust to be the third lowest of acute non-specialist providers at 74.13.

The trust responded to the CQC publication 'Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England' (2016) and the National Quality Board (NQB) subsequent guidance (March 2017).

The trust executive lead for learning from deaths is the Medical Director and there is a nominated non-executive lead. The trust board has oversight through the Quality Committee via, quarterly reports.

There is a requirement in the NQB document that any methodology used for mortality review should be robust and evidence based. The recommended tool is the Royal College of Physicians (RCP) 'Structured Judgement Review' (SJR) introduced in late 2016. There is a requirement to conduct in depth 'case record review' of selected patient deaths or cohorts with the aim of identifying 'problems in care' which may have contributed to death.

The NQB guidance includes a requirement to have a 'Trust mortality surveillance group (TMSG) with multi-disciplinary and multi-professional membership'. The purpose of the Trust Mortality Surveillance Group (TMSG) is primarily to enhance opportunities to improve patient safety whilst assuring the trust board that in-patient deaths are actively monitored, reviewed, reported and where necessary investigated to ensure appropriate lessons are learned and actions implemented to improve outcomes.

In September 2017 the trust updated its existing mortality review policy and process to include the requirements of the national learning from deaths policy, and the Structured Judgement Review (SJR) process. The trust has a standardised approach to reporting and reviewing inpatient deaths. The process involves review by the patient's consultant within seven days of death; where the death is considered potentially 'avoidable', an additional review is undertaken at a local Mortality and Morbidity meeting (M&M) occurring within 30-days of death. (The frequency of M&M is specialty specific).

Deaths which are still considered as potentially avoidable following local review, or deaths that trigger independent review as outlined in the trust policy, are subject to an SJR. The SJR is undertaken by a trained reviewer (the trust has around 36 staff – including nurses - trained as reviewers), within 30 days of allocation. If the SJR outcome score is between 1-4 the case is reviewed at the trust's monthly Mortality Review Group (MRG). The MRG is chaired by the associate medical director for safety, the cases are reviewed by the group and the score is confirmed. This does not include outpatient deaths.

The SJR process identifies learning opportunities from each death which are shared locally as well as through the divisional quality governance meetings. Themes have been aligned to the trust's nine safety-streams where appropriate to ensure that they remain relevant and cover the areas of risk identified through investigative processes e.g. SIs. All confirmed cases of avoidable deaths are discussed in divisional quality and safety meetings with actions then taken forward there.

There were five avoidable deaths in 2018/19. These were investigated as serious incidents and learning was shared through the trust's processes for sharing learning from incidents.

The trust is reviewing its learning from deaths process to consider how to implement the medical examiner model in 2019/20.

We randomly selected the records of three deceased patients and found the trust had followed the processes described.

The skills of the pharmacy workforce are increasingly being utilised in outpatient clinic settings across a number of different specialties in the trust to provide a medicines optimisation service, including in cardiac failure, critical care, renal, paediatric rheumatoid arthritis, outpatient antibiotic therapy, antifungal therapy and multiple sclerosis. This has led to improvements in patient centred care, including in terms of medication review, patients having timely information about their

medicines and positive input into treatment pathways to improve both patient experience and outcomes.

Ensuring trust staff are up to date with the mandatory skills to do their jobs was identified as an improvement priority in the trust's quality account. Work undertaken included reviewing the training modules. Seven modules were identified and removed as either duplications or not a core skill requirement. Individual emails were sent to all non-compliant staff. There was a trial of new methods for core skills completion for junior doctors at induction.

The trust's internal annual ward accreditation programme (WAP) was launched in 2014 and continues to support ward, unit and department managers to understand how they are delivering care, identifying what works well and where further improvements are needed. Areas are assessed against a number of criteria and given a rating, from gold (achieving highest standards with evidence in data) to white (not achieving minimum standards and no evidence of active improvement work).

In 2017 overall, out of 90 areas reviewed, 38 had improved since last the previous year. 34 per cent of clinical areas were rated as gold, 32 per cent were rated as silver, and four per cent were rated as white.

The chief executive retains overall responsibility for complaints, however the Director of Nursing is the trust's executive lead. The Deputy Director of Patient Experience oversees the performance management aspects of the trust's complaint process. The Complaints and Service Improvement Manager is responsible for the day-to-day management of the complaint process. The total number of staff dedicated to complaint management is: Central Complaints Team 10 WTE, PALS Team 6 WTE plus 10 PALS Volunteers

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Current performance
What is your internal target for responding to complaints?	3	98.7% achieved
What is your target for completing a complaint	Average 40 working days	30 achieved
If you have a slightly longer target for complex complaints please indicate what that is here	Low risk: 25wds Medium risk: 45wds High risk: 65wds	Low: 29wds Medium: 44wds High: 67wds
Number of complaints resolved without formal process in the last 12 months?	3,221 (November 2017 to October 2018)	

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

The trust received 967 complaints from November 2017 to October 2018. Outpatients core service received the most complaints with 300 (31.0% of all complaints) followed by medicine core service with 169 (17.5% of all complaints).

A breakdown by core service can be seen in the table below:

Core Service	Number of Complaints	Percentage of total complaints
Outpatients	300	31.0%
Medicine	169	17.5%
Surgery	159	16.4%

Urgent and Emergency Care	107	11.1%
Maternity	84	8.7%
Gynaecology	41	4.2%
Diagnostic Imaging	35	3.6%
Provider Wide	35	3.6%
Children and Young People	25	2.6%
Critical Care	10	1.0%
Medicine	1	0.1%
End of Life Care	1	0.1%
Total	967	100%

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The top theme for PALS during the last 12 months was "Appointments"; in particular, delays and cancellations. This reflects the pressures the trust is under in terms of demand for services as well as short notice cancellations of appointments and delays to treatment resulting from the cancellation of non-elective surgery during the winter of 2017/18. PALS work with patients to resolve concerns about appointments as quickly as possible before they escalate unnecessarily to formal complaints. Other key themes during the year were "communication", "values and behaviour" and "Admissions/Discharges",

The trust gave examples of changes made as a result of learning from complaints during the last 12 months for the three clinical Divisions in the trust:

- In Medicine & Integrated Care: a complainant was concerned about the wording of a sexual health screening questionnaire, as they believed it was stigmatising to certain groups of people. Following a discussion within the sexual health team, the laminated questionnaires were from the pathway for asymptomatic patients.
- In Surgery, Cancer and Cardiovascular Services: a patient complained they were instructed to come in for surgery at 7.30am even though it was known that they were last on the list and their operation would therefore not take place until 2.30pm or 3.00pm. As a result of this the ENT surgeons are now staggering the arrival times of their patients.
- Women's, Children's & Clinical Support: a recommendation was made for midwives to be reminded about the need to apply the Triage service's 20-week gestation rule more flexibly after several complaints from women who at 19+6 had been turned away from triage (one of whom later went on to have a stillbirth at around 28 weeks).

Three complaints referred to the ombudsmen (PHSO) between 1 November 2017 and 31 October 2018 were partially upheld.

We randomly selected four complaints received and dealt with by the trust since the last inspection and looked at the trust's response. We found the trust had followed the process described.

From November 2017 to October 2018, the trust received a total of 352 compliments. A breakdown by core service can be seen in the table below:

Core Service	Number of Complaints	Percentage of total compliments
Urgent and emergency services	92	26.1%
Surgery	79	22.4%

Medical care (including older people's care)	49	13.9%
Maternity	34	9.7%
Outpatients	32	9.1%
Diagnostics	20	5.7%
Critical care	19	5.4%
Gynaecology	11	3.1%
Other	9	2.6%
Services for children and young people	5	1.4%
End of life care	2	0.6%
Total	352	100%

The trust reported that there were no themes identified in compliments during the last 12 months. Mainly patients want to say thank you for service they received from members of staff across the trust.

Urgent and emergency services were the directorate that received the highest number of compliments (which is possibly a reflection of the high footfall in the service), followed by maternity, cardiology, general surgery and vascular and ophthalmology.

The complaints and service manager shares all compliments as part of a fortnightly complaints and compliments tracker which goes out to key divisional staff as well the Executive. This process ensures buy-in for the complaints process as well as allowing staff members to receive wider recognition for their good work.

(Source: Routine Provider Information Request (RPIR) – Compliments)

There were several external reviews external reviews of the trust between 1 October 2017 and 30 November 2018:

- The SCC JACIE cited improvements needed in relation to the use of multiple documentation systems (paper and electronic). Additional Consultant Anaesthetists are needed to match anaesthetic capacity with theatre demand. Recommendations were made to improve theatre utilisation.
- The MBI assurance independent assurance review was requested by previous chief executive Ian Dalton when it first became clear that the trust's projection of RTT recovery was going to be significantly worse than submitted plans. Recommendations were made to help address this.
- The maternity service achieved two of the three BFI standards.
- Birth Rate Plus outcomes were to identify safe staffing levels in midwifery. St Mary's Hospital was compliant but recommendations for Queen Charlotte's and Chelsea Hospital are going through the trust approval process.
- One immediate mandatory requirement was issued for diagnostic general radiology consultant checking of trainee scans at weekends. This has been complied with.
- Pharmacy HEE issued one immediate mandatory requirement around the communication of time-off-in-lieu arrangements for weekend working (complied with). Three major issues were raised by the MHRA, however two of these related to the trust Wholesaler Dealer's Licence, which has since been relinquished.

- An immediate mandatory requirement was issued by HEE regarding arrangements for consultants to review out of hours work at the weekend. Interim arrangements were put in place, with plans for a formal robust and resilient consultant checking of trainee ED and urgent IP scans for the non-neuroradiological clinical setting which was implemented in January 2019.
- NHSE Higher Level RO quality visit and external quality assurance of appraisal and revalidation identified a need to improve the undertaking of appraisals for medical staff. Two areas identified as top level actions were space for clinical teaching and recognition of Educational Programmed Activities (EPAs) in job plans.
- Following a reportable HSE incident at Charing Cross Hospital, security of external building works compounds were reviewed and new instructions issued for future construction.
- The key findings of the HEE Quality Review of Haematology Trainees at St Mary's Hospital (Adult & Paediatric quality of training and supervision reviewed) found challenges within workload and recruitment.

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust's services have been awarded an accreditation.

Accreditation scheme name	Service accredited
Joint Advisory Group on Endoscopy (JAG)	Charing Cross Hospital: June 2018 Hammersmith Hospital: June 2018 St Mary's Hospital: June 2018
Medicines and Healthcare Products Regulatory Agency (MHRA)	Pharmacy aseptic unit reaccreditation 2018.
Accreditation of Endoscope Reprocessing Units (RUs)	Accredited to: BS EN ISO 13485:2016 (since 13/12/12). Accreditation recently reviewed and re-accreditation achieved until September 2019.
CHKS Accreditation for radiotherapy and oncology services	Oncology Services (including radiotherapy and radiation physics) accredited in September 2017 for three years. Surveillance annually. Continued accreditation awarded September 2018.
National School of Health Care Science (NSHCS) (part of Health Education England (HEE))	Medical Physics accreditation - part of the London North Medical Physics Training Consortium.
Psychiatric Liaison Accreditation Network (PLAN)	Psychiatric liaison services all sites (2016) rated excellent.

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)

St. Mary's Hospital

Imperial College Healthcare NHS Trust was formed on October 1, 2007 by merging St Mary's NHS Trust and Hammersmith Hospitals NHS Trust and integrating with the faculty of medicine at Imperial College London.

The trust has 12 registered locations and employs almost, 11,000 staff. The registered locations are:

- Queen Charlottes and Chelsea Hospital
- Western Eye Hospital
- Hammersmith Hospitals
- Northwick Park Renal Centre
- Ealing Renal Satellite Unit
- St Charles and Hammersmith Renal Centres
- West Middlesex Renal Centre
- Brent Renal Centre
- Charing Cross Hospital
- St Mary's Hospital
- Hayes Renal Centre
- Watford Renal Centre

The trust has an estimated range of population served is between 1,500,000 and 2,000,000 people.

- The trust has a total of 1004 inpatient beds spread across various locations
- 534 outpatient clinics per week.
- 297 day case beds.
- 38 Children's beds.
- No dedicated End of Life Care beds.
- 52 inpatient wards.

Critical care

Facts and data about this service

The trust has 107 adult critical care beds.

Critical care services are provided at the St Mary's, Charing Cross, and Hammersmith hospitals sites.

There is an intensive care unit at each of the sites delivering level 2 and level 3 care. There are speciality differences within each of the units, reflective of the configuration of services provided at each site.

St Mary's Hospital has a major trauma centre, covering North-West London. Charing Cross Hospital is a tertiary referral centre for Neurosciences. At Hammersmith Hospital there are two separate Intensive Care Units (ICU): cardiothoracic ICU and the general ICU.

In addition, the Charing Cross site and St Mary's Hospital sites have acute respiratory units (ARUs), which provide non-invasive respiratory support for a defined patient population. There is also a renal unit at the Hammersmith Hospital site which provides level 2 care for this speciality group.

Critical care services at St Mary's Hospital were provided in two hospital areas. One was the intensive care unit (ICU) and the other was the acute respiratory unit (ARU) which provides non-invasive respiratory support. The intensive care unit consisted of 32 beds where level 2 and level 3 care was provided. The ARU had 8 beds available to level 2 patients.

The critical care service also included a critical care outreach team who supported patients in other areas of the hospital. The team was led by specialist nurses who were available seven days a week between 8am and 8pm.

The two units were managed within two different directorates. The intensive care unit was managed within the critical care directorate, while the acute respiratory unit within the integrated medicine directorate. They both had similar senior management structure and were led by different general managers and nurse leads. The ICU was led by a consultant intensivist and the ARU was led by a consultant in respiratory medicine.

(Source: Routine Provider Information Request (RPIR) – Context acute)

This inspection took place between 25 and 27 February 2019. We spoke with five patients and their relatives and 28 members of staff including: senior managers, support staff, junior and senior nurses, doctors, and allied health professionals. We reviewed the healthcare records of nine patients and spoke with six patients and relatives.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental, or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills and made sure doctors and nurses completed it. However, the trust's target was met for nine of the 15 mandatory and statutory training modules for which doctors in training were eligible.

Band 7 nurses led teams of nurses within the critical care service and ensured mandatory training was completed and up to date. Staff were able to access the electronic learning management system to check their completion and sign up to courses. Mandatory training completion rates were collected in a dashboard and monitored by senior members of staff.

The trust provided a structured induction and mandatory training programme for staff. Staff working in critical care, including staff on the acute respiratory unit, received additional training courses specific to critical care. Courses specific to critical care included modules in intensive care unit medicines, sepsis, ventilators and intravenous therapy (IV) competency. The critical care

outreach and resuscitation team delivered non-invasive ventilation (NIV) and tracheostomy training for the staff working on the acute respiratory unit.

Staff working on the intensive care units and acute respiratory unit also completed a critical care competency workbook.

Mandatory training was delivered through face-to-face sessions and online courses. Staff received protected time to complete training courses. Critical care staff received seven and a half hours of protected time every three years and an additional three and a half hours for extra e-learning annually. Temporary (agency) staff had a local induction which included orientation on the wards and a checklist which the nurse in charge kept so that when the agency staff worked on the ward again a record of their competencies was available. Nursing staff, including agency nursing staff, told us the induction process was very thorough.

The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory and statutory training courses as at February 2019 at St Mary's Hospital for support to doctors and nursing staff in critical care services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Conflict Resolution	134	134	100.0%	85%	Yes
Duty of Candour	11	11	100.0%	85%	Yes
Health and Safety	134	134	100.0%	85%	Yes
Moving and Handling Level 1	134	134	100.0%	85%	Yes
Equality and Diversity	133	134	99.3%	85%	Yes
Infection Prevention and Control Level 2	133	134	99.3%	85%	Yes
Invasive Procedures Policy	133	134	99.3%	85%	Yes
Nutrition	133	134	99.3%	85%	Yes
Consent	132	134	98.5%	85%	Yes
Fire Safety Awareness	131	134	97.8%	85%	Yes
ANTT	129	134	96.3%	85%	Yes
Medicines Management	129	134	96.3%	85%	Yes
Blood Transfusion	126	134	94.0%	85%	Yes
Information Governance	126	134	94.0%	85%	Yes
Resuscitation Level 3	124	134	92.5%	85%	Yes
Moving and Handling Level 2	122	134	91.0%	85%	Yes

In critical care services, the 85% target was met for all 16 mandatory and statutory training modules for which support to doctors and nursing staff were eligible.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at St Mary's Hospital for medical staff in critical care services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
ANTT	11	11	100.0%	85%	Yes
Blood Transfusion	11	11	100.0%	85%	Yes
Conflict Resolution	11	11	100.0%	85%	Yes
Consent	11	11	100.0%	85%	Yes
Duty of Candour	11	11	100.0%	85%	Yes
Equality and Diversity	11	11	100.0%	85%	Yes

Fire Safety Awareness	11	11	100.0%	85%	Yes
Health and Safety	11	11	100.0%	85%	Yes
Invasive Procedures Policy	11	11	100.0%	85%	Yes
Medicines Management	11	11	100.0%	85%	Yes
Moving and Handling Level 1	11	11	100.0%	85%	Yes
Resuscitation Level 2	11	11	100.0%	85%	Yes
Venous Thromboembolism	11	11	100.0%	85%	Yes
Infection Prevention and Control Level 2	10	11	90.9%	85%	Yes
Information Governance	9	11	81.8%	85%	No

In critical care services, the 85% target was met for 14 of the 15 mandatory and statutory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at St Mary's Hospital for doctors in training in critical care services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Invasive Procedures Policy	24	25	96.0%	85%	Yes
Blood Transfusion	23	25	92.0%	85%	Yes
Conflict Resolution	23	25	92.0%	85%	Yes
Consent	23	25	92.0%	85%	Yes
Infection Prevention and Control Level 2	23	25	92.0%	85%	Yes
Venous Thromboembolism	23	25	92.0%	85%	Yes
Equality and Diversity	22	25	88.0%	85%	Yes
Medicines Management	22	25	88.0%	85%	Yes
Nasogastric Tube Placement	22	25	88.0%	85%	Yes
Fire Safety Awareness	21	25	84.0%	85%	No
Information Governance	21	25	84.0%	85%	No
Moving and Handling Level 1	21	25	84.0%	85%	No
ANTT	20	25	80.0%	85%	No
Health and Safety	20	25	80.0%	85%	No
Resuscitation Level 2	20	25	80.0%	85%	No

In critical care services, the 85% target was met for nine of the 15 mandatory and statutory training modules for which doctors in training were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

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.

Staff were trained to level two in both adult and child safeguarding. They demonstrated a good understanding of safeguarding vulnerable adults. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to make a referral. Staff knew how to escalate concerns to the senior nurse and safeguarding team. Staff had knowledge

about female genital mutilation (FGM) which was part of mandatory safeguarding training.

Safeguarding information was flagged within a patient's record within the electronic patient record system.

We reviewed the trust's adult safeguarding policy which was available on the trust intranet. The policy detailed individual responsibilities and processes for reporting and escalation of concerns.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as at February 2019 for support to doctors and nursing staff in critical care services at St Mary's Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults Level 2	132	134	98.5%	85%	Yes
Safeguarding Children Level 2	129	134	96.3%	85%	Yes

In critical care services at St Mary's Hospital, the 85% target was met for both safeguarding training modules for which support to doctors and nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as at February 2019 for medical staff in critical care services at St Mary's Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults Level 2	11	11	100.0%	85%	Yes
Safeguarding Children Level 2	11	11	100.0%	85%	Yes

In critical care services at St Mary's Hospital, the 85% target was met for both safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as at February 2019 for doctors in training in critical care services at St Mary's Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults	24	25	96.0%	85%	Yes
Safeguarding Children Level 2	20	25	80.0%	85%	No

In critical care services at St Mary's Hospital, the 85% target was met for one of the two safeguarding training modules for which doctors in training were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust's guidance allowed patients aged 16 or 17 to be admitted into the ICU. The matron was responsible for taking the decision and the senior clinician told us the decision would be taken after reviewing each case independently. The guidance aimed to ensure that the young person

was admitted to the department which best met their needs and the process was detailed in a flow chart in the standard operating procedure. The procedure advised staff about environmental and young-person-centred needs e.g. activities and educational resources, with details of leads to contact within the children's services, both in, and out of hours. Data provided by the trust for 2018 indicated that no person of that age stayed at the hospital's ICU.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff mostly adhered to infection prevention and control practices and they kept equipment and the premises clean. They used control measures to prevent the spread of infection.

There were housekeeping staff responsible for cleaning all areas of the department and we found all areas were maintained to a good standard of cleanliness. Patients and relatives told us they were satisfied with the level of cleanliness in the department. Areas we visited were tidy, clean, and uncluttered.

We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. We noticed information explaining waste segregation procedures and waste segregation instructions.

There was sufficient access to hand gel dispensers, handwashing, and drying facilities. Hand washing basins had a sufficient supply of soap and paper towels. Services displayed signage prompting people to wash their hands and gave guidance on good hand washing practice. We saw staff adhering to good hand hygiene practice. Personal protective equipment such as disposable gloves and aprons were readily available in all areas.

We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. IPC standard operating procedures were accessible to all staff on the hospital intranet.

There was a sufficient number of negative pressure isolation rooms for isolation of patients with serious and infectious diseases. Staff reported that some of these rooms only had low pressure and were therefore not suitable for multi resistant infections; however, they still could be used for isolation and to provide accommodation to patients at their end of life. This issue was recorded on local risk register.

Infection prevention control (IPC) was part of mandatory training and trust records showed a compliance rate of 99% for nursing staff which was better than the trust target of 85%. The compliance rate for medical staff was 91% which met the trust target.

The trust target for MRSA (methicillin-resistant *Staphylococcus aureus*) screening compliance was 90% and overall the trust was meeting that target. Screening rate was monitored through the divisional governance processes and was reported through the directorate's 'harm free care' reports.

MRSA screening compliance (Aug 2018 to Jan 2019)

Ward	Site	Overall compliance
AICU	SMH	95%
Manvers ARU	SMH	93%

Between June 2018 and September 2018, 17 patients were identified with MRSA on the ICU. The trust informed us that 15 patients were confirmed as having the same typing which indicated a potential host and cross transmission within the unit. The trust had managed to identify a source of infection and eliminated it effectively. They organised audits which took place over four weeks and focused on handwashing and observing infection prevention and control practice. It was noted that consultants needed to follow the trust policy in relation to hand hygiene which was discussed at the consultants' meetings.

The trust contracted an external company to provide cleaning, patient dining, and portering services. They told us the performance of the contractor was inconsistent and they intervened regularly to maintain acceptable standards. Interventions involved penalties related to poor infection control and isolation practices by domestic staff. All domestics were re-trained and competency checked on infection control and isolation practices as a result. Senior leaders met with the contractor's representatives to ensure focus and commitment was maintained to improving standards.

The trust had a quality and contract monitoring team, which carried out spot check cleaning audits every 10 days. They told us that increase in monitoring highlighted the need for additional cleaning resources, which had been implemented. The provision of cleaning was included on the trust's risk register.

Cleaning audit results	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
MANVERS / ARU	87%	96%	92%	96%	95%	91%
ADULT INTENSIVE CARE UNIT	98%	98%	64%	86%	93%	93%

The trust introduced a new approach to hand hygiene in May 2018 to improve the quality of audit data and encourage improvement. It involved checking for compliance with the five moments for hand hygiene as recommended by the World Health Organisation. The results from hand hygiene audits in the critical care core service wards performed in May and November varied between 17% and 62%. Both units had been receiving focussed support to develop local improvement plans since the November 2018 audits.

Hand hygiene audit compliance results	May 2018	November 2018
ICU	40%	35%
Manvers Ward /ARU	62%	17%

Environment and equipment

The service had suitable premises and equipment and looked after them well.

The areas we visited were in a good state of repair. Staff felt the equipment used by them was relatively modern and well maintained. Equipment we checked had servicing and electrical safety stickers on indicating it was safe to use for the designated purpose. Critical care services were supported by technologists who managed the medical equipment and conducted maintenance. Routine maintenance was completed by the trust's estates department medical engineers.

In April 2018, the directorate launched an equipment training programme, in response to the updated trust's medical devices training policy. A training needs analysis was completed for various staff groups, in which appropriate specific items of equipment were identified. Equipment training was provided by unit technologists supported by the lead nurse for education. Equipment training for doctors was delivered during their induction.

The entrance to the intensive care unit had secure entry and buzzers to let visitors in. Medicines rooms were locked to prevent unauthorised entry. Linen cupboards and storage rooms were appropriately stocked and tidy. Resuscitation equipment stored on the resuscitation trolleys was readily available and easily accessible. The trust developed a system to ensure it was checked daily, fully stocked and ready for use.

The areas where care and treatment were provided looked spacious and had suitable facilities such as hand washing basins. However, the trust could not confirm that they fully met requirements of the suitable health building note (Critical care units: planning and design: HBN 04-02). Bed spaces were clear and uncluttered allowing free movement for staff around the clinical area. There were designated side rooms available for patients who had infection.

Oxygen tanks were stored securely and were in date. The consumable equipment sampled was in date and packaging was intact, indicating it was sterile and safe for use in patient care.

Assessing and responding to patient risk

Staff completed and updated risk assessments for patients. They undertook suitable checks to ensure safe practice was followed and staff new how to provide care and treatment should patients health deteriorate.

The service carried out a review of all patients on admission to establish if their needs would be suitably met by the department.

The division had a deteriorating patients group and issues related to management of deteriorating patients were discussed at the divisional board meeting.

The electronic patient records system used on the medical and surgical wards was designed to alert staff of the potential risk of sepsis based on readings. Hospital wards used a national early warning scoring system to identify deteriorating patients that needed input from the critical care outreach team. The escalation response was documented in the electronic patient record. The hospital was due to launch an upgraded version of the tool in March 2019 (NEWS2).

In May 2017, the trust launched an outreach and resuscitation service (OARS) The trust previously had two separate teams: outreach, and resuscitation. These were combined into the OARS team. Most of the posts within the team were offered to outreach practitioners with expert resuscitation skill. This aimed to improve effectiveness in response to cardiac arrest and to medical emergencies.

The OARS supported all aspects of the acutely and critically ill patient pathway including follow up of patients post discharge from ICU, responding to the needs of the deteriorating patient, facilitating timely admission to ICU, and providing on-going support to patients until their admission. They also provided training in the management of critically unwell patients, tracheostomy, non-invasive ventilation, and in resuscitation training.

The critical care outreach team operated a seven-day 8am to 8pm service. They collected data to identify which days and times ward staff needed their support the most, and what type of patients were referred to them. The majority of patients the team were involved with required post critical

care review (40%). At night the service was maintained by the site practitioners within the site management team. A formal written handover took place twice a day between the site team and the outreach team to inform them of any patients who needed follow up. The overnight escalation calls and bleeps were diverted to ensure the correct team responded. 24-hour outreach provision was being reviewed by the trust to detail the benefits and investment required for this provision.

The trust did not complete an audit of time it took for a new patient to be seen by a consultant following their admission. Consultant rotas were designed to ensure all patients received a review by a consultant within 12 hours of admission in line with national standards. There were two consultant led ward rounds a day and two handover rounds on the ICU. All potential admissions to the ICU were discussed with the consultant on duty so that a decision to admit and a care plan for the patient could be agreed and had a consultant's oversight. The consultant then reviewed each patient directly, once they arrived on the unit, either in the general ward round or an ad hoc review.

On the acute respiratory unit (ARU) all patients were reviewed by a consultant in respiratory medicine once a day. There were level 2 patients on the ARU, however, the intensivist did not review them twice daily. Physicians who specialized in the care of critically ill patient visited the ARU once a day to meet with the medical team there and discuss patients' treatment plans. This meant that the hospital did not meet core standards for intensive care units which specifies a consultant must see all patients under their care at least twice daily (including weekends and national holidays).

The ARU was set up to enable the safe admission and management of medical patients with respiratory failure resulting from a primary respiratory cause and those requiring specialist respiratory tracheostomy care. Patients requiring level 3 care and those requiring level 2 care for anything other than the respiratory system fell under ARU exclusion criteria and would be admitted to ICU.

The department had an escalation policy and procedure that was updated in late 2018 after the service reconfiguration. It clearly highlighted steps the directorate should take to respond to a surge in demand and process for identification of current and potential capacity. It was supported by the business continuity plans, which described the triggers and actions required to be undertaken by each unit during various levels of escalation.

The trust told us that within the directorate of critical care, 100% of staff undertook training in sepsis management. This was completed in three ways: junior nursing staff new to critical care attended the foundation to critical care programme which covered pathophysiology and sepsis 6 approach (involves three treatments and three tests, known as the sepsis 6). Sepsis approach was also taught on the course attended by any staff member progressing to more senior level (band 6). Sepsis was also included in the competency framework.

We saw that patients had venous thromboembolism (VTE) assessments completed and that these were reviewed in line with the trust policy. Between September 2018 to January 2019, 97% of patients on the intensive care unit had an assessment for venous thromboembolism (VTE). In the same period, 59% of patients on the acute respiratory unit had VTE assessments. It was below the target set by the trust of 95%.

Nurse staffing

At the time of the inspection there were enough staff on duty to meet the needs of the patients. Staff had the right qualifications, skills, training, and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust reported their staffing numbers below in critical care for Charing Cross Hospital, Hammersmith Hospital, and St Mary's Hospital as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
Charing Cross Hospital	109.8	106.4	96.9%
Hammersmith Hospital	152.1	132.3	87.0%
St Mary's Hospital	140.1	143.6	Over-established by 2.5%
Total	402.0	382.3	95.1%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 10.1% in critical care at St Mary's Hospital. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Senior leaders told us they carried out staffing review at the end of 2018. It was driven by the co-location changes within the department. The department had increased numbers of available ICU beds and staffing establishment by 14 posts. Senior nurses told us they successfully recruited to most of the available posts.

The outreach team developed a 'hybrid outreach and resus service'. From October 2017, the service started a seven day a week provision and started collecting activity data. There was a trust resus lead. The outreach team were developing key performance indicators to allow them to monitor quality of the service provision and more visibility about their activity data.

From November 2017 to October 2018, the trust reported a turnover rate of 6.2% in critical care at St Mary's Hospital. This was lower than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 3.6% in critical care services at St Mary's Hospital. This was slightly higher than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From October 2017 to September 2018, the trust reported 24,216 (11.8%) bank hours and 6,345 (3.1%) agency hours at the trust were filled by qualified nurses in critical care. There were 17,444 hours (8.5%) that were over-filled by bank/agency staff.

A ward breakdown is shown below:

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
DAAU HDU	35,019	9,107	26.0%	1,952	5.6%	3,572	10.2%
Intensive care (ICU)	169,557	15,109	8.9%	4,393	2.6%	Over-filled by 21,016	Over-filled by 12.4%
Total	204,576	24,216	11.8%	6,345	3.1%	Over-filled by 17,444	Over-filled by 8.5%

During the same period, the trust reported 6,979 (85.8%) bank hours and 97 (1.2%) agency hours were filled by nursing assistants in critical care. There were 5,502 hours that were over-filled by bank/agency staff.

A ward breakdown is shown below:

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Intensive care (ICU)	8,131	6,979	85.8%	97	1.2%	Over-filled by 5,502	Over-filled by 67.7%
Total	8,131	6,979	85.8%	97	1.2%	Over-filled by 5,502	Over-filled by 67.7%

The trust confirmed that the over-establishment reflects actual v planned for months where the actual was greater than the planned (i.e. over established due to provision of one to one support, enhanced care, etc.). The trust reported that the bank staff usage was attributed to vacancies.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

To achieve under 20% usage of bank and agency staff as guided by the intensive care standards the trust assessed their ICU workforce twice a day during cross site teleconference.

All nursing rotas were completed by a senior member of the team who had good knowledge and experience of the nursing workforce, to be able to ensure that staff rostered to each shift had an appropriate skill set. A senior nurse (band 7) was on duty for every shift with an exception where they were attending dedicated study days or in short term absence. The role then was covered by an experienced nurse (band 6). A matron also reviewed and approved the rota to ensure sufficient rota cover and appropriate skill mix. Safe staffing was monitored through the monthly senior nurses meeting when the department compared actual staff on duty against planned numbers.

The service was meeting the Guidelines for the Provision of Intensive Care Services, 2015 and level three patients were nursed at a ratio of one to one, level two patients were nursed at a ratio of one nurse to two patients. The duty rosters demonstrated this ratio was met.

The trust applied British Thoracic Society standards when reviewing nursing staffing levels on ARU. These were similar to ICU as the guidance stated that one to two nursing care should be provided for all patients treated with acute non-invasive ventilation (NVI) until NIV requirements reduce to nocturnal use only.

Nursing staff were regularly re-deployed to work on critical care units located on all three sites managed by the trust. Nursing staff are rotated if they wished to expand their learning and experience. Junior nurses were offered an 18-month rotation across the three adult ICUs, spending 6 months in each unit. All nursing staff who were taking the critical care course had a six-week rotation to another unit of their choice. Nurses were also required to respond to staffing shortfalls when required.

Nurses in charge participated in staffing conference calls at 5am and 5pm each day. They discussed staffing needs, patient acuity, and patient dependency across the directorate. If a nursing shortfall was identified, suitable staff were redeployed under the re-deployment of staff procedure. Staff working in the acute respiratory unit did not rotate across sites.

Medical staffing

There was sufficient number of doctors with the right qualifications, skills, training, and experience to keep people safe from avoidable harm and to provide the right care and treatment within critical care areas.

The trust has reported their staffing numbers below for Charing Cross Hospital, Hammersmith Hospital, and St Mary's Hospital as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
Charing Cross Hospital	32.7	32.1	98.2%
Hammersmith Hospital	18.0	18.0	100.0%
St Mary's Hospital	33.5	39.4	Over-established by 17.6%
Total	84.2	89.5	Over-established by 6.3%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 5.1% in critical care at St Mary's Hospital. This was lower than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 0.0% in critical care at St Mary's Hospital, compared to a trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 0.2% in critical care services at St Mary's Hospital. This was lower than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From November 2017 to October 2018, the trust reported no locum or agency hours available. However, 205 agency hours were filled in critical care. The trust was unable to confirm the number of locum or agency hours that were unfilled.

A breakdown of agency usage by ward is shown below:

Ward	Total hours available	Agency Usage
		Hrs
COS ITU CX	0	14
SM ITU Medical staff	0	191
Total	0	205

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

The trust told us that staffing requirements were calculated according to national guidance recommendations. There were two consultants on duty on each shift for the 32 beds within the ICU. They were supported by two core trainee doctors and further two specialist training doctors with at least one with appropriate emergency airway management training. The medical rotas were the responsibility of the allocated consultant lead. There was a process for addressing shortage in staffing levels where the leads would find appropriate cover and/or escalate to the directorate senior leadership. It would also be formally reported as an incident.

Medical staff did not rotate among the ICUs located on different sites managed by the trust apart from normal trust wide training rotations.

The consultant to patient ratio did not exceed a range between 1:8 - 1:15 and the ICU resident to patients ratio did not exceed 1:8. It was in line with the national guidance. The trust applied British Thoracic Society standards when reviewing medical staffing levels on ARU, these did not mention staffing ratio but referred to frequency of review and time to initial review.

All on-call consultants were available over the phone and available to attend within 30 minutes. Consultants were on site every day until 10 pm. The trust told us there were no incidents where consultants had not been available by phone or did not attend when required. The availability requirements of each consultant were set out within the job descriptions and included: a requirement to reside less than ten miles or half an hour from the main hospital during on-call duties, clinical duties that extended into the evenings, on-call duties as set out in duty rotas.

Records

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

An electronic patient records system was used at two out of three sites where the trust provided critical care services. Introduction of the system was delayed due to the lack of funds and prioritisation of integration plans at St Mary's hospital, which did operate the system. The nine electronic patient's records we reviewed were complete, detailed and reviewed regularly. They contained information on patient's allergies, any medical interventions that took place, and relevant social circumstances information.

Senior leaders recognised that mix of paper and electronic records and use of different systems across sites was a risk and it was on the divisional risk register. Clinical staff told us they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for patients.

Since the department had moved to an electronic patient record in April 2016, audits regarding the quality of the notes included in the electronic patient records were not undertaken. The trust told us internal reviews, such as ward accreditation, core service reviews, and peer reviews, looked at a sample of patient records. For example, a local end of life care audit that reviewed 80 records of patients who died in the hospital in 2016/2017 or audit of records related to nutritional support which took place monthly.

Medicines

The service followed best practice when prescribing, administering, and recording medicines. Patients received the right medicines at the right dose at the right time. The medicines were stored in accordance with published guidance.

Medicines were stored securely. Controlled drugs were stored in line with national guidance, and appropriate records were maintained.

Where patients were prescribed medicines that required additional monitoring, it was documented appropriately.

Staff had access to current version of the British National Formulary (BNF), a pharmaceutical reference book that contains information and advice on prescribing and pharmacology, along with specific facts and details about medicines available. They could also access the online version of the BNF.

The service used an electronic prescription and administration records system. The records were completed, and notes were made when any non-administration had taken place. The ICU used a different system for prescribing and administration (electronic system) to the remainder of the hospital. There was a system for the handover of information when a patient was discharged from the unit to ensure continuity of prescribing.

Anti-microbials were seen to be reviewed in line with the trust policy. The trust carried out bi-annual pharmacy antimicrobial point prevalence study (PPS). It was undertaken in February and August 2018 and provided data as to how the hospital performed in relation to key antimicrobial prescribing and safety indicators as advised by national guidance. The audit was also designed to act as a mechanism to identify areas for improvement. The audit of August 2018 indicated that within the critical care 93% of antimicrobials were reviewed in 72 hours, and over 90% were of a duration advised by the policy/ infection related guidance. Key actions identified within the study led to changes in the antibiotics prescribed due to a resistance strain. The team also organised three-weekly infection ward rounds on ICU during which the microbiology team and critical care pharmacy team were raising awareness of these indicators and the importance of documentation. The trust's antimicrobial review group and infection prevention and control team monitored overall antimicrobial consumption quarterly as part of the quality and innovation goal set out by commissioners of the service (CQUIN). The trust told us there were no indications of inappropriate antimicrobial usage.

Staff had access to emergency medicines and the emergency trolleys we inspected were regularly checked with all the drugs and oxygen cylinders in date and appropriate.

Incidents

Staff recognised incidents and reported them appropriately. The service managed patient safety incidents well. Managers investigated incidents and in most cases 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. We noted that in one case information about an incident was not shared appropriately to prevent future occurrences.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From November 2017 to October 2018, the trust reported no incidents classified as never events for critical care.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from January 2018 to December 2018.

Of these, the types of incident reported were:

- HCAI/Infection control incident meeting SI criteria with one (25.0% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (25.0% of total incidents).
- Pending review (a category must be selected before incident is closed) with one (25.0% of total incidents).

- Sub-optimal care of the deteriorating patient meeting SI criteria with one (25.0% of total incidents).

Site specific information can be found below:

- St Mary's Hospital: one incident (25.0% of total incidents).
(Source: Strategic Executive Information System (STEIS))

Serious incidents were discussed during various staff meetings and directorate audit days where overall trends were analysed and any follow up actions reviewed including the duty of candour requirement where any potential harm occurred. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were able to explain the duty of candour and were aware of their responsibilities regarding this duty.

Records related to serious incidents which took place at the time of the inspection indicated that staff ensured relatives were informed of the incident. This incident related to a safety alert issued by The Faculty of Intensive Care Medicine and the Intensive Care Society following a coroner's report issued in April 2018. The information was shared on the same day the incident took place. The family was offered support and explained their rights should they wish to complain or take part in the investigation process. Staff on the ICU who we spoke to on the day following the incident knew about it, potential contributory factors, and of immediate lessons which were to be learnt from it. The matron told us that generic information on the procedure and reminder of the safety alert had been shared via email with all staff who could perform similar procedure. However, staff on the ARU, where similar incidents could take place due to the nature of patients admitted to the unit, were not informed of it. Senior nurses told us informal debriefing meetings were organised around a week or two after a serious incident to allow for an appropriate reflection.

Consultants reviewed patient deaths in their service using the electronic mortality-screening tool (level 1 review), which allowed them to identifying patients who require further review either through their speciality mortality and morbidity forum (level 2 review) or an independent 'structured judgement review'. Consultants were also responsible for ensuring that any deficiencies in care, systems or process identified through the review were shared and escalated through the divisional structures. All patient deaths identified through level 1 review were reported to weekly medical director's incident review panel (MD panel). The panel decided whether it required investigation under the serious incidents framework. Critical care level 2 reviews were submitted monthly to the MD panel. Mortality review group, which met quarterly, received the divisional reports. It was responsible for overseeing the mortality review process and report on the themes emerging for institutional learning.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients, and visitors. Managers used this to improve the service.

The safety thermometer information was available in areas we inspected. There was a board that displayed information such as the last incidence of MRSA on the unit and last incidence of Clostridium difficile. The board also displayed the last incidence of pressure ulcers and last fall.

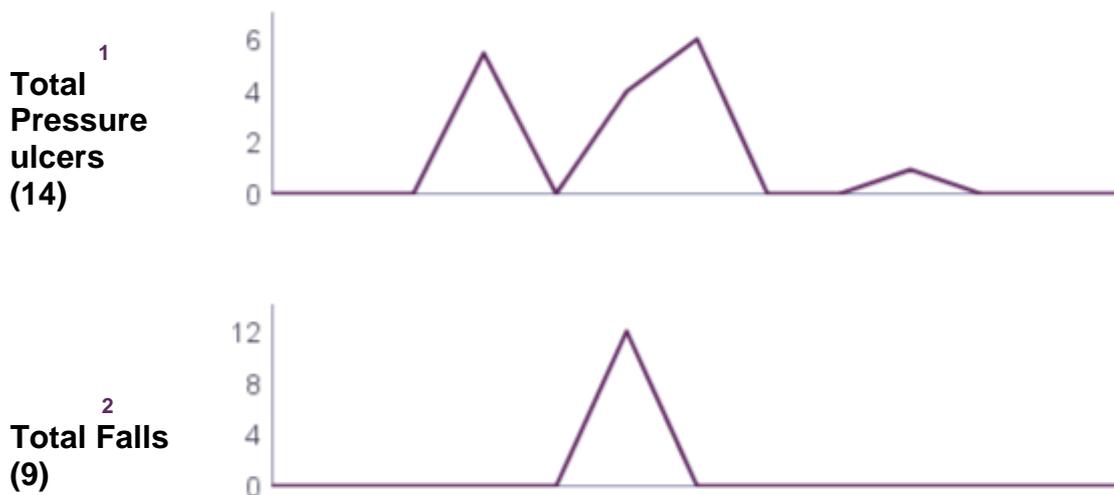
The safety thermometer is used to record the prevalence of patient harms and to provide

immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 14 new pressure ulcers, nine falls with harm and no new catheter urinary tract infections from November 2017 to November 2018.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Imperial College Healthcare NHS Trust



1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6

(Source: NHS Digital)

Between September 2018 to January 2019, 97% of patients on the intensive care unit had an assessment for venous thromboembolism (VTE). In the same period, 59% of patients on the acute respiratory unit had VTE assessments. It was below the target set by the trust of 95%.

From April 2018 to January 2019, between 60% (October 2018) and 100% (April 2018 and January 2019) of patients were screened for ventilator-associated pneumonia (average of 90%). In the same period, screening compliance for central vascular access for patients with central lines was 100% in nine out of 10 months. Screening compliance for peripheral vascular access for patients with central lines was 100% in eight out of 10 months.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and was able to provide evidence of its effectiveness. Senior leaders checked to make sure staff followed

guidance. Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

The pharmacy department undertook antibiotic use audits. They checked if charts indicated why the antibiotic was prescribed and if antibiotic use was compliant with a suitable guidance.

The trust's standard operating procedure for delivery of critical care followed guidelines for the provision of intensive care services and the National Institute for Health and Care Excellence (NICE) guideline on rehabilitation after critical care. It was updated after service reconfiguration which took place in 2018. The physiotherapy clinical lead and the quality improvement team were in the process of auditing compliance with the guideline after introduction of weekly proforma in February 2019. It was to check if physiotherapy assessment took place within 24 hours from admission as advised by the guidance.

ICU contributed data towards Intensive Care National Audit and Research Centre programme (ICNARC) they used quarterly reports for benchmarking their results and comparing clinical outcomes against other hospitals participating in the programme. They used those reports to identify any achievements and to prepare action plans to address areas of concerns.

The service used evidence based 'care bundles'. A care bundle is a set of evidenced based interventions that, when used together, can improve patient outcomes. They audited compliance with care bundles such as central line bundle, ventilator care bundle or peripheral access care bundle to ensure staff followed the best practice (over 90% of patients screened overall).

% of patients screened	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
VAP Bundle Compliance	100	89	95	95	81	92	60	96	95	100
Central Vascular Access Compliance	100	100	100	95	100	100	100	100	100	100
Peripheral Vascular Access Compliance	100	100	100	100	96	91	100	100	100	100

The department reviewed its compliance with national guidelines during clinical audit days. This included reviewing compliance with guidance related to: nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition, organ donation for transplantation, intravenous fluid therapies, delirium in adults, antimicrobial stewardship, venous thromboembolism, or rehabilitation after critical illness.

The department engaged with the North-West London critical care network and coordinated their critical care service delivery with the network. For example, to inform the development of their business continuity plans and response in situations when there is limited critical care beds capacity under conditions of system stress (e.g. winter, pandemic, or major incident). This cooperation enabled units under unusual stress to be instantly visible and to trigger mutual aid, for example through neighbouring units stopping elective activity or opening reserve beds. The hospital participated in the networks peer review programme, they had not been assessed by their peers since July 2016.

National guidance related to rehabilitation after critical illness recommends that following hospital discharge, follow-up is needed for adults who were in critical care for more than four days and at

risk of morbidity. This is to address further needs which may become apparent after discharge. A review to reassess health and social care needs two to three months after discharge from critical care ensures that any new physical or non-physical problems are identified and further support is arranged as needed. The guidance also recommends that patients have their rehabilitation goals agreed within four days of admission to critical care or before discharge from critical care, whichever is sooner. At St Mary's hospital there was no structured approach to organising follow up clinics. There was a limited clinic which is run by one consultant. The trust informed us that they did not review all patients after discharge from critical care as recommended.

A critical care guidelines group, a multidisciplinary team led by education senior nurse practitioner met monthly. It was tasked with reviewing new guidelines and policies and ensure these were consulted within the directorate and ratified by the divisional board. The membership of the group included medical and nursing staff from each site. The group was also responsible for making sure policies were reviewed regularly. Some of the policies implemented by the group related to: insulin infusions, traumatic brain injury, targeted temperature management, citrate anticoagulation for continuous veno-venous hemofiltration (CVVH), and sedation guideline amongst others.

A tracheostomy task and finish group was created and tasked with implementation of the national tracheostomy guidance and its review when it was due for updating.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Patients we spoke with were satisfied with the drinks they were offered. We saw fluids were available to patients and within their reach. Patients and their relatives could access snacks, or hot drinks. Patients we spoke to said they were offered enough to eat and drink and were happy with the variety of food offered.

The dietetics service had a specific allocation to critical care beds with two whole time equivalent (WTE) allocated to ICU and 0.4 WTE to ARU. All level 3 patients were provided with a routine dietitian support and level 2 patients required individual referrals. The service managed and maintained nutritional requirements of all patients referred via alternative nutrition support primarily i.e. enteral tube feeding and parenteral feeding.

Speech and language therapy (SaLT) service was a referral based service. Referrals for swallowing assessment and management were prioritised over referrals for SaLT input to communication support.

ICU feeding guidelines had out of hours feeding regimes standardised and available to all staff. Staff had access to guidance such as these related to confirmation of position of nasogastric feeding tubes.

Nutritional support was audited monthly with a use of bespoke audit tool created jointly with specialty dietitians. It aimed to ensure staff captured data appropriate to critically ill patients. This data was fed into the trust performance report, which was reviewed monthly by matrons and the divisional director of nursing or their deputy. Staff checked: if patients had gastrointestinal nursing care plan completed on admission and then reviewed daily; if their weight was taken and recorded; if nutrition support was started within 48 hours from admission; and if the correct feeding plan was followed. Staff also reviewed if food and fluid intake was recorded, for those patients who could eat and drink, and if reason for stopping parenteral nutritional support was recorded in

patient's notes. Overall the audit indicated good compliance with the expected standard and food and nutritional support guidance.

Pain relief

Staff assessed and monitored patients regularly and checked if they were in pain. They supported those unable to communicate using assessment tools and gave additional pain relief to ease pain.

The department used a critical care pain observation tool for patients unable to verbalise their pain.

The pain service led an epidural compliance audit in August and October 2018. It checked if epidural infusions were managed safely and as guided by professional guidance. The audit in August found critical care areas were not always consistent when labelling epidural infusions and compliant with the trust guideline. Epidural lines did not always have appropriate label on them. Trust's guidelines stated two epidural labels should be used, one at the epidural filter of the epidural line and another on the epidural giving set. A yellow epidural giving set was used for every epidural and a smart pump, pre-programmed for epidural use, was used for all epidurals. All epidural opioid Infusion bags were clearly marked 'for epidural use only' and all were in date. Not all critical care areas were compliant with the guidance for the storage of epidural infusions containing opioid, however, the anaesthetic infusion bags were always stored away from other intravenous fluids. Staff used only ready-made bags to reduce the need for complex calculations and mistakes in preparations. The department prepared an action plan in response to the findings and re-audited in October 2018 where they noted improvements in adherence to guidance on storage and labelling.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The trust has three units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered, and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

For St Mary's Hospital the risk adjusted hospital mortality ratio was 1.0 in 2016/17. This was within expected range. The figure in the 2015/16 annual report was 1.0.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
478 admissions	Risk-adjusted hospital mortality ratio (all patients)	1.0	1.0	1.0	none	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

For St Mary's Hospital the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.4. This was within expected limits. The figure in the 2015/16 annual report was 0.8.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
288 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	0.8	1.4	1.0	none	Within expected limits

We received updated ICNARC results from April 2018 to September 2018 which showed that the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than xx% was 0.xx. This was within expected limits

The outreach and resuscitation team contributed to the cardiac arrest audit. The service responded to approximately 50% more cardiac arrest cases in 2018/2019 compared to 2017/2018. The rise in referrals was partially attributed to acuity of deteriorating patients that were not suitable for level 3 care but whom remained for active management on the ward. Prior to the reallocation of ICU this group of patients would have been cared for with enhanced monitoring or within HDU areas on specialty wards. The rise in referrals was also attributed to increased presence of the team and implementation of the seven-day service in October 2017.

The trust participated in organ donation and reported to the NHS Blood and Transplant national potential donor audit. The trust referred 104 potential organ donors during 2017/18. There were 12 occasions where potential organ donors were not referred. When compared with UK performance, the trust was average (bronze) for referral of potential organs. Audits showed a specialist nurse for organ donation was present for 65 organ donation discussions with families during 2017/18. There were four occasions where the specialist nurse was not present. When compared with UK performance, the trust was average (bronze) for specialist nurse for organ donation presence when approaching families to discuss organ donation.

Competent staff

The service made sure staff were competent for their roles. Managers appraised most of the staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

From November 2017 to November 2018, 91.1% of required staff within the critical care department at St Mary's Hospital received an appraisal compared to the trust target of 95%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met? (Yes/No)
Qualified healthcare scientists	1	1	100.0%	Yes

Qualified nursing and health visiting staff	4	4	100.0%	Yes
Qualified allied health professionals	1	1	100.0%	Yes
Support to doctors and nursing staff	146	137	93.8%	No
NHS Infrastructure support	5	0	0.0%	No
Total	157	143	91.1%	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

In April 2018 the directorate launched an equipment training programme, in response to the updated trust's medical devices training policy. A training needs analysis was completed with various staff groups, in which appropriate specific items of equipment were identified. The nursing workforce receive face to face twice a year equipment training. Equipment was rated as high, medium, and low risk. Medical devices which fell within the 'high risk' category, required face to face training, three yearly. The 'medium risk' category equipment required face to face training once. Equipment training compliance rate for ICU at SMH reported by the trust was 48%. The trust told us that training was on-going and this percentage was on an upward trajectory. There were no serious incidents related to medical devices and equipment training. Equipment training was delivered to doctors during their Induction as an hour training session. It which covered the main items of equipment used at the ICU. Use of all medical devices was informally taught to nurses during the new starter six-week supernumerary period and supported in competencies in the competency framework. The trust told us between 30% to 50% of the workforce on duty were fully trained. Matrons told us they were aware of who completed which training and used this information when planning rotas. Equipment training was provided by unit technologists supported by the lead nurse for education. Equipment training for doctors was delivered during their Induction.

Non-invasive ventilation and tracheostomy training days were held at the trust by the critical care outreach and resuscitation team. Junior doctors also joined the rolling programme for NIV training. The respiratory medical team held regular educational meetings where they covered the key elements of respiratory medicine.

The trust's standard for nurses working in epidural areas was that 75% qualified nurses should be trained and obtain their epidural competency. In critical care areas, as there was a senior nurse always on duty, the standard was that 95% senior nurses complete the epidural competency and they can assess their teams. Training consisted of attending the epidural study day and passing the written test, a period of supervised practice in their ward area, and assessment by an approved assessor. Due to the high turnover of nursing staff in some areas, the trust was not able to achieve suitable competency levels. In October 2018, the competency was at 10% amongst junior nurses and 100% amongst senior nurses within the critical care areas at the hospital. All nurses attended an epidural study day. In some areas completing the epidural competency was difficult if a small number of patients received epidural therapy. Members of the pain service met with the clinical educators to facilitate improvement in completeness of epidural competencies, especially in areas with a high turnover of staff.

Adult nursing students were placed across adult services within the hospital, including critical care. Their placement was managed and supported by a team of practice education facilitators who ensured students were supervised and assessed by staff in the service areas and in promoting effective learning environments. The team also support nursing staff to be able to meet their professional college requirements for learning and assessment in practice in the clinical areas and by delivering annual updates.

There were no national competencies for critical care outreach and training was developed in house. The critical care outreach team (CCOT) completed a twelve-week competency period, during which time specific competencies were completed in several areas such as tracheostomy care and non-invasive ventilation. The 12-week course was built around improving assessment skills, response to emergency scenarios and use equipment. They were also sent to the other trust sites to learn about them; one day at each site. They were part of the London North West Critical Care Network. The critical care outreach team were all trained in advanced life support. They carried out training with staff for basic life support sessions, which included an assessment module, to enable staff to better stabilise the patient.

The intensive care unit at Charing Cross Hospital had a bespoke simulation suite available to staff cross site where simulation teaching sessions could be held. Nursing teams on their team days had sessions in the simulation suite focusing on learning from specific incidents or covering scenarios that the unit did not deal with often such as chest drains. All teams undertook airway simulation sessions every two years.

Junior doctors felt there were lots of good learning opportunities. They received a basic course on their first two days which included an introduction to intensive care medicines and ventilators. Junior doctors also attended case meetings and teaching sessions every other week. They were supported by the critical care lead consultant.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses, and other healthcare professionals supported each other to provide good care.

Care planning took place at multidisciplinary team meetings where there was involvement from all members of the team including doctors, nurses and allied healthcare professionals. Staff reported good multidisciplinary working with other services within the trust and with external organisations when appropriate. We observed a good culture in multidisciplinary working and a good team ethos.

The trust had a critical care delivery group which was responsible for ensuring a trust wide multidisciplinary approach to critical care and supporting the organisation's strategic direction. Membership of the group was extended to neurology, vascular, and trauma specialist services leads from different sites. Emergency department, outreach and pharmacy were also represented during the group's quarterly meetings.

The physiotherapy team members attended handovers and ward rounds where the weaning of patients was discussed. Team members fed into discussions as to the need for a tracheostomy and they took a lead on the weaning process and provided a detailed weaning chart for the nursing staff to follow.

A senior member of the physiotherapy team attended morning ward rounds and was involved in the weaning of long-term patients from mechanical ventilation. They also provided patient specific rehabilitation. They aimed to offer rehabilitation sessions three days a week, and provide additional input engaging a multidisciplinary approach to rehabilitation. Senior clinical physiotherapy lead oversaw the service delivery across the trust's three sites.

Occupational therapy team's service was referral based. Nurses at the ICU told us it was a responsive service and it had capacity to provide support to critical care patients when it was requested.

Speech and language therapy service prioritisation cases for initial assessments and follow up management. They carried out 'nutrition rounds' during weekdays. The therapists were present during tracheostomy rounds and supported training and competency development and provision across the hospital. It included delivering training sessions on tracheostomy management and swallowing techniques

A team of five critical care dedicated pharmacists provided clinical pharmacy support Monday to Friday.

Seven-day services

There was always suitable provision of services to ensure care and treatment delivery and supporting achievement of the best outcomes for patients. However, the critical care outreach team did not provide service at night.

All on-call consultants were available over the phone and available to attend within 30 minutes. Consultants were on site every day until 10 pm.

The physiotherapy team provided Monday to Friday 8.30am to 4.30pm service for respiratory interventions and rehabilitation to patients within the critical care. There was a physiotherapist available on site who provided weekend cover, with an additional person rostered as on-call; to be called if the caseload required. This service was only for patients who required emergency respiratory intervention or those who would acutely deteriorate without on-going intervention. There was an overnight on-call service for those who needed emergency respiratory intervention.

The occupational therapy service provided a Monday to Friday service 8.30am to 4.30pm and was a referral-based service.

Dietitians provided a Monday to Friday service from 7.30am to 6.00pm.

Speech and language therapy service was a referral based it operated Monday to Friday 8.30am to 5.30pm.

The pharmacy team provided daily support. They were available Monday to Friday 9am to 6.30pm. Outside of these hours there were out-of-hours arrangements. During weekends the pharmacy department was open for five hours and on Bank Holidays hours varied (minimum of two hours service was available). The trust had a pharmacist present on site 24 hours a day, seven days a week. This pharmacist was based on the Charing Cross site after midnight to 8am and provided a 'residential on-call' service.

The outreach service started a seven day a week provision in October 2017. They offered 8am to 8pm service and were not available during the night. Night support to patients deteriorating on hospital's inpatients wards was provided by the site team.

Health promotion

Health promotion information on the intensive care unit was limited.

Follow up clinics did not take place regularly. This meant that the service did not utilise opportunities for ongoing assessment and providing advice on rehabilitation and health promotion.

Trust leaflets were available, giving information on a number of health-related subjects such as delirium, deep vein thrombosis, non-invasive ventilation, complaint.

Consent, Mental Capacity Act, and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

The mandatory consent training module provided by the trust included the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Training rates for the module indicated all medical staff completed the training and the nursing staff's completion rate was at 98%.

Not all staff we spoke with had a good knowledge of MCA and DoLS, but they were aware of how to get assistance with cases when required.

Patients we spoke to told us they had been given clear information about the benefits and risks of their treatment in a way they could understand. They were given enough time to ask questions if they were not clear about any aspect of their treatment. We observed staff obtaining informal consent and explaining procedures to patients and carers. Patient records we reviewed demonstrated consent was sought and clearly recorded in the patients' notes.

We did not identify any patients being treated under DoLS within the critical care environment at the time of the inspection.

Is the service caring?

Compassionate care

Patients were treated and cared for with compassion, respect, and dignity.

Patients' dignity was protected, and staff were caring in their attitudes. Patients were made to feel at ease and the environment was quiet and calm.

Patients we spoke to were very positive about the care they received and said staff had time to provide compassionate care. They said, "staff always introduce themselves", "they [nurses] are always here when needed" and that they could observe "good care being provided" to other patients.

Throughout our inspection, we witnessed good staff interaction with patients. We observed how the nurses and doctors assisted patients, with compassion and skilled care.

The service had a patient experience questionnaire which asked questions around privacy and dignity, visiting times, noise at night, pain management and whether patients had ample opportunity to speak to doctors and have procedures explained to them. Overall results trust wide between February 2018 and January 2019 were positive with 75.7% of patients reporting an 'excellent' experience and 21.6% reporting a 'good' experience of critical care. On the Charing Cross site, overall patient satisfaction in the same period showed 86% of patients were satisfied with their experience on the intensive care unit. 88.3% of patients were satisfied with their experience on the acute respiratory unit. At the St Mary's Hospital's ICU 89% of patients responded that they were satisfied with their experience within the unit.

Emotional support

Staff understood the impact of patients care, treatment or condition to their wellbeing and those close to them. Patient we spoke to told us they felt staff were concerned not just about their clinical condition but also about their emotional, and social needs.

The National Institute for Health and Clinical Excellence (NICE) has recommended that services should be developed to meet the psychological care needs of patients following critical illness. The service offered structured psychological support to all trauma patients, however, there was no designated psychological service to meet needs of all critical care patients.

Patients who were sedated for some time while they were mechanically ventilated, after their discharge from critical care often report having gaps in their memory. This is direct cause of their illness. Patients diaries are often introduced to help fill this memory gap and help patients to understand what happened during their stay in critical care. They help to support patient's emotional needs in the period of recovery and rehabilitation. This diary is written for a patient by staff, particularly nurses and family members and friends. The department did not use diaries and relied on verbal communication to recollect their time at the ICU.

Spiritual support was offered by multi-faith chaplains which staff could request for patients and relatives. The chaplaincy team provided an emergency service for end of life situations or for people who were experiencing extreme distress. Volunteers who visited the unit, talked with patients and visitors and provided information on chaplaincy services.

Understanding and involvement of patients and those close to them

Patients and those close to them were treated as active partners in the planning and delivering of their care and treatment. Patients were giving appropriate information and encouraged to make decisions about their care and treatment.

Patients told us staff were patient, very thorough and answered all their questions. We observed that patients were given information on their condition and who they could ask questions; they knew the name of the staff supporting them throughout the day. Doctors and nurses actively involved the patient in their conversation.

Patients' relatives told us they had been involved in their relatives care and had been given regular updates. Records indicated discussions involved relatives and patients. Staff communicating with patients and relatives in ways they could understand avoided medical jargon and gave them opportunity to ask questions. Relatives confirmed that everything was explained to them in a way they could understand and that they felt confident to challenge staff if needed.

The team was supported by a specialist nurse for organ donation when a conversation with relatives about potential organ donation was needed. The palliative care team were also called upon for sensitive conversations with patients or relatives.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and delivered care in a way that reflected the needs of the population of patients who accessed the service to ensure continuity of care. Patients' needs, and

preferences were considered and acted on to ensure services were delivered to meet those needs.

Critical care services at St Mary's Hospital were provided in two hospital areas. One was the intensive care unit (ICU) and the other was the acute respiratory unit (ARU) which provides non-invasive respiratory support. The intensive care unit consisted of 32 beds where level 2 and level 3 care was provided. The ARU had 8 beds available to level 2 patients.

The critical care service also included a critical care outreach team who supported patients in other areas of the hospital. The team was led by specialist nurses. Visiting times were flexible and staff could accommodate patients' needs based on their individual needs. There were two sitting rooms that could be used by relatives or to have a sensitive conversation in. If patient was placed in a single occupancy room relatives could stay overnight, should patient require their emotional support

There was sufficient number of single accommodation rooms within the ICU available to patients who needed them most, such as those at their end of life. Within the ARU four rooms were shared with the respiratory medicine ward which the service was collocated within.

There was clear signage indicating where services and individual wards were located. Staff were readily available to help provide directions if needed.

Due to delayed discharges, there were frequent mixed sex breaches on the unit for patients awaiting discharge to a ward bed. The trust report 572 breaches across the critical care areas from October 2017 to November 2018. The unit was monitoring these breaches, and this was captured on the risk register, staff also reported each occurrence as an incident. The trust did not report any mixed sex accommodation breaches for the acute respiratory unit where there were designated single sex multi occupancy rooms. Shower and toilet facilities were available on both the acute respiratory unit and the intensive care unit.

The trust had Wi-Fi for public use. Relatives and patients were able to purchase food on site and had access to variety of catering services locally.

There was a chapel and a quiet room for reflection located on hospital ground accessible to relatives. The multi-faith chaplaincy service was available at any time to support patients and relatives.

Meeting people's individual needs

The needs and preferences of patients were considered when delivering and coordinating services, including those who were in vulnerable circumstances or had complex needs. Care and treatment was coordinated with other services and stakeholders, to ensure the needs of patients and their families were met.

There was a vulnerability and inclusion officer who also acted as the learning disability liaison within the hospital and staff told us they would contact them to seek advice in relation to supporting patients with learning disabilities. ICU had link staff that had special interest in developing expertise in the subject of learning disabilities. They advised others on how to adjust care and treatment delivery or who to contact should support be required.

Dementia training was not deemed as 'core' training for critical care staff by the trust. The trust told us some dementia related information was included in the trust's induction programme. In addition, all junior trainee doctors were provided with the dementia awareness training (foundation year 1 and 2). At the St Mary's Hospital 70% of nursing completed dementia awareness training,

however, none of the 36 senior medical staff had attended it. The critical care service was at the process of launching a new confusion assessment method tool for intensive care units to improve assessment of patients with delirium. This was a standardized evidence-based tool that enabled non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately within the clinical setting.

The department did not undertake environmental assessments to assess if the environment was responsive to needs of people with visual or hearing impairment.

The department accommodated to cultural needs of the local population. For example, they had wide variety of culturally diverse food choices for patients presented in a form of a visual menu.

There were toilets that were accessible to people with mobility difficulties and nappy changing facilities for parents with children within the hospital.

Patients who were identified to be at the end of their life had their needs assessed and were supported by the palliative care team who could be called upon at any time.

Patients had access to the chaplain and could receive spiritual support on request. The chaplain service covered the Anglican, Catholic, Free Church, Jewish and Muslim faiths. Representatives of other faiths could be contacted as the chaplain service had established links with members of other faith communities.

Staff were aware of how to access specialist equipment, such as equipment to support bariatric patients, and were aware of limitations of the equipment available within the unit. They said that the specialist equipment was accessed promptly and was fit for purpose.

The national guidance related to rehabilitation after critical illness recommends that following hospital discharge, follow-up is needed for adults who were in critical care for more than four days and at risk of morbidity. At St Mary's hospital there was no structured approach to organising follow up clinics. The trust informed us that they did not review all patients after discharge from critical care as recommended. The trust's internal audit indicated there was inconsistency in documentation of patient's goals. Less than 10% of patients had their needs assessed and goals formulated within four days of admission to critical care. The trust planned to provide a follow-up clinic for all patients who were admitted to critical care for more than 4 days and at risk of ongoing problems by end of March 2019.

Interpreter services were available for patients whose first language was not English and staff knew how to access them.

Access and flow

From November 2018 to October 2018, Imperial College Healthcare NHS Trust has seen adult bed occupancy about the same as or slightly higher than the England averages for 10 months out of the 12-month period. In the latest period, October 2018, performance for adult bed occupancy was 84.6%, compared to the England average of 80.8%.

Adult critical care Bed occupancy rates, Imperial College Healthcare NHS Trust.



Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

For St Mary's Hospital there were 5,840 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 6.3%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 8.8%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
5,840 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	8.8%	6.3%	4.9%	0%	Not in the worst 5% of units

(Source: Intensive Care National Audit Research Centre (ICNARC))

For St Mary's Hospital there were 512 admissions, of which 1.8% had a non-clinical transfer out of the unit. This was within expected range. The figure in the 2015/16 annual report was 0.2%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
512 admissions	Crude non-clinical transfers	0.2%	1.8%	0.4%	0%	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

For St Mary's Hospital 2.9% of admissions were non-delayed out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within expected range. The figure in the 2015/16 annual report was 5.4%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
173 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	5.4%	2.9%	1.9%	0%	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

Critical care leads attended bed meetings which helped ensure better patient flow from ICU. However, the trust reported there were still occasional cancellations of elective surgery due to the lack of ICU beds available (mainly on another trust's site). In addition, there were daily teleconference calls between ICU departments on all three sites to discuss staffing and acuity on each site.

From April 2018 to January 2019 there were 10, out of 1039, patients ventilated outside of the critical care areas. Four of them at the emergency department, one in the recovery area, and further five in theatres following surgical procedure. These patients waited between four to 11 hours to be admitted to the ICU.

Out of hours bed moves and transfers data was collected and could be extracted from the electronic patient record, but the reason for the move was not recorded and it was not used as a performance indicator by the trust. The trust was unable to identify bed moves and transfers which occurred for non-clinical reasons.

The leadership team attended a trust wide flow group meeting on a weekly basis which was a hospital wide group looking at how to prevent delayed discharges from the unit to the ward. Delayed discharge data was reported monthly to the divisional quality and safety meeting

Learning from complaints and concerns

There were processes in place to ensure complaints were dealt with effectively.

From November 2017 to October 2018, there were 10 complaints about critical care, with nine of these closed. The trust took an average of 33 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed in an average of 40 working days.

- St Mary's Hospital: There were two complaints, relating to values and behaviours and patient care.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From November 2017 to October 2018 there were no compliments within critical care at St Mary's Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The trust told us that none of the patients' complaints related to critical care at St Mary's Hospital were referred to the Parliamentary Health Service Ombudsman in 2018.

Complaints initially were handled by senior member of staff. They spoke directly with patients and relatives to resolve the issue at a local level. If patients or relatives were not satisfied with the response, they were directed to take the Patient Advice and Liaison Service (PALS). Leaflets about the PALS office were available on the ICU and ARU.

Formal complaints were discussed at the directorate quality and safety meeting as well as senior nurses' meetings with any learning was disseminated to staff through team meetings.

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

Critical care services were managed by the critical care directorate which was part of the surgery, cancer and cardiovascular sciences division. As part of trust reconfiguration, critical care services became a standalone directorate in 2016. The critical care directorate leadership team consisted of a clinical director, general manager and senior nurse who managed the trust's critical care services across the three sites: Charing Cross Hospital, St Mary's Hospital and Hammersmith Hospital. Site leadership was managed by a lead consultant / head of speciality, lead nurse and outreach and resuscitation lead.

Acute respiratory unit (ARU), which also provided level 2 care and treatment, was managed within the division of medicine and integrated care, and belonged to the integrated medicine directorate. ARU had similar senior management structure.

It was noted during directorate meetings that staff occasionally were not clear who they should go to when immediate line manager was not available. Not everyone knew how to contact directorate or divisional leads. The lead nurses agreed to put a list of contacts on each unit so that it was clear where to go for advice.

The local leadership team were experienced and demonstrated a good understanding of the performance challenges and risks within the critical care services. Ward managers and senior nurses we spoke to had good knowledge of their staff, the hospital, and its systems.

Staff spoke positively about the service they delivered as a team and about the directorate leadership teams.

Department's staff did not share with us any negative comments about their senior or local management teams. Divisional and ICU level management appeared experienced, competent and knowledgeable.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The service was in a process of developing their strategy. This was driven by the trust's vision of providing high quality care, maintaining a high research profile, and delivering high quality general and specialist services. They were also aiming to attract competent and motivated staff to individual teams and develop new roles such as nurse practitioners and advanced critical care practitioners. They had a workforce steering group that focused on these developments.

The directorate's clinical strategy supported staff with "leading a co-ordinated and responsive critical care service for all trust patients". It talked about "a world leading service that maintains excellent quality care, is responsive to patient needs, attracts staff worldwide and maintains leading research performance". To deliver this strategy the directorate focused on: further development of the outreach model across all sites; reconfiguration of high dependency services across the trust to bring them under the management of the critical care directorate; integration of

all ICU services under one directorate; and investing in intensive care medicine fellowship scheme to develop trust grade doctors.

The trust was in a process of exploring themes and concepts around their vision, values, and behaviours. They told us they involved around 2000 of their workforce in its development. This work was designed to develop organisational strategy and to define future priorities.

Culture

Managers across the department promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We attended numerous meetings during our inspection and observed many staff interactions; staff demonstrated respect for each other and acted as a team. None of the staff had mentioned any concerns about patients' safety. Staff we spoke with had good knowledge of whistle blowing procedures.

Staff told us they enjoyed working at the hospital and felt supported in their roles. They were happy working for the trust and felt well supported in their development.

Incident reporting culture was strong and feedback was provided to staff that reported incidents.

Staff were proud of their work. They felt they "did not have an ICU footprint" in the trust prior service reconfiguration in 2016 but it had improved since they established the critical care directorate. Senior staff told us it helped to lift the profile for critical care at the trust board level.

Staff told us that they were occasionally faced by aggression from patients or relatives. They had access to body cameras in situations when potential issues were identified and informed patients/relatives that these could be used should there be a need. The trust told us it had been a deterrent, so they had not needed to be turned on. The department had also introduced personal alarms for staff. The department organised weekly wellbeing meetings, which included counsellor, where staff could discuss any issues affecting their well-being or culture at workplace.

Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Critical care services were managed, and governance structures were aligned within the trust wide division of surgery, cancer, and cardiovascular division. Critical care formed its own clinical cross site directorate within that division. The division was managed by a divisional director supported by divisional director of nursing and a divisional director of operations. ARU was managed within the division of medicine and integrated care and belonged to the integrated medicine directorate. ARU had similar senior management structure. Finance and human resources business partners were allocated to, and supported, each of the divisions.

All deaths were reviewed in the ICU and post discharge with mortality and morbidity meetings organised every two weeks.

A senior management meeting and a senior nurse meeting for nurses at band 7 and above were organised monthly.

The trust had a critical care delivery group established in accordance with national guidance and chaired by divisional director or divisional director of nursing. The group oversaw the trust wide development and performance of critical care services. The group was responsible for providing advice to the executive board on any issues affecting services for acutely ill patients and ensure a robust clinical governance process for acutely ill patients. Quarterly reports from group's meeting were submitted to divisional committee meeting, then to executive quality meeting.

Critical care directorate meeting was organised bi-monthly. There was a standard agenda which covered; clinical performance, financial performance, staffing issues, quality and safety, research and education, and strategic developments. It was attended by senior divisional leaders and arranged on different site each time it took place.

A critical care clinical guidelines group was held monthly and was attended by the clinical director, senior nurse and cross site clinical education teams. The group looked at clinical guidelines that had reached their review dates and discussed topics for audit post implementation.

Respiratory governance meetings for the acute respiratory unit were provided through the medicine directorate and took place every three months. These meetings were open to all staff involved with the unit and included clinical updates, presentations of audits and quality improvement projects, discussion of incidents and a morbidity and mortality session.

Management of risk, issues, and performance

The department had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There were allocated staff to gather and review data collected by the department. The data helped senior leaders to monitor performance and benchmark it against other trust's sites and other health providers.

There were regular meetings where risk, issues and performance reports were monitored and managed. We reviewed the minutes of the quality and safety meetings and senior nurses' meetings and saw evidence of monitoring and management of risk.

The service had a local risk register which was updated regularly. The risks highlighted on the risk register were current and controls had been put in place to minimise it.

Divisional leads told us that their top risks included:

- Staffing – sickness, turnover, consultant numbers, recruitment and retention.
- Electronic patient records system – lack of availability on all sites
- Violence and aggression; at St Mary's Hospital site which was linked to some of the trauma cases.
- Meeting in full guidelines for the provision of intensive care services– ensuring that all times they are met.
- Provision of tracheostomy services outside of ICU – outreach service maintained main responsibility in delivering the service and there is an operating procedure staff followed.
- Maintain good patient flow – delays in discharging to wards once patients medically fit. This was also linked to increase in emergency department's attendances.

Senior members of the critical care team were aware of directorate's financial performance. The trust told us that some funding for the directorate was not transferred and the budget needed to be

reviewed to mirror changes introduced to the service delivery in 2018. The department was planning to deliver a 5% cost improvement in 2018/2019.

The directorate undertook strength and weaknesses analyses in March 2018 to understand potential service development opportunities, inform business planning and any other developments within the directorate. They assessed that they provided high quality care with good clinical outcomes had motivated and engaged work force and top performing research centre. They recognised risks and areas for development related to delayed discharges, follow up clinics, lack of 24/7 provision of critical care outreach service and variability in use of electronic patient record systems amongst some other issues.

Information management

The department collected, analysed, managed, and used information well to support all its activities, using secure electronic systems with security safeguards.

We were not made aware of any data security breaches that occurred at the hospital within the past 12 months prior the inspection.

Access to individual patient's records was restricted to authorised staff who had varied access rights and editing privileges granted in accordance with their job role. Electronic patient's records were stored in line with data security standards and entries made in patient's records could be easily ascertained to person creating them.

When required the department submitted reports through available systems such as the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS) promptly to support shared learning and to share information with external bodies.

The department used information available through performance reports and local audits to inform and improve service planning. This was easily available and easy to understand for staff involved in care and treatment delivery, the information was also timely and relevant.

Staff had sufficient access to IT devices to allow them to access records and perform they job effectively.

Information governance formed part of mandatory training for nursing and medical staff. Compliance levels for nursing staff was 94% which was better than the trust target of 85%. Compliance levels for medical staff was 82% and 84% amongst doctors in training, which was slightly below the trust target of 85%.

Engagement

The department engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The department used a patient experience questionnaire as part of patients' engagement strategy. They aimed to gain feedback from 10% of patients. Compliance was monitored through submission of this data to the North-West London critical care network. Staff told us about some initiatives where they responded to patient's feedback, for example in relation to noisy environment at night. They introduced a noise level monitoring device to reduce noise and help staff to control the environment. A directorate wide visitors standard operating procedure was developed to unify practice across trust's sites and provide clarity related to visiting for visitors.

The department did not have structured approach to organising follow up clinics for all patients which could provide them with better insights to patients experience and engage with patients post discharge from critical care.

The trust used a variety of methods to engage their staff including sending email newsletters out, producing weekly messages, organising staff meetings and encouraging staff to participate in the staff surveys.

Following the trust staff engagement survey in 2018, the senior nursing team planed a directorate wide staff engagement strategy. The overall engagement score dipped slightly when comparing with 2017's survey (81% to 78%) and was one percent higher than in 2016.

The trust told us they were concerned by some of the negative free format text responses, particularly those which mention racism and favouritism. They carried out a further in-depth review of the result. The negative comments included: work pressures and short-staffing, engagement and visibility of local leaders, rota uncertainty, limited promotion opportunities and access to education and training. In response the division prepared staff engagement plan for 2019. This included focused recruitment, recruiting a general manager, increased focus on staff engagement from the local leadership team.

The trust named 2019 as the 'year for critical care' with a view to engage all trust's staff with issues facing patients requiring intensive care and raise awareness of importance of the work the directorate carried out.

Learning, continuous improvement and innovation

The department was committed to improving services by learning from when things went well and when they went wrong, promoting training, research, and innovation.

In October 2018, the department initiated a delirium quality improvement project based on national and international guidelines. The project focused on embedding consistent delirium assessment, interventions to prevent and manage delirium within the department, improve the quality of training, and assessing the environment to promote patient's wellbeing. In addition, they were to introduce admission boxes containing items designed to improve sleep and mobility, and reduce delirium. These were to include eye mask, ear plugs, non-slip socks, and an information leaflet for family alongside the delirium risk questionnaire form.

There was a trust wide ward accreditation scheme to monitor quality and safety performance in each inpatient ward. As part of this scheme, each clinical area was reviewed by a team of senior staff who undertook an unannounced inspection, where they rated the area against a set of criteria. Results were then used to identify areas of good practice and areas for improvement. The intensive care unit was awarded gold ward accreditation which was the highest rating.

Maternity

Facts and data about this service

The Imperial College Healthcare NHS Trust (ICHNT) provided maternity services across two main sites, St Mary's Hospital (SMH) and Queen Charlotte's and Chelsea Hospital (QCCH) and was part of the women's, children's and clinical support (WCCS) division.

Independently funded maternity healthcare service was also delivered at SMH as part of Imperial Private Healthcare in the Lindo Wing. The Lindo Wing had labour and postnatal wards and offered antenatal appointments. The Lindo Wing introduced the community postnatal midwifery service in July 2018 to improve women's outcome.

St Mary's Hospital including the Lindo Wing provided maternity services in the hospital and community to approximately 4,000 women in Paddington and surrounding areas. The maternity service provided consultant-led and midwife-led care for both high and low risk women. The hospital also offers a wide range of services and specialist care within maternity services. This included a consultant-led labour ward, birth centre, an outpatient antenatal clinic, a fetal medicine unit (FMU), a day assessment unit (DAU), a triage unit, antenatal and postnatal inpatient wards (including transitional care), perinatal services and bereavement services.

Low risk antenatal and postnatal care was also provided in community clinics which were either located in children's centres, GP surgeries or the Ealing community hub. There were two community midwifery teams who were attached to GP practice, had their designated antenatal clinics and conducted home visits. Women who chose to have a home birth were supported by the community midwives which accounted for 0.4% (11) home births within the last 12 months which was lower than the regional target of 1.5%.

St Mary's Hospital breakdown is shown below:

Ward/unit	Description of ward	Number of inpatient beds (if applicable)
Lindo Wing	Consultant led service, including a dedicated obstetrics theatre and access to an emergency theatre. Antenatal clinic on the second floor.	Five labour rooms and 11 post-natal rooms
Alec Bourne 1	This floor consisted of the Labour ward, triage, obstetrics theatres, recovery and high dependency (HDU) beds	16 beds with one room used for invasive monitoring for arterial lines Four recovery beds which included one HDU bed Two triage beds and one recliner chair
Alec Bourne 2	Postnatal and Antenatal ward	35 beds
Fetal medicine / maternity ultrasound	The fetal medicine unit	N/A

	<p>(FMU) was on the ground floor of Cambridge wing, which had ultrasound services. The FMU services included fetal and perinatal scans and post termination of pregnancy and specialist pre-pregnancy fetal counselling.</p> <p>The FMU had four scanning and consultation room, waiting area and a counselling room for bereavement and breaking bad news.</p>	
Maternity day assessment unit (DAU)	The maternity day assessment unit allowed for the monitoring of pregnant women five days per week; this unit operates by way of an appointment system or low risk referrals from the emergency department.	N/A
Maternity outpatients	Outpatient clinics run by the division of women, children and clinical support	N/A
Birth Centre	The birthing centre was a midwife-led service located on ground floor Cambridge wing, managed deliveries for those women who had been risk assessed as being low-risk pregnancies. It had five birthing rooms.	Five beds with two birth pool.
Antenatal clinic	<p>There was an ante-natal outpatient service within the main outpatient department, which provided ultrasound and blood tests.</p> <p>Six clinical room, two scan rooms, one phlebotomy room and an immunisation room</p>	

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The postnatal and antenatal ward (Aleck Bourne 2) was located on the second floor in Clarence wing with 35 inpatients beds. The 25-bedded postnatal ward was on the west side and on the east side there was a 10-bedded antenatal ward.

The labour ward (Aleck Bourne 1) was located on first floor in Clarence wing and had eight delivery rooms, two theatres and two birthing pools; the ward also had a dedicated bereavement room. Women who underwent elective or emergency caesarean sections (c-sections), or who developed complications before, during or after birth were supported by a team of high dependency nurses and midwives and included three recovery and one high dependency beds on the labour ward.

There was a level two neonatal intensive care unit (NICU) with 22 cots including four intensive care beds, four high dependency beds and 14 special care cots.

Maternity triage services were provided by way of three beds; this was a short stay area and open 24 hours per day, seven days per week.

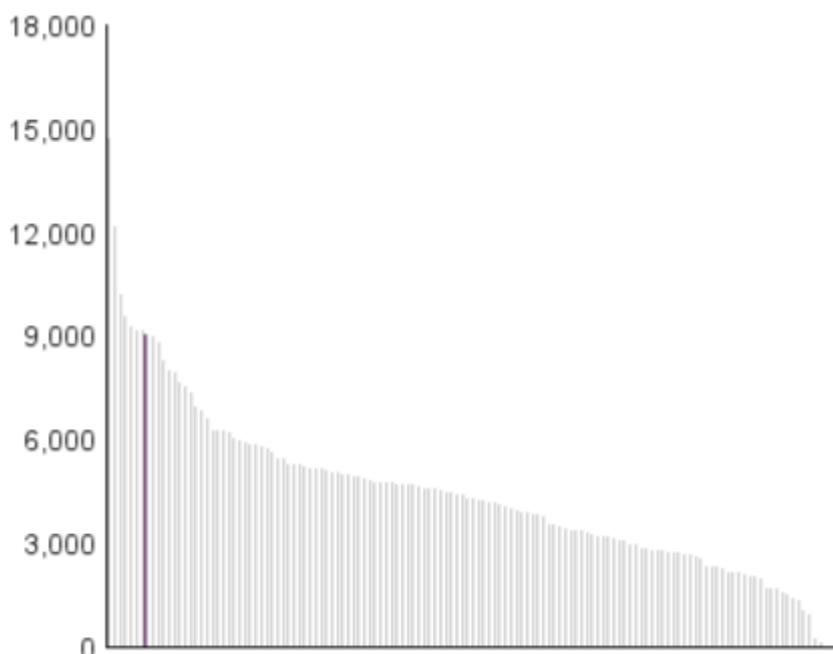
On the Lindo Wing, the labour ward was located on the 3rd floor and had five delivery rooms, five overflow rooms and one theatre. The wing also had 11 post-natal beds.

For the period of 11 February 2018 to 31 January 2019 the Lindo Wing reported 847 deliveries of which 400 were normal delivery, 497 were c-sections and 27 were instrumental delivery.

From July 2017 to June 2018 there were 8,987 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at Imperial College Healthcare NHS Trust – Comparison with other trusts in England.



A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below.

Profile of all deliveries (April 2017 to March 2018)			
	IMPERIAL COLLEGE HEALTHCARE NHS TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Single or multiple births			
Single	9,031	98.5%	98.6%
Multiple	142	1.5%	1.4%
Mother's age			
Under 20	112	1.2%	3.1%
20-34	5,997	65.4%	74.9%
35-39	2,365	25.8%	18.1%
40+	699	7.6%	4.0%
Total number of deliveries			
Total	9,173		596,828

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Gestation periods (April 2017 to March 2018)			
	IMPERIAL COLLEGE HEALTHCARE NHS TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Gestation period			
Under 24 weeks	*	*	0.1%
Pre term 24-36 weeks	*	*	7.8%
Term 37-42 weeks	2,938	93.7%	91.9%
Post Term >42 weeks	*	*	0.2%
Total number of deliveries with a valid gestation period recorded			
Total	3,134		498,704

Source: Hospital Episode Statistics, April 2017 to March 2018

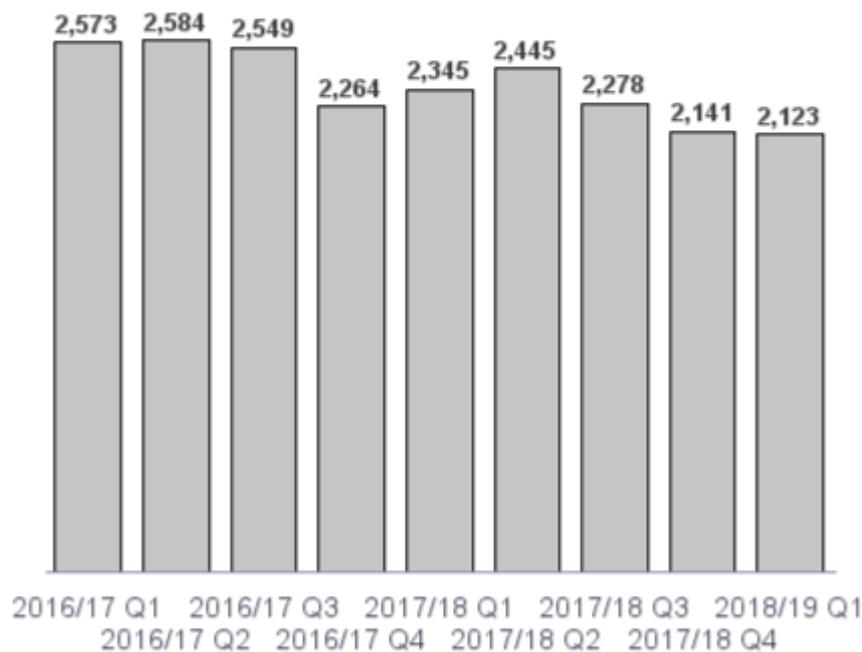
Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with "*" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, additional numbers have also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at Imperial College Healthcare NHS Trust by quarter



The number of deliveries has seen a slight decrease over the period. In the latest quarter, April 2018 to June 2018, the number of deliveries was at its lowest number per quarter (2,123) in the last two years.

(Source: Hospital Episode Statistics - HES Deliveries (April 2016 - June 2018))

We last carried out an unannounced comprehensive inspection of the maternity service in March 2017. The service was rated requires improvement for safe, responsive and well-led and good for effective and caring. The service was judged to be requires improvement overall.

We carried out an announced inspection of the maternity service on 26 to 28 February 2019. We also carried out an unannounced inspection at night on 27 February 2019. During our inspection, we visited all clinical areas in the service including labour ward, theatres, antenatal and postnatal wards, the birth centre, transitional care, antenatal clinics, FMU, DAU and the Lindo Wing maternity areas. We spoke with six women and their relatives and 67 members of staff, including midwives, consultants, anaesthetists, senior managers, student midwives, pharmacist, housekeepers, receptionists, matrons, ward co-ordinators, midwifery risk leads, perinatal mental health team and support staff. We observed care and treatment and reviewed 13 medical care records and prescription charts. We reviewed range of equipment including resuscitation equipment, birthing pools, beds, mattresses, resuscitaires and cardiotocography (CTG) devices. We also reviewed the trust's performance data. We observed one multidisciplinary meeting, two handovers and two patients' procedures and outpatient appointment.

Is the service safe?

Mandatory Training

The service provided mandatory training in key skills to all staff

The maternity service provided mandatory training in key skills to all staff, such as equality and diversity, conflict resolution, resuscitation, consent, information governance, fire safety awareness, moving and handling, infection prevention and control, and medicine management. Training was provided via e-learning modules or face-to-face sessions. Staff understood their responsibility to complete mandatory training.

There were annual, announced and unannounced, simulation “skills and drills” training to rehearse response to obstetric emergencies. Staff could access e-learning and could select bespoke course for their working area such as cord prolapse and shoulder dystocia. Staff told us the training took a multidisciplinary approach and they had found it useful to improve their practice.

Temporary staff were required to provide evidence of mandatory training compliance from their employers.

The service had a recording system in place to monitor staff mandatory training, which highlighted when training was needed and gave a good oversight of completion. Staff told us they received verbal and email reminders from the matron and through the training platform when they were due training. Staff also attended a “big four” training which covered topics such as medicine management, infection control and equipment.

The trust set a target of 85% for completion of all mandatory training courses. A breakdown of compliance for mandatory training courses as at November 2018 for qualified nursing and midwifery staff in the maternity department at St Mary’s Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Moving and handling level 1	107	107	100.0%	85%	Yes
Resuscitation level 2	103	106	97.2%	85%	Yes
Equality and diversity	102	107	95.3%	85%	Yes
Fire safety awareness	102	107	95.3%	85%	Yes
Moving and handling level 2	81	86	94.2%	85%	Yes
Blood transfusion	99	107	92.5%	85%	Yes
Conflict resolution	99	107	92.5%	85%	Yes
Health and safety	98	107	91.6%	85%	Yes
ANTT	97	107	90.7%	85%	Yes
Invasive procedures policy	97	107	90.7%	85%	Yes
Consent	96	107	89.7%	85%	Yes
Medicines management	96	107	89.7%	85%	Yes
Venous thromboembolism	93	107	86.9%	85%	Yes
Nutrition	92	106	86.8%	85%	Yes
Information governance	91	107	85.0%	85%	Yes
Infection prevention and control level 2	88	107	82.2%	85%	No

At St Mary’s Hospital maternity department, the 85% target was met for 15 of the 16 mandatory training modules for which qualified nursing and midwifery staff were eligible. Infection prevention and control level 2 did not meet the trust target with 82.2% completion rate which was slightly better than the trust average of 80.4%.

During inspection, the trust provided a current breakdown of compliance for mandatory and statutory training courses as at February 2019 at St Mary's Hospital for qualified nursing and midwifery staff in maternity services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Duty of Candour	38	38	100.0%	85%	Yes
Resuscitation Level 2	131	131	100.0%	85%	Yes
Invasive Procedures Policy	130	131	99.2%	85%	Yes
Moving and Handling Level 1	130	131	99.2%	85%	Yes
Equality and Diversity	129	131	98.5%	85%	Yes
Health and Safety	128	131	97.7%	85%	Yes
ANTT	127	131	96.9%	85%	Yes
Consent	127	131	96.9%	85%	Yes
Conflict Resolution	126	131	96.2%	85%	Yes
Infection Prevention and Control Level 2	126	131	96.2%	85%	Yes
Medicines Management	124	131	94.7%	85%	Yes
Venous Thromboembolism	124	131	94.7%	85%	Yes
Information Governance	123	131	93.9%	85%	Yes
Nutrition	123	131	93.9%	85%	Yes
Blood Transfusion	122	131	93.1%	85%	Yes
Fire Safety Awareness	122	131	93.1%	85%	Yes
Moving and Handling Level 2	108	122	88.5%	85%	Yes

In maternity services the 85% target was met for all 17 mandatory and statutory training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for mandatory training courses as at November 2018 for medical staff in the maternity department at St Mary's Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
ANTT	4	5	80.0%	85%	No
Blood transfusion	4	5	80.0%	85%	No
Conflict resolution	4	5	80.0%	85%	No
Consent	4	5	80.0%	85%	No
Equality and diversity	4	5	80.0%	85%	No
Fire safety awareness	4	5	80.0%	85%	No
Health and Safety	4	5	80.0%	85%	No
Infection prevention and control level 2	4	5	80.0%	85%	No
Information governance	4	5	80.0%	85%	No
Invasive procedures policy	4	5	80.0%	85%	No
Medicines management	4	5	80.0%	85%	No
Moving and handling level 1	4	5	80.0%	85%	No
Resuscitation level 2	4	5	80.0%	85%	No
Venous thromboembolism	4	5	80.0%	85%	No

At St Mary's Hospital maternity department, the 85% target was not met for any of the 14

mandatory training modules for which medical staff were eligible. However, this is due to one eligible staff member not completing any of the mandatory training modules.

During inspection the trust provided the current breakdown of compliance for mandatory and statutory training courses as at February 2019 at St Mary's Hospital and Queen Charlotte and Chelsea Hospital for medical staff in maternity services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Conflict Resolution	27	27	100.0%	85%	Yes
Equality and Diversity	27	27	100.0%	85%	Yes
Blood Transfusion	26	27	96.3%	85%	Yes
Consent	26	27	96.3%	85%	Yes
Fire Safety Awareness	26	27	96.3%	85%	Yes
Health and Safety	26	27	96.3%	85%	Yes
Infection Prevention and Control Level 2	26	27	96.3%	85%	Yes
Invasive Procedures Policy	26	27	96.3%	85%	Yes
Medicines Management	26	27	96.3%	85%	Yes
Moving and Handling Level 1	26	27	96.3%	85%	Yes
Resuscitation Level 2	26	27	96.3%	85%	Yes
Venous Thromboembolism	26	27	96.3%	85%	Yes
Duty of Candour	25	27	92.6%	85%	Yes
Information Governance	25	27	92.6%	85%	Yes
ANTT	24	27	88.9%	85%	Yes

In maternity services the 85% target was met for all of the 15 mandatory and statutory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses as at November 2018 for doctors in training in the maternity department at St Mary's Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Consent	11	13	84.6%	85%	No
Infection prevention and control level 2	11	13	84.6%	85%	No
Invasive procedures policy	11	13	84.6%	85%	No
Blood transfusion	10	13	76.9%	85%	No
Conflict resolution	10	13	76.9%	85%	No
Equality and diversity	10	13	76.9%	85%	No
Resuscitation level 2	10	13	76.9%	85%	No
ANTT	9	13	69.2%	85%	No
Health and safety	9	13	69.2%	85%	No
Information governance	9	13	69.2%	85%	No
Medicines management	9	13	69.2%	85%	No
Moving and handling level 1	9	13	69.2%	85%	No
Nasogastric tube placement	9	13	69.2%	85%	No
Venous thromboembolism	9	13	69.2%	85%	No
Fire safety awareness	8	13	61.5%	85%	No

At St Mary's Hospital maternity department, the 85% target was not met for any of the 15 mandatory training modules for which doctors in training were eligible. The fire safety awareness training module had the lowest completion rate with 61.5%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During inspection, the trust submitted the current breakdown of compliance for mandatory and statutory training courses as at February 2019 at St Mary's Hospital and Queen Charlotte and Chelsea Hospital for doctors in training in maternity services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Blood Transfusion	51	51	100.0%	85%	Yes
Conflict Resolution	50	51	98.0%	85%	Yes
Consent	50	51	98.0%	85%	Yes
Equality and Diversity	50	51	98.0%	85%	Yes
Health and Safety	50	51	98.0%	85%	Yes
Infection Prevention and Control Level 2	50	51	98.0%	85%	Yes
Invasive Procedures Policy	50	51	98.0%	85%	Yes
Moving and Handling Level 1	50	51	98.0%	85%	Yes
Nasogastric Tube Placement	50	51	98.0%	85%	Yes
Medicines Management	49	51	96.1%	85%	Yes
Venous Thromboembolism	49	51	96.1%	85%	Yes
Fire Safety Awareness	47	51	92.2%	85%	Yes
Information Governance	47	51	92.2%	85%	Yes
ANTT	45	51	88.2%	85%	Yes
Resuscitation Level 2	42	51	82.4%	85%	No

In maternity services the 85% target was met for 14 of the 15 mandatory and statutory training modules for which doctors in training were eligible. Staff were slightly below the trust target for resuscitation level 2 training (82.4%)

The hospital provided doctors and midwives (including community midwives) with maternity specific skills training and signed off competencies in addition to mandatory training. This covered areas such as care of deteriorating woman (sepsis), fundal height measurement, perinatal mental health, cardiotocography (CTG) training, bereavement, and reduced fetal movement. The maternity specific training data showed the midwifery staff were compliant with their training and performed above the trust target.

Staff were required to attend an annual three-day midwifery education programme which included bereavement, skills and drills, perinatal mental health and care of deteriorating woman (sepsis). During inspection we noted that the compliance rate was 85.5% which was better than the trust target of 75%.

The Lindo Wing reported 97% compliance on the sepsis and high dependency unit (HDU) training and reported 93.3% compliance on the skills and drills training as at February 2019.

The annual fetal monitoring assessment training compliance for midwives was 98.6%. Two midwives were not compliant and the trust told us these staff were not permitted to work in a labour or antenatal environment until they had completed the assessment. This was an improvement from the last inspection.

During inspection, the hospital maternity CTG annual training compliance showed 93.9% compliance. We saw that 45 midwives had attended the advanced CTG two day master class and course in the past 18 months funded by NHS England. We reviewed the attendance register for five CTG meetings for the period of November 2018 to January 2019 which showed good attendance by 78 multidisciplinary (MDT) staff. There were also weekly multi-professional meetings where the MDT discussed intra-partum management together with CTG analysis. The hospital data for the Lindo wing showed 93.3% compliance and one midwife was absent for their CTG assessment and this had been rebooked. This was an improvement from the last inspection.

The annual in-house perinatal mental health training programme showed that 44 midwives had completed this training. The Lindo Wing midwives received annual perinatal mental health training as part of the midwifery education week. The Lindo wing reported 97% compliance on the perinatal mental health training. The nominated safeguarding midwife for the Lindo Wing had attended additional perinatal mental health training in support of their role. Two midwives had presented CTG teaching and audits at the weekly Monday morning CTG meeting in 2018.

There was no formal standard for perinatal mental health training for doctors; however, the trust was supported by another NHS trust that provided access to perinatal consultant psychologists, both during the antenatal and postnatal period as well as on the wards during the intra-partum period. The perinatal midwives run study days twice a year which medical staff attended.

During inspection, we noted that 18 (100%) midwives coordinators on the labour ward and birth centre had completed the newborn life support (NLS) course and had a valid certificate on air way support and resuscitation of newborn. In the Lindo Wing, 23 midwives had completed the NLS course. Staff that did not yet completed the course were new starters to the trust and were booked on to the November 2019 course.

All Lindo Wing staff had completed the NLS course as part of the annual midwifery education week. The Lindo Wing had an in-house NLS instructor who was able to assist staff in meeting this competency.

At the last inspection we had concerns on the low staff mandatory and maternity specific compliance. During this inspection, there had been improvement and midwifery and medical staff training compliance was better than the trust target.

Safeguarding

The trust had clear systems, processes and practices in place to safeguard adults and children from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. Staff understood how to protect patients from abuse and the service worked collaboratively with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust had policies to safeguard women with, or at risk of, female genital mutilation (FGM), safeguard children at risk of child sexual exploitation (CSE) in accordance with national guidance and legislation.

Staff had received training on safeguarding vulnerable women, babies and their families, and knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies and organisation. Staff we spoke to knew how to make a safeguarding alert and did that when it was appropriate. The maternity safeguarding team liaised with other professionals and agencies, such as social workers, the police, independent domestic violence advisors, family nurse partnership, and the perinatal mental health team, as needed.

We saw several examples where safeguarding concerns were identified by staff including

administrative staff. Referrals were made to the hospital safeguarding team and liaised with the local authority and the patient GP and health visitor were notified. Staff gave examples of safeguarding referral they had completed for concerns around substance misuse, FGM and teenage pregnancy. We saw examples of where staff had attended court hearing in relation to safeguarding concerns to ensure the women and their babies' safety. Staff kept records of safeguarding referrals to the local authority safeguarding team and had protection plans in place to keep patients safe.

The maternity had designated safeguarding team and specialist midwives that provided further support, supervision, training and updates for staff and participated in serious case reviews.

For the period of 1 November 2017 to 1 November 2018 there were 314 referrals reported for the maternity services in the trust.

The service ran a weekly clinic for women who had undergone FGM to ensure timely access to the specialist obstetrician, midwives and psychological support to ensure better birth planning. The service had designated FGM team which included the specialist midwives, FGM health advocate, counsellors and social worker who were available during the joint clinic appointment.

There were systems in place to track and support young women in the trust. Teenage mothers that were pregnant or had given birth were under the case loading midwives (a term used by hospitals for continued care received by a senior or specialist named midwife throughout pregnancy and birth) with support from the safeguarding teams. The service had a charity based in the hospital called Redthread that supported young people through the vulnerable transition of adolescence and Child and Adolescent Mental Health Services (CAMHS). Redthread is a local community based charity which provides support to young people in their personal and social development. We noted this was not a service provided by the hospital, but a collaborative arrangement. The Redthread team also supported staff with concerns around child sexual exploitation, modern slavery and gangs.

The care of vulnerable women with complex social or safeguarding needs were also overseen by the caseloads midwives who were known as the blue team. Women were referred to them following booking and plan of action was agreed on the postnatal ward. Staff would also alert the team to assess un-booked women that accessed the service. Staff we spoke to told us they had few teenage parents that accessed the service. The caseload midwives would liaised with other staff and develop the care plan for vulnerable women.

During inspection we observed good comprehensive verbal and written handover for safeguarding concerns. We noted that seven safeguarding cases were reported for the service at the cross-site safety huddle meeting. We observed the labour ward handover and noted that safeguarding concerns were also highlighted to staff at the beginning of their shifts to ensure follow-up of care and assessment.

The community midwives prioritised work such as safeguarding referrals and concern to ensure patients that were identified with safeguarding risk were seen and assessed appropriately in line with the trust policy.

The level 3 safeguarding training was developed in compliance with national guidelines, legislations and The Royal College of Paediatrics and Child Health (RCPCH) framework. Staff we spoke to told us the training was comprehensive and covered topics such as signs and symptoms of abuse, modern day slavery, child sexual exploitation, serious case review and learning, consent, parenting capacity, child death and procedures, domestic violence, referrals, and safeguarding in children, adolescence and maternity.

The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding training courses as at November 2018 for qualified nursing and midwifery staff in

the maternity department at St Mary's Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding adults level 2	94	107	87.9%	85%	Yes
Safeguarding children level 3	70	107	65.4%	85%	No

At St Mary's Hospital maternity department, the 85% target was met for one of the two safeguarding training modules for which qualified nursing and midwifery staff were eligible. Safeguarding children level 3 did not meet the trust target with 65.4% completion rate.

Recent data received by the trust as at February 2019 is shown below.

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults Level 2	129	131	98.5%	85%	Yes
Safeguarding Children Level 3	113	131	86.3%	85%	Yes

In maternity services at St Mary's Hospital, the 85% target was met for both of the safeguarding training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for safeguarding training courses as at November 2018 for medical staff in the maternity department at St Mary's Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding adults level 2	4	5	80.0%	85%	No
Safeguarding children level 3	3	5	60.0%	85%	No

At St Mary's Hospital maternity department, the 85% target was not met for either of the safeguarding training modules for which medical staff were eligible. Safeguarding children level 3 had the lowest completion rate with 60.0%. However, performance should be taken in context when dealing with small numbers of eligible staff.

During inspection, data provided by the trust showed improvement in staff training compliance. A breakdown of compliance for safeguarding training courses as at February 2019 for medical staff in maternity services at St Mary's Hospital and Queen Charlotte and Chelsea Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults Level 2	26	27	96.3%	85%	Yes
Safeguarding Children Level 3	26	27	96.3%	85%	Yes

In the maternity services at St Mary's Hospital and Queen Charlotte and Chelsea Hospital, the 85% target was met for both of the safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as at November 2018 for doctors in training staff in the maternity department at St Mary's Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults	9	13	69.2%	85%	No
Safeguarding children level 3	8	13	61.5%	85%	No

At St Mary's Hospital maternity department, the 85% target was not met for either of the safeguarding training modules for which doctors in training staff were eligible. However, performance should be taken in context when dealing with small numbers of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During inspection, we saw that doctors in training had met their target. A breakdown of compliance for safeguarding training courses as at February 2019 for doctors in training in maternity services at St Mary's Hospital and Queen Charlotte and Chelsea Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults	47	51	92.2%	85%	Yes
Safeguarding Children Level 3	46	51	90.2%	85%	Yes

In the maternity services at St Mary's Hospital and Queen Charlotte and Chelsea Hospital, the 85% target was met for both of the safeguarding training modules for which doctors in training were eligible.

Cleanliness, infection control and hygiene

The service controlled infection risk well. There were systems and processes to control and prevent the spread of infection. The majority of the department was visibly clean, tidy and free of any odours, however the standards of cleanliness was not always maintained on the antenatal and postnatal ward at night.

We inspected all areas of the maternity unit and the Lindo Wing including the labour ward, obstetric theatres, wards and midwife led birth unit. All maternity areas were visibly clean and tidy during the day however when we visited the antenatal and postnatal ward at night we observed that one of the patient toilet was soiled, bin full and was overflowing and sanitary pad seen. Another toilet which was last cleaned at 12.55pm on the cleaning schedule was blocked and had offensive smell, full of toilet paper and with blood splatter. This was escalated to staff and we were informed this would be cleaned immediately. Staff told us there had been changes to the cleaning provision arrangement by the cleaning company. The service used to have two cleaners that cleaned the wards twice daily and this had been changed to once a day by a cleaning staff. Staff could only request the cleaning of patients beds during out of hours. The midwifery and support staff were expected to clean other dirty areas and equipment out of hours.

The maternity service provided staff with personal protective equipment (PPE), to prevent and protect people from a healthcare-associated infection. We observed clinical staff adhering to the trust's 'arms bare below the elbow' policy to enable effective hand washing and reduce the risk of spreading infections. There was access to hand washing facilities, hand sanitisers and a supply of PPE, which included sterile gloves, gowns and aprons, in all areas. The private wings had liquid soap women and staff used to wash their hands, which helped to prevent cross-contamination and infection.

We observed that the maternity rooms had hand washing sinks with sensory taps which reduced the risk of infection and cross contamination as staff and patients were not required to close the taps after washing their hands.

Hand sanitising gel dispensers were readily available at all entrances, exits and clinical areas for staff, patients and visitors to use. We observed staff applying hand sanitising gel when they entered clinical areas. We observed that majority of staff washed their hands between patient contact, in accordance with national guidance (National Institute for Health and Care Excellence (NICE) *Infection prevention and control: QS61*). We saw that staff prompted colleagues and visitors to wash their hands or use the hand sanitiser when they entered or exited the wards.

The Lindo Wing hand hygiene audit for the period of 1 September 2018 to 1 February 2019 showed 100% compliance on the five moment of hygiene outcomes.

The May 2018 hand hygiene audit on the World Health Organisation (WHO) five moments of hygiene showed poor compliance with staff. The result showed that the Lindo wing achieved 69%, the labour ward achieved 50% while the antenatal and postnatal ward achieved 17%. This audit prompted a trust wide hand hygiene improvement plan and the postnatal ward was selected for a focus intervention. A re-audit took place in November 2018 for the antenatal and postnatal wards which showed 39% compliance, which was a slight improvement from the previous audit. The service had a hand hygiene improvement plan with 22 recommendations assigned to senior staff. The recommendation included; formal teaching, identify hand hygiene staff champions and changing and installing all hand wash and sanitisers. We noted that 14 of the recommendations had been completed and the others were on-going.

The environmental audit for the period of August 2018 to December 2018 showed an overall compliance of 95.4% which was similar to the Trusts target (95%). The highest compliance was achieved in September 2018 (96.4%) and October 2018 (96.2%). The labour ward achieved 98% while the birth centre achieved 97.3% in this period. The antenatal and postnatal wards reported 97% compliance, while the ultrasound achieved 96.3%.

The environmental audit for the Lindo Wing labour ward and postnatal ward for the period of September 2018 to January 2019 showed an overall average of 96.2% which was better than their target (95%).

From discussion with staff and records reviewed we saw that women were offered screening for infectious diseases, such as hepatitis B and syphilis. Women were also offered influenza (flu) and pertussis (whooping cough) vaccination in pregnancy, which was in line with NICE *Antenatal care guidance*.

Staff adhered and followed the use of aseptic technique during surgical procedure, catheterisation and wound dressing, which prevented the risk of infection.

The service monitored postnatal readmission rates for infection. The hospital reported 11 (0.4%) maternal readmissions within 42 days of delivery for puerperal sepsis, for the period of April 2018 to January 2019 which was better than the national average. The Lindo Wing reported one readmission with puerperal sepsis in the last 12 months which equates to a 0.1% readmission rate.

Lindo Wing carried out a saving lives audit for the period of September 2018 to February 2019 to monitor staff compliance on the peripheral vascular access devices and insertion site. The vascular access devices (VADs) are inserted into veins via peripheral or central vessels for diagnostic or therapeutic reasons, such as blood sampling, administration of medication, fluids and blood transfusions and have risk of infections. The audit result showed 100% compliance on the five outcomes audited.

As at February 2019, there was zero cases of hospital acquired MRSA (antibiotic resistant bacteria) and *Clostridium difficile* in the last 12 months.

Staff carried out the decontamination of surgical instruments in accordance with national guidance: Choice Framework for local Policy Procedures 01-01: Management and decontamination of surgical instruments. Staff we spoke with understood their responsibilities in this process. We also saw that midwifery staff re-sanitised the birthing pool after use following a birth delivery.

There were systems in place to ensure the deep cleaning of rooms following a patient discharge or transfer.

Green 'I am clean' stickers were in use in all the maternity areas visited. There was consistency in the use of the green stickers and these were updated following the cleaning of equipment's by staff across the maternity wards.

Environment and equipment

The maternity service had suitable premises and equipment for women who accessed the service. The service had processes in place to ensure equipment were maintained and tested for electrical safety, to ensure it was fit for purpose and safe for patient use. Although the service had systems to ensure emergency equipment was checked daily, compliance within the service varied.

Access to the labour ward, antenatal wards and maternity care unit was by means of swipe card or an intercom buzzer system. There was a CCTV screen in the maternity area for staff to identify visitors and ensure women and their babies were kept safe. The theatres, recovery, HDU and triage were on the same floor and very close to the labour ward which allowed timely transfer when required.

There were two dedicated obstetric theatres in the maternity unit and Lindo Wing respectively, which was in line with safe practice and had necessary equipment. Both areas had access to a theatre which was accessible 24 hours for an emergency caesarean section. We observed the theatres were spacious in size and well equipped.

There were arrangements in place to safely manage waste and dispose clinical specimens. Waste was handled appropriately with separate colour-coded arrangements for general waste, clinical waste and sharps. We observed that clinical waste such as general, sharps, clinical waste, cytotoxic sharps and medical sharps bin were correctly segregated and changed frequently by staff during the inspection. All sharps bins inspected were assembled correctly, dated, signed and were not over full. The Control of Substances Hazardous to Health (COSHH) cupboard was secured and equipment stored appropriately during inspection.

The maternity service labour wards and birth centre met the Department of Health (DoH) recommendation that all birthing rooms should include ensuite facilities (DoH *Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities*, 2013).

CTG machines were available in the service for women who required continuous electronic fetal heart rate monitoring. These were also used to record uterine contractions during pregnancy and labour, which allowed early detection of fetal distress.

Staff told us they used to have only one carbon monoxide monitor in the clinic and they now have enough which enabled them to check women's carbon monoxide level at booking.

Community midwives had adequate equipment which had been serviced and calibrated.

Birthing equipment was delivered to women's home by 36 weeks into their pregnancy, while Entonox was sent from the labour ward when women were in labour to ensure safety.

Staff had access to a fetal blood gas analyser and laboratory facility for bloods including a blood fridge available on the wards, which was in line with national recommendations (RCOG *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*, 2007).

Transcutaneous Bilirubinometer (TCB) monitors which are used for screening for babies with jaundice were available on the wards and midwives were trained to use them which was in line with national guidance.

All equipment including scanners, observed during inspection had their equipment maintenance completed. The equipment department kept the log of when equipment was due maintenance. Staff checked equipment daily and also kept the note of portable appliance testing.

The service had appropriate emergency equipment on the maternity units including resuscitation equipment, evacuation net, postpartum haemorrhage intravenous (IV) trolley, drug boxes for specific emergencies such as neonatal emergency box, sepsis and cardiac arrest. We observed hypo box on the maternity wards which contained dextroglucose, glucose juice and glucose-tablets which were used during diabetic emergencies.

At the last inspection we had concerns around the environment, poor state of repair of the kitchen and showers due to the limitation of the hospital building.

During this inspection, there had been improvements to the service including the kitchen and shower areas. However, there were still issues around space, storage, lifts and temperature control in the maternity unit areas.

We observed that the maternity wards and Lindo Wing were hot and staff said it was a recurring issue but heating was controlled centrally and it took a while for temperature to be adjusted. On the general antenatal and postnatal wards, we noted the temperature was 30 degree on an occasion which was raised with senior staff and resolved immediately. During inspection, one of the lifts to the labour and maternity wards was broken and out of service. Staff told us the lifts sometimes broke down and the maintenance of the hospital environment was an area for improvement. The antenatal and postnatal ward were cramped with some equipment and trolleys stored in the corridors due to lack of storage.

During the inspection we checked a range of consumable items from the resuscitaires and hypo box, including syringes, medicines, airways and naso-gastric tubes and all were in-date. All resuscitation trolley drawers seen were secured with a tamper evident tag. All equipment such as anaesthetic machines and trolleys were clean however, resuscitation trolleys and equipment checks were not completed daily as per standard to ensure equipment was in date and in working order.

On the antenatal ward, the resuscitaires checklist were completed but were not signed for in approximately half of the months reviewed. On the postnatal ward there was no checklist for postpartum haemorrhage (PPH) tray in the fridge although all items were in date. On the antenatal and postnatal ward, we noted two missing entries in the month of January 2019 for the hypoglycaemia box checklist.

The July 2018 checklist audit of emergency equipment such as neonatal emergency equipment, PPH trolley, PET box and crash trolley on the Lindo Wing showed 99.2% compliance on checklist completed overall, while the 0.8% were missing or incomplete entry. The November 2018 checklist audit of emergency equipment showed 95% compliance overall.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Staff completed risk assessments for women and babies from the antenatal to the postnatal period of the maternity pathway, in line with national guidance. The criteria for women planning to have their baby at home, birth centre or labour ward were in line with national guidance. Staff completed a comprehensive risk assessment for women at the initial booking appointment which covered areas such as women's medical history, previous birth history and complications, mental health, social needs, substance misuse, social services history, high blood pressure, gestational diabetes to assess and identify risk, which was in line with national guidance. A summary of bookings was printed and kept in patient hand held notes so staff could identify risks during follow-up appointments. We saw that women who were at high-risk of gestational diabetes were referred to the weekly diabetic clinic for glucose tolerance test to monitor and assess their blood sugar to prevent gestational diabetes, hyperglycaemia or hypoglycaemia. The findings of these risk assessments were used to help women choose their preferred place of birth and plan future care provision. This was confirmed in the patients' records we reviewed. Staff we spoke to told us multidisciplinary (MDT) staff were proactive in assessing and responding to patient risk.

We observed staff assessed patient risk frequently including during handovers, clinics and team briefs. This included women's previous caesarean history, third or fourth degree tear, blood results and rhesus status.

The service had an antenatal and postnatal mental health pathway that guided staff on steps to take where patient was at risk of committing suicide or harming others. Staff assessed and monitored women using 'whooley questions' (tool used for screening depression) and the 'feelings and questionnaire tool' at risk of depression and anxiety. Where concerns were identified, referrals were made to the perinatal mental health team and specialist midwife. We saw evidence that referrals had been made and patient care was well managed in the patient's record we reviewed. Safeguarding and mental health issues were flagged up on the system and where a woman with severe mental health issues did not engage with staff this was flagged up as a safeguarding concern. During inspection, on the patients' records, we saw that staff had completed the mental health assessments, which were very detailed when mental health issues were identified.

In Lindo Wing, private patients that were considered high risk, had cardiac issues or needed HDU would have their babies in the general NHS labour ward and would then be transferred to the Lindo Wing after delivery. Staff told us this rarely happen and occurred once a year. When this occurred the Lindo Wing midwife went with the patient to the HDU unit.

Senior staff were proud of staff response to minimise patient risk during a lift crisis in the hospital. They said staff responded appropriately to the risk and had organised and arranged safe transfer of patients to another unit to ensure safety and continuity of care.

The maternity service used the modified early obstetric warning score (MEOWS), designed to allow early recognition of deterioration in pregnant and postnatal women by monitoring physical parameters, such as blood pressure, heart rate and temperature.

The service used the newborn early warning trigger and track (NEWTT) tool, which was designed to identify babies at risk of clinical deterioration following birth and initiate prompt investigation and intervention. From the records reviewed we saw that staff completed NEWTT appropriately in line with the trust guidance. The service carried out a spot-check NEWTT audit in March 2019 following our inspection which showed 91% full compliance in the maternity service. The result showed one of the 11 notes reviewed was not fully completed.

The computerisation of MEOWS in the electronic records worked well and helped to assess and respond to patient risk effectively. NEWTT and MEOWS were completed on the patient's electronic record and could alert staff to escalate if scores were outside the range if each section were fully completed.

The maternity service used the World Health Organisation (WHO) surgical safety checklist for women having a c-section or other obstetric surgical procedure, such as instrumental delivery, to prevent or avoid serious patient harm in the operating theatre. This was in line with national recommendations (NPSA *Patient Safety Alert: WHO Surgical Safety Checklist*). The checklist was completed by the anaesthetist and completed after clinical procedures. We observed an elective c-section and saw staff adhered to the WHO '5 steps to safer surgery' checklist, swabs were counted, staff asked the patient allergy, patient identity was verbally confirmed and checked against the identity bracelet used. The 2018 WHO surgical safety checklist audits showed an overall 95% compliance. Full compliance was achieved in nine months and while 80% compliance was achieved in February, March and October 2018. We noted significant improvement in the 2018 audit compared to the 2017 results. In the 2017 result there was poor performance on safety briefing, time out, sign out and staff debrief and compliance ranged from 50% to 80% compared to 2018 result (100%).

The service had a buddy system (fresh eyes) in place for review of CTG interpretation, with guidance for escalation where concerns were noted. Fresh eyes involved a second midwife checking a CTG recording of a baby's heart rate to ensure it had been interpreted correctly and appropriate actions taken when indicated. We noted that the labour ward used the Cerner Electronic Whiteboard and allocated the buddy role separately. This was in line with national recommendations (NHS England *Saving Babies' Lives: A care bundle for reducing stillbirth*).

CTG's were electronically recorded every hour and reviews were within 15 minutes of the designated midwife CTG assessment. The fresh eye audit carried out on 21 February 2019 showed 83% compliance. This was an improvement from the last inspection which showed 12.5% compliance.

The service had a safety stream tasked with improving fetal monitoring through updating clinical guideline, full implementation of the electronic fetal central monitoring station (Fetalink) on the labour ward. The safety stream also looked at developing human factor training for staff and undertaking additional two day fetal monitoring training for labour ward coordinators and medical staff. The fetalink is a fetal and maternal monitoring system that allows data flow from medical devices to a central screen. Since the fetalink was introduced the trust reported there had been no CTG related incidents. The hospital planned to commence the fetalink on the Lindo Wing the following week of inspection.

The service completed venous thromboembolism (VTE) risk assessments, which was used to determine a patient at risk of developing a blood clot, in line with national recommendations. From records reviewed we saw that staff completed VTE assessments regularly and appropriately.

The October 2018 VTE audit showed that 79% of patients were given advice on deep vein thrombosis (DVT) prevention, 50% had VTE assessment on admission, 12.5% were re-assessed within 24 hours and 26% were not re-assessed due to timescale. The audit identified that low-molecular-weight heparin medicines was prescribed, advice given in DVT and anti-embolism stockings (use for compression) were given to 62.5% of patients.

The entry and exit to wards was controlled via CCTV, entry button and swipe access to ensure secured access in all areas.

Staff received training on sepsis and we saw posters of sepsis six (management of sepsis that usually involves three treatments and three tests) and escalation using the 2222 (internal emergency) service in the maternity areas. The trust had an electronic screening protocol which alerted staff on the patient record to prompt clinical review and diagnosis. There was a weekly 'sepsis big room meeting' where staff and patients came together to discuss improvements in sepsis identification and management across the trust. Progress against all measures in the sepsis six bundle was tracked utilising data on a weekly basis, and the views of staff members responsible for the care of patients with sepsis on a daily informal basis. Staff could use the 2222 service to escalate concerns to the newborn infant emergencies, obstetric emergencies, maternal cardiac arrest or collapse, or peri-arrest. Staff used the situation, background, assessment and recommendation (SBARD) tool for escalation.

The 2018 SBAR audit was conducted to establish the baseline audit of Cerner documentation in the maternity in the hospital and Queen Charlotte's and Chelsea hospitals. The result showed the use of SBAR during the intra-partum care was 45% which was below target. In response to this result the midwifery team made some changes which included training on the use of SBAR handover documentation as part of the annual updates on midwifery training days and new starter training. They provided one on one reminders and support during their clinical work and reviewed the Cerner workflow to make the SBAR tool more accessible to midwives. The service had a plan to carry out a follow up audit in April 2019 as part of a repeated documentation audit.

The service had a fetal medicine unit (FMU) which supported women who had complications or abnormalities in their pregnancy. In line with the NHS England 'Better Birth' outcome staff asked women about their baby's movements at each antenatal contact to reduce the risk of still birth. Staff also advised women to contact the maternity telephone line, maternity day assessment unit (MDAU) or maternity triage unit if they had any concerns about their baby's movements.

The service gave women and babies wrist bands for patient identification and to reduce patient risk such as medicines incidents and baby abduction. We saw that babies had two identification bands on both feet and a security baby tag was placed on one foot to ensure the safety of the baby. The tag alerted staff by an alarm if a baby was taken beyond the reception desk which prevented baby being taken out of the unit.

The maternity wards and Lindo Wing had access to a second theatre that was used for categories 1-3 emergencies (life threatening illness, emergency and urgent calls) and had access to an anaesthetist, scrub nurse and midwife during nights and weekends. A dedicated team covered the theatre for out of hours obstetric emergencies and emergency caesarean sections (EMCS). We noted that if a second theatre was needed for EMCS the main theatre central team came in to cover the second theatre.

For the period of October to December 2018, the Lindo Wing carried out an audit on the admission of babies to their nursery. The result showed 100% compliance overall on managing risks, security and patient transfer from the nursery to patients.

The service had a maternal neonatal death and still birth checklists in place, which guided staff in caring for women with late miscarriage and foetus or baby born after 23+6 weeks with no sign of life and those born before 23+6 weeks.

Vaginal birth after a caesarean (VBAC) was offered to all women unless there was a medical condition including tokophobia (fear of birth) to ensure patient safety.

The service had a lone working policy in place and the community midwives understood their responsibility, used their diary appropriately and called each other to ensure theirs and women's safety.

The maternity service had a security drill around baby abduction in December 2018. The service identified that the reception area was secured, staff notified security promptly and the woman was challenged twice by staff. However, staff did not challenge the woman when spotted in the labour ward entrance and allowed her in. Following the drill the managers had debrief sessions with staff, raised awareness about vigilance and reminder to staff to challenge anyone carrying a baby who is not the mother.

There was a baby abduction policy to guide staff on the steps to take to prevent abduction or when it occurred.

The Lindo Wing had access to simulation mum training which was held every Friday on the general labour and had undertaken two major obstetric haemorrhage simulations, in December 2018 and January 2019.

Community midwives carried out the newborn blood spots test, which is a screening for sickle cell disease, cystic fibrosis, congenital hypothyroidism and inherited metabolic diseases. The community

midwife had an on call team available to assess and respond to pregnancy related emergencies and for home birth from 8pm to 8am.

The band 7 staff including the caseload midwives were responsible for assessing and managing high risk patient.

Midwifery and nurse staffing

The service had enough midwifery and nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust reported their qualified nursing, midwifery and health visiting staffing numbers for St Mary's Hospital and Queen Charlotte's and Chelsea Hospital below as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
St Mary's Hospital	122.7	108.3	88.3%
Queen Charlotte's and Chelsea Hospital	180.2	166.2	92.2%
Total	302.9	274.5	90.6%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 7.5% for qualified nursing and midwifery staff in maternity at St Mary's Hospital. This was better than the trust target of 10% and average of 9.5%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The recent clinical indicator dashboard as at January 2019 showed the trust vacancy rate was 6.3% at inspection for midwifery staff. During inspection, staff told us there were two vacancies on the Lindo wing.

From November 2017 to October 2018, the trust reported a turnover rate of 7.1% for qualified nursing and midwifery staff in maternity at St Mary's Hospital. This was better than the trust target of 12% and trust average turnover rate of 10.4% for the maternity service.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 4% for qualified nursing and midwifery staff in maternity at St Mary's Hospital. This was slightly worse than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Staff told us that sickness was well-managed by their managers and they had a return to work resolution meeting when back to work from sick leave. During inspection staff told us they had two staff on Lindo Wing on long term sickness.

From October 2017 to September 2018, the trust reported 33,366 (16.3%) bank hours and 1,458 (0.7%) agency hours were filled by qualified nursing and midwifery staff in maternity. There were 3,945 hours (1.9%) that were not filled by bank/agency staff for St Mary's Hospital which was better than the trust average of 14% (97,623 hours).

A ward breakdown is shown below:

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Alek Bourne 1 & 2	116,715	20,928	17.9%	622	0.5%	1,273	1.1%
Lindo 3 & 4	46,605	9,932	21.3%	827	1.8%	Over-filled by 780	Over-filled by 1.7%
Antenatal Clinic	13,263	1,707	12.9%	0	0.0%	2,596	19.6%
Birth Centre	18,414	800	4.4%	10	0.1%	138	0.8%
Caseload midwives	9,831	0	0.0%	0	0.0%	718	7.3%
Total	204,828	33,366	16.3%	1,458	0.7%	3,945	1.9%

During the same period, the trust reported 3,669 (4.8%) bank hours and 12 (0.0%) agency hours were filled by nursing assistants in maternity. There were 1,106 hours (1.5 hours) that were over-filled by bank/agency staff which was better than the trust average of 10% (18,575 hours) shifts not filled by bank/agency staff.

A ward breakdown is shown below:

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Alek Bourne 1 & 2	37,199	392	1.1%	0	0.0%	2,058	5.5%
Lindo 3 & 4	26,990	2,507	9.3%	12	0.1%	Over-filled by 4,338	Over-filled by 16.1%
Antenatal Clinic	4,215	553	13.1%	0	0.0%	1,043	24.8%
Birth Centre	8,163	217	2.7%	0	0.0%	131	1.6%
Total	76,568	3,669	4.8%	12	0.0%	Over-filled by 1,106	Over-filled by 1.5%

The trust confirmed that the over-establishment reflected actual versus planned for months where the actual was greater than the planned (i.e. over established due to specialising, enhanced care, etc.). The trust reported that the usage of bank staff was mainly attributed to vacancies.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

The service has an effective system in place for managing the use of bank and agency staff. Agency and bank staff were inducted and receive orientation to new areas. Staff told us there was limited usage of agency staff and if used there was an agency pack that would be utilised. Staff mainly covered shifts through the bank system. Staff were redeployed to other areas of high acuity. For example, during inspection when the labour ward was less busy staff were redeployed to the postnatal ward to support staff with discharges.

From July 2017 to June 2018, the trust had a ratio of one midwife to every 29.9 births. This was

similar to the England average of one midwife to every 25.5 births.

(Source: *Electronic Staff Records – EST Data Warehouse*)

The service used a national acuity tool (Birthrate Plus), to assess staffing requirements based on patients' needs. Staffing levels and skill mix were regularly reviewed and actions were taken to meet patient acuity. The service used temporary staff or redeployed staff within the maternity unit when needed to ensure patient safety and prevent avoidable harm. The coordinators and site managers were responsible for the management of the activity on the ward and staffing levels.

A full Birthrate Plus assessment was undertaken in April 2018 to assess the staffing and acuity level. This showed an established staffing ratio of 1:24 and better than the national average of 1:28 and trust overall ratio of 1:26.

According to national recommendations, all women should expect to receive one-to-one care in established labour (RCOG *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*, 2007). For the period of April 2018 to January 2019, 98.4% of women received one to one care during active labour. During inspection staff told us one to one care in established labour was good and had been maintained for the past months.

For the period of April 2018 to January 2019, the trust data showed 100% of women had a named midwife in the service.

Midwives worked different shift patterns such as day and night shifts and some staff worked across sites. Staff reported flexible working hours and they could choose if they wanted night shifts only. For example, the bereavement midwives worked across sites (QCCH and SMH) and covered the maternity services, Lindo Wing and emergency unit. The bereavement midwives also supported midwives on the wards if they were no bereavement cases in the service.

The recovery unit had designated trained staff that were trained in delivery high dependency care. This ensured the safe delivery and continuity of care for patients. Staff in the recovery unit would also accompany women to the theatre during their procedure.

The birth centre had six midwives and was staffed with two midwives and one maternity support worker during the day and night. These figures were maintained during inspection when we visited.

Staffing levels were monitored regularly by managers, labour coordinators and during the cross site safety call huddle. The lead midwives and coordinators were supernumerary. During the inspection we noted that all maternity areas were well staffed and rated green during the safety call huddle we listened to. When we visited the service unannounced at night, the maternity services including the Lindo Wing were reported as green and no concerns around staffing and acuity.

Senior managers felt staffing was adequate on the labour ward and they had eight to nine midwifery staff per shift (excluding the coordinators) which included; four midwives, 1 newborn and infant physical examination (NIPE) midwife, a manager, two midwifery support worker (MSW) and a breastfeeding support worker. The matron was supernumerary and was able to support and have oversight. Also the lead midwives and coordinators were supernumerary and could supported staff.

We requested the actual staffing levels for HDU for February 2019 and found that shifts had been covered by HDU trained staff and outreach team. The trust informed us that staff were always redeployed to provide HDU cover and other areas were back filled.

In the theatre, the service had scrub nurses that worked 8.30am to 6.30am Monday to Friday and senior staff scrubbed out of hours. The scrub midwives were shared with the Lindo Wing over weekend. We were told the head of midwifery was reviewing scrub process in the theatre. During inspection, we observed that the theatres were appropriately staffed and a midwife and scrub nurse were present during a lower (uterine) segment Caesarean section (LSCS). There was adequate cover for the emergency theatres which were staffed with a scrub nurse, midwife, one HCA and one runner. This was an improvement from the last inspection.

The triage was staffed with a midwife from 7.30am to 8pm. The day assessment unit was staffed with a band 7 or 6 midwife, a MSW and receptionists that worked long day shift from 7.30am to 8pm. Staff told us if there were reduced appointments they would support the triage unit. The 31 bedded antenatal and postnatal wards were staffed with four midwives and four MSW. The fetal medicine unit was staffed with a band 7 midwife, three band 6 midwives and three MSWs.

The hospital had two community midwifery team; the north team and east team. The north team was staffed with 10 community midwives and while the east team was staffed with six midwives. The community midwives had an on-call service from 8pm to 8am to respond to women queries and for home birth. Each midwife was allocated to an average of three on call shifts per months.

The antenatal clinic had two phlebotomists and two midwifery staff to do glucose tolerance testing (GTT) clinic and blood tests. There were six sonographers in the team.

The antenatal screening team was staffed with two full time band 7 coordinators and 0.6WTE band 6 midwives. The team also had a band 4 full-time administrator as fail safe and was in post for a year. Two administrators covered both site and supported the specialist midwives on areas such as the risk, bereavement and immunisation. The team had a genetic counsellor that worked fulltime for both site and two thalassaemia/sickle cell counsellors.

The service had a designated NIPE midwife that worked one day per week and was looking to implement NIPE Screening Management and Reporting Tool (NIPE SMART) as a fail-safe system. This aimed to track newborn babies throughout the screening pathway to ensure no babies were missed out on the detailed physical examination. The service had a list of all midwives who conducted NIPE and refreshers were set up for these midwives to keep their skills current.

The staffing levels in Lindo Wing included 33 midwives, 13.61WTE MSWs and 6.3WTE nursery nurses. The services provided one to one care in line with national recommendations during labour and a staffing ratio of one midwife to four women which was better the national standard and enabled them to provide high standard of safety. Since the last inspection the Lindo Wing had introduced the community midwifery service as part of a visiting scheme to ensure continuity of care and support in the community. They had a midwifery clinic four times a week. There was a midwifery coordinator and floater. All Lindo midwives worked flexible hours and worked in all areas.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust reported their medical staffing numbers below as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
Cross site	59.2	62.4	Over-established by 5.5%
Queen Charlotte's and Chelsea Hospital	2.0	0.0	0.0%
Total	61.18	62.41	Over-established by 2.0%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The trust did not submit any specific data for St Mary's Hospital.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 5.7% in maternity, compared to the trust target of 10%. The trust did not submit vacancy data for medical staffing at St Mary's Hospital.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

The recent clinical indicator dashboard as at January 2019 showed that the trust vacancy rate was 2.2% for consultants.

From November 2017 to October 2018, the trust reported a turnover rate of 2.4% across all sites in maternity, which was better compared to the trust target of 12%. The trust did not submit turnover data for medical staffing at St Mary's Hospital.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

There was 84 hours obstetric consultant cover seven days a week from 8am to 8.30pm in the hospital maternity service. There was an on call consultant, registrar and senior house officer (SHO) cover at night. There were two SHO on the wards and triage during the day. All consultants were within 30 minutes from the hospital when needed at night.

The hospital had a team of 13 anaesthetists trained for obstetric emergencies that provided 24/7 cover which ensured they were able to support and provide additional cover if a second anaesthetist was required.

The hospital maternity service had a consultant anaesthetist and one trainee cover from 8am to 6pm. Out of hours was covered by a registrar and on call consultants (two adults and one paediatric) overnight. The on-call was seven days a week at night and weekends. The registrar cover was seven days a week and while the consultant cover was five days. We noted that the on call medical staff were free from all other duties and cover was at weekends and nights.

The Lindo Wing was staffed by an anaesthetist and obstetricians. The majority of the consultants in the Lindo Wing worked in the hospital maternity service but did their private practice in the Lindo Wing. There was on call cover at night and out of hours. There was a second on call or additional anaesthetist cover which was covered by the general labour ward during emergencies. The Lindo Wing had a resident registrar that also covered during an emergency.

The anaesthetist on the Lindo Wing worked from 7.30am to 12.30pm for the morning shift, 12.30pm to 5.30pm for the afternoon shift and from 5.30pm to 7.30am for the night shift. Staff felt the shift worked well and there was always a second on call anaesthetist in the service when needed.

There was only Trust wide data for medical staff in maternity. From November 2017 to October 2018, the trust reported a sickness rate of 0.4% in maternity for medical staff working cross sites. This was better than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From November 2017 to October 2018, the trust reported no locum or agency hours available. However, 2,230 agency hours were filled in maternity and of which 53 agency hours related to the maternity services at St Mary's Hospital. The trust was unable to confirm the number of locum or agency hours that were unfilled.

A breakdown of agency usage by site is shown below:

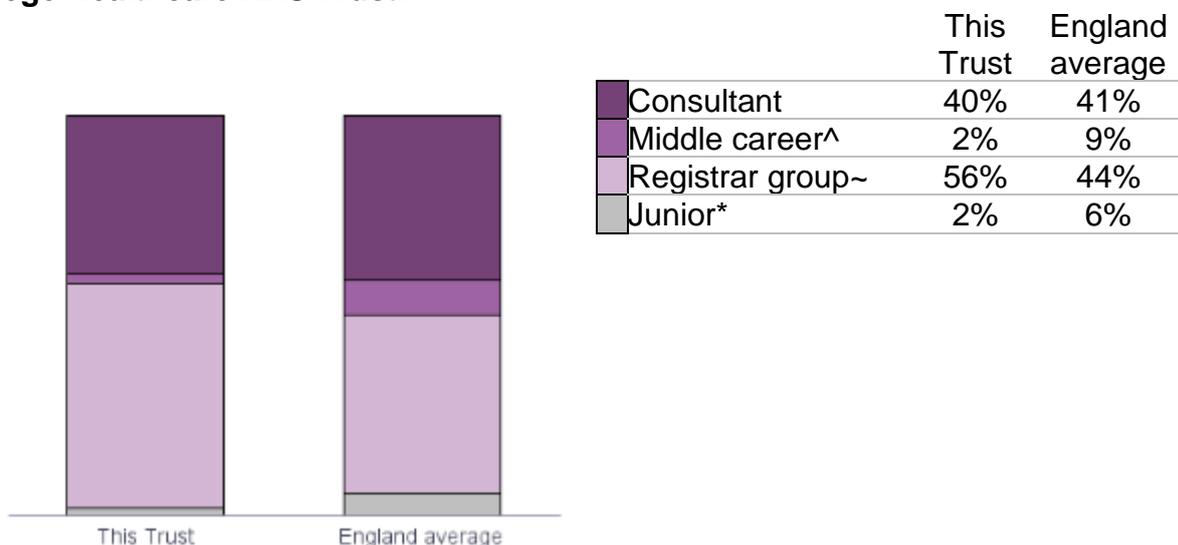
Location	Total hours available	Agency Usage
		Hrs
St Mary's Hospital	0	53
Queen Charlotte's and Chelsea Hospital	0	2,177
Total	0	2,230

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

During inspection senior staff told us they mostly use in house locum for unfilled shift.

In September 2018, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff reported to be working at the trust was lower.

Staffing skill mix for the 102.9 whole time equivalent staff working in maternity at Imperial College Healthcare NHS Trust.



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

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

The maternity service used paper and electronic record to document patient records. Staff had received training on the the electronic records used in the service. Hand held notes were documented and given to patients. Women carried their own handheld pregnancy records, which staff documented on and advised women to bring at each antenatal appointment and any occasion when they attended the hospital. This was in line with the NICE *Antenatal care for uncomplicated pregnancies* guideline. Staff told us the trust had plans to go paper light in future.

Women were given the national personal child health record (also known as the ‘red book’) by staff on discharge after birth. The red book is a national standard health and development record and is used to monitor growth and development of the child, up to the first four years of life.

Staff kept appropriate records of patients’ care and treatment. We observed that records were legible, clear, up-to-date and were available to all staff providing care. We noted that staff had access to patient information, could see all care episodes and make informed decisions on patients’ care, management and treatment. We saw that staff documented telephone advice to patients on their records to ensure continuity of care when they arrived to the hospital during labour.

The electronic record was implemented four years ago however the full journey of pregnancy on the system as well as fetal link went ‘live’ in August 2018. There were plans for the fetal link (electronic CTG) system to go live on the antenatal ward and Lindo Wing in March 2019.

The service had introduced the role of an information technology (IT) midwife since the introduction of the new electronic system. The IT midwife trained colleagues on electronic records, responded

to email queries, corrected errors on system and attended a weekly meeting for fetal link and data correction.

The new electronic system was to be rolled out on the Lindo Wing later in March 2019 and MEOWS were currently recorded manually. We reviewed six sets of patient notes on Lindo Wing and of which three had MEOWS score. Out of the three notes reviewed, staff carried out 22 observations of which 12 (55%) had MEOWS scores. This was escalated to senior staff who told us this was an on-going issue as staff were not adding up scores. Senior staff had developed teaching materials for staff to educate them on the importance of MEOWS and how to score the findings. Senior staff told us this would improve when they go paperless. The new electronic records would automatically score the MEOWS chart if all areas were completed and would alert staff if scores were out of range. Following the inspection, staff received further training on MEOWS score and managers reinforced the importance of adding scores to staff. The service carried a MEOWS audit post inspection on the maternity services including the Lindo Wing which showed 100% compliance. The hospital planned to carry out a re-audit in October 2019.

All community midwives had electronic tablets and were able to access real time patient records with security system to ensure information exchanges were secured.

The e-diary record audit for the period of 2 January 2018 to 30 June 2018 on Lindo Wing identified areas of improvement on staff documentation as entries were messy and difficult to interpret. We saw that the audit was shared with staff. Record keeping and documentation was included as a regular theme in the staff meetings and handovers.

We reviewed 12 maternity records for women at different stages of the maternity pathway and found these were completed in line with national standards (NMC *The Code: Professional standards and behaviour for nurses and midwives*, 2015). The records reviewed also included prescriptions, mental health, safeguarding and termination of pregnancy. The records reviewed were contemporaneous, and entries were legible, signed and dated. Regular clinical assessments by the multi-disciplinary team (MDT) were evident in the maternity records we reviewed. Clinical assessments such as safeguarding alerts, VTE, emotional assessment, care plans, allergies, smoking status, blood pressure and abdominal palpation were documented. We saw that discharge summaries were sent to health visitors and GPs. The summary included information about the woman's pregnancy, labour and postnatal care, any medications they had been prescribed, and any ongoing risks and/or follow-up care needed. We saw that staff communicated effectively with community staff where there were safeguarding, domestic violence and specific mother or baby concerns. We saw evidence of SBAR (situation, background, action and recommendations) handover in the patient notes.

As of February 2019, an average of 93.9% of maternity staff had completed information governance training. This was better the trust target of 85% compliance.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Medicines were supplied by the onsite trust pharmacy. Staff ordered, dispensed and disposed of medicines safely and securely. Arrangements were in place to facilitate medicines supplies out of hours.

There was effective process in place for managing medicines including controlled drugs (CDs) and emergency medicines used in the community during home birth. CDs were stored securely and managed appropriately. CDs were checked twice daily by two midwives and appropriate records

were maintained. Some areas checked CDs more frequently. We saw that controlled drugs were stored and managed appropriately. Medicines reconciliation was completed and recorded while identified areas of discrepancy were actioned and processes were audited.

The service used electronic prescription and administration records. We checked a sample of electronic medicines administration records and saw that they were accurate, completed fully with no missing administrations.

We saw that there was a current version of the British National Formulary (BNF) available and staff could also access the online version.

Allergy status of people, weight and venous thromboembolism (VTE) risk assessment outcomes were routinely recorded on the electronic medicines administration records. The service uses a paper based prescribing and administration records system. Staff understood their responsibilities for ensuring accurate medication records were kept. The records were completed and notes were made when any non-administration had taken place. Anti-microbial were seen to be reviewed in line with the Trust policy.

We saw that where babies were prescribed medicines that required additional monitoring that this was documented as being completed.

Patient group directions (PGDs) were in place for all midwives trained and permanently employed at the trust. These are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. All PGDs had been reviewed and were up to date.

We saw that as drugs were given to patient as required. The Lindo Wing had a resident doctor on the second floor that prescribed medicines and also contacted the patient's consultant when necessary.

Arrangements were in place to ensure adequate supplies of emergency medicines and equipment were available, especially out of hours.

We found medical gas cylinders used in the maternity units were stored appropriately in a locked room, in line with national guidance. Oxygen cylinders were full and within date. Tamper evident seals were in use to ensure oxygen were readily available when needed.

The pharmacy team provided advice, strategic direction and governance to optimise the use of medicines and the management of medicines across the service. The pharmacy team carried out medicines audits routinely to monitor sustained compliance with medicines security, medicines reconciliations, allergies, antibiotic breaches, VTE risk assessments, oxygen prescribing and dose omission. The pharmacists checked stocks regularly and the senior midwives also checked medicines weekly and carried out stock drugs audit. All medicines were reviewed during consultant led ward rounds which were attended by a clinical pharmacist where possible.

We observed that discharge summaries detailed the verbal and written information provided to patients about the medicines they were given. Staff provided appropriate medicines counselling on wards including discharge and all high-risk medicines.

The trust 'medicines matter' audit for the period of 4 October 2018 to 18 February 2019 showed 98% compliance on the medicines fridge audit and the medicines storage and security audit.

A missed dose 2018 audit was completed across all sites of the trust which highlighted an omission rate of approximately 3% for critical medicines which was better than the national average (7%).

The trust pharmacy medicines reconciliation rates 2018 audit highlighted the need to improve the timeliness of medicines reconciliation in some clinical areas. The result showed there was good assurance that timely (<24hrs) medicines reconciliation occurred within acute (non-elective) admissions areas within the trust where workforce was prioritised. Following this audit a medicines management safety stream was established to co-design a number of products and guides for clinical staff on how to manage medicines in clinical areas. This included the on-going production of updated fridge temperature monitoring and action algorithms, guide for disposal of CDs, new CD key fobs and clear guidance on roles and responsibilities.

Medicines were stored in locked cabinets, fridges and trolleys within locked clinical treatment rooms and only relevant clinical staff could access them. Medicines used for internal use and external use were stored separately. However, we found that the maternity areas were hot including the clinical rooms where medicines were stored due to the old hospital building. The service had identified this as a risk and was on their risk register.

Certain medicines are needed to be stored below 25 degrees centigrade to ensure safe use. During inspection we found 11 of these medicines such as metronidazole, adrenaline, frusemide, gentamycin were in a clinical room which was 29 degrees centigrade which was escalated to staff. Staff told us the temperatures were controlled centrally and the nurse leads for medicines worked collaboratively with the chief pharmacist to decide when to adjust the temperature. The hospital had a quality improvement project around medicines temperature monitoring. To mitigate the risk the pharmacist had shorten the shelf life of these medicines to six months before their use by date to account for the increased temperature and ensure it was safe to use. During inspection, we saw that staff had labelled these drugs for easy identification and ensure they were used within the time frame recommended by the pharmacist.

Fridge temperatures and clinical room ambient temperatures were monitored and recorded daily. During inspection we saw that fridge and room ambient temperatures were generally monitored by staff in all maternity areas. However, we reviewed the February 2019 room temperature checklist of the antenatal ward which showed temperature should range from 25 to 28 degree. The checklist showed that staff had not completed the checks twice and had recorded 24 degree for three days in that month, which was slightly out of range. Where the temperatures were out of range staff completed an action in place form to highlight steps taken to address the issue.

Incidents

The service managed patient safety incidents well.

Staff recognised incidents and reported them appropriately. 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.

Never events (NE) are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January 2018 to December 2018, the trust reported no incidents which were classified as a never event for maternity at St Mary's Hospital.

(Source: Strategic Executive Information System (STEIS))

During inspection we saw the service had reported a NE in 2018 at the QCCH site which related to a retained medical swab post-delivery. In January 2019 in response to the recent NE, the medical director and director of nursing sent an email update to all staff across the trust and asked for their ideas in preventing future events. The email outlined what the previous six NEs were and actions taken to prevent their reoccurrence. The email emphasised importance of reporting issues on datix, learning from everything staff does and identifying issues before these escalate to more serious incidents.

The trust had adapted the WHO checklist in response to the never event. The swabs policy and guideline had been updated and all staff had been informed and had to complete the swab safety online training. Since swabs had been identified as one of the biggest clinical risk the service now had IT midwives who checked on their system to ensure swab counts had been completed. This was then reported to the senior team and board weekly. Findings from this were shared at the handover, posters in staff rooms and the risk newsletter (risk manager) which highlight the top issues. This showed good learning practice and dissemination of information following a NE.

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from January 2018 to December 2018.

Of these, the types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with six (54.6% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother only with two (18.2% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with two (18.2% of total incidents).
- Major incident/ emergency preparedness, resilience and response/ suspension of services with one (9.1% of total incidents).

Site specific information can be found below:

- St Mary's Hospital: four incidents

(Source: Strategic Executive Information System (STEIS))

We reviewed three root cause analysis investigation reports relating to the maternity service. We found these to be comprehensive, detailed and included an action plan with allocated action lead, target date to implement the actions as well as arrangements for monitoring and evaluation. When applicable, we saw evidence of duty of candour documented in formal letter sent to patient and details of conversation in patients notes. We saw that following incidents the service involved staff and patients and their relatives in the investigation as well as offering support where necessary. Where incidents involved the death of a mother and/or baby the service liaised with the family, police, staff, coroner and the bereavement team.

At the last inspection we had concerns around the investigation of SIs and during this inspection we noted improvement in the SIs and incidents investigation processes.

Incidents were reviewed daily by the senior managers and if categorised as moderate or severe harm, this was escalated to the risk team. All incidents were discussed at the weekly governance meetings and the risky business newsletter was produced to disseminate messages to all staff. Information around incidents were also conveyed in clinical half day meetings, daily and weekly handovers in different medium to capture all staff. Incidents were also reported to quality and safety meetings where incidents were assessed and added onto the service risk register by the head of midwifery and director of midwifery. Staff told us they used a multi-disciplinary approach in

investigating incidents and all investigators had completed a root cause analysis and human factors trainings.

Staff told us that manager had oversight of incidents reported on the incident reporting system and, they followed up reported incidents and gave feedback to staff, including those involved, verbally and formally via email.

The trust used an electronic system for reporting incidents. Maternity, support and medical staff we spoke with said they were encouraged to report incidents, and felt confident to do so. Staff were involved and had received automatic feedback after reporting incidents. Student midwives we spoke to had also reported incidents and received feedback. Staff were aware of the incidents trends which included a swab error, medicines errors, third degree tear, aggression from patients and staffing, serious incidents and recent never events in the trust.

For the period of 1 February 2018 to 31 January 2019, the hospital reported 806 incidents for the maternity service of which 728 (90%) were related to patient safety incidents while 78 (10%) were non patient safety incidents.

Top categories of incidents:

St. Mary's Hospital categories of incidents

	Total	Total %
Near Miss	61	7.6%
No harm	544	67.5%
Low harm	186	23.1%
Moderate harm	11	1.4%
Major harm	0	
Extreme harm	0	
Not yet specified	4	0.5%
Total	806	100%

The risk team looked at all incidents and reviewed all the notes to determine where there might be harm to women including all babies admitted at term to the neonatal unit. The team also reviewed the neonatal admission list as a failsafe to ensure staff had completed a datix for all neonatal unit transfer.

Staff we spoke to reported a good incident reporting culture including near misses. Staff were able to recognise clinical and non-clinical risks and knew what incidents to report and how to report them. Staff were informed of recent incidents and learning at the safety huddle, handovers, team meeting newsletter and bulletin. We saw examples of learning and improvement to the service as a result of recent serious incidents. For example, as a result of recent incidents around CTG, the service had implemented the fetal link system which monitored heart and CTG and ensured rapid escalation. Since the fetalink was introduced there has been a reduction in the number of CTG related incidents".

We saw another example of learning and improvement from an SI which was related to transfer of a deceased baby to the mortuary and bereavement provision. As a result of issues identified from the investigation, the service had changed the bags used to transport deceased babies to the mortuary and midwives have since been required to escort bereaved parents to the mortuary to view and identify babies, and stay with them during this process. There were bereavement rooms on the wards and the introduction of petal counselling service in the maternity units to ensure six sessions of counselling were offered to women and their families. This was an improvement from the last inspection.

The service held monthly perinatal mortality and morbidity (M&M) meetings which were attended by MDT staff in the maternity and neonatal unit. Pathology and neonatal staff also attended this meeting and the group would consider each case. The mortality and morbidity group reported to the trust

board. Learning from cases were identified and action plans were set up where indicated. The bereavement midwife attended perinatal M&M meetings and other serious incidents governance meetings. Staff told us the list of cases to be discussed at these meetings were sent in advance to ensure adequate preparation and access to patient records. All still births and neonatal deaths were investigated and reported to the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) in line with the national guidance. We were assured the service had an effective system in place to ensure learning from perinatal M&M was shared, and actions were taken to improve the safety and quality of patient care.

The bereavement newsletter for the period of January and February 2019 showed there had been four still births, five late miscarriage and two neonatal death incidents in the trust.

From 30 April 2018 the Secretary of State for Health and Social Care had appointed the Healthcare Safety Investigation Branch's (HSIB) to investigate all cases of early neonatal deaths, term intrapartum stillbirths, cases of severe brain injury in babies (Each Baby Counts cases) and maternal deaths in England. During inspection we noted that the risk team also invited all teams to their bi-monthly meeting where HSIB maternity investigations were discussed. Senior managers told us they were pleased about HSIB and investigations as their reports helped to improve quality of services. Staff we spoke with were happy about this new process and support received from the trust with these investigations. Staff told us the HSIB reports took six months to produce and they ensured they communicated with families promptly during this process.

MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) launched the perinatal mortality review tool kit (PMRT) and staff told us the hospital used this tool with support from another hospital. The service used the structured judgement review for reviewing death and we noted that bereavement midwife were involved in this process. The trust had organised a pan London meeting to review the PMRT with the local maternity system (LMS) to ensure consistency on its use and to avoid duplication of work. The trust had also engagement with HSIB on PMRT who emphasised on communication with parents. The trust had 'buddies' at other hospital to review each other structured judgement review (SJR). This feedback and decision from the monthly neonatal M&M informed the information to be used to complete the PMRT forms by the lead.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The trust reported 37 occasions where the duty of candour had been used in the maternity services in the last 12 months before inspection. We saw that staff apologised and gave patients information and support when things went wrong. Staff understood the principle of duty of candour and importance of being open and honest with women and those close to them when something went wrong. They understood the need to offer appropriate support to put matters right and explain the effects of what had happened.

For the period of October 2017 to September 2018 the percentage of incidents reported in the trust that had had stage 1 and stage 2 of their duty of candour process completed was 91% for SIs, 90% for internal investigations and 97% for moderate and above incidents. The completion of duty of candour were monitored at the medical director incident review panel and reported at the executive committee, board quality committee, trust board and to the commissioners.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The safety thermometer is used to take a 'temperature check' on harm and record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus

attention on patient harms and their elimination. The service used this information to improve the service.

We observed that the updated safety thermometers were displayed on the maternity ward with the exception of the postnatal ward. This meant that the public could see the harm specific to maternity care. This was an improvement from the last inspection.

Data from the harm free care report and incident log for the period of 1 February 2018 to 31 January 2019 showed the service reported two pressure ulcers (0.2%) and eight (1%) falls or trips.

Is the service effective?

Evidence-based care and treatment

The maternity service had effective systems in place to ensure policies, protocols and clinical pathways were reviewed regularly and reflected national guidance, best practice and legislations.

Guidelines were available on the intranet and reflected by the Royal College of Obstetricians and Gynaecologists (RCOG) and National Institute for Health and Care Excellence (NICE) guidance when reviewed. The trust maternity specific guidelines and pathways included breastfeeding and artificial feeding, sepsis, antenatal management of diabetes (NICE *Diabetes in pregnancy: management from preconception to the postnatal period*), baby abduction, anaesthesia for operative deliveries, multiple pregnancies (NICE *Multiple pregnancy: twin and triplet pregnancies*), pain relief, newborn physical examination and jaundice.

The development of guidelines was governed and reviewed by the clinical audit and effectiveness group which consisted of an obstetrician, neonatologist, midwife and anaesthetist. Regular guideline committee meetings were held by the clinical audit and effectiveness group to review and renew guidelines before publishing and there was a flag system in place when a guideline was due for review. New guidelines were cascaded via the weekly staff newsletter, risky business newsletter and discussed at staff training days

The service also held annual audit meetings where audits were discussed and professionals like doctors, midwives, midwifery support workers (MSW) and children nurses could attend.

Staff told us they were informed of any changes in guidelines or practices via email, staff away days or team meeting. For example, staff were informed of the new perinatal mental health guideline by the risky business newsletter.

Staff told us the national bereavement pathway was currently in a pilot stage and would soon be in place nationally. They were going to implement this in the service afterwards as it would be useful to change practice and care provision for bereaved families.

The service had a midwife responsible for infectious disease who was currently developing the infection pathway. We noted that all infectious disease pathways were up to date including three antenatal and postnatal pathway for sepsis.

The service used cardiotocography (CTG) and had introduced the fetal link to enhance the delivery of effective care and treatment to support labour and birth, which enabled staff to have oversight of all CTG traces and abnormalities. CTG monitoring is evidence-based and has been shown to improve outcomes as it reduces the reliance on individual staff, which carries the risk of something being missed and means senior staff can intervene as indicated, without waiting to be asked. There were CTG weekly meeting which supported staff on evidence practice on fetal monitoring.

The maternity service used current evidence-based guidance and quality standards to inform the delivery of care and treatment for women and babies. We observed that the service participated in local and national audits programmes and collated evidence to monitor and improve care and treatment when indicated. Staff told us audits were treated as a priority in the trust which were used to inform risk, incidents and national audits.

Medical and midwifery staff including students were allocated and involved in the maternity audits process. The audit group decided on the audit programme in response to national audits, national guidance, best practice initiative, divisional objectives, practice related issues, risks and trends from data.

Women's antenatal and postnatal records showed they received care in accordance with national guidance and standards. For example, the service held weekly clinics for women with mental health needs, substance misuse and complex needs. The service also held FGM and bereavement clinics. We saw that staff followed the NICE guidelines on antidepressants in pregnancy. Women's records contained complete record of antenatal test results and referrals. Women's record also contained a completed comprehensive mental health assessment of patients' needs at booking and where patients required further input from the perinatal mental health team their plans of care was personalised and included details of action to be taken out of hours if the patient became unwell.

Staff managed the care of women who needed a caesarean section (c-section) appropriately in accordance with NICE guidance. For example, vaginal birth after caesarean section support and counselling was offered to all women who had had a previous c-section if no medical condition or complication were identified. This provided women with the opportunity to discuss birth options in their current pregnancy.

Pregnant women at risk of gestational diabetes were referred to the weekly diabetic clinic for glucose tolerance testing and those with pre-existing diabetes were referred for retinopathy screening in the first trimester (weeks one to 12 of pregnancy). Diabetic retinopathy is a condition that can lead to sight loss. We noted that staff monitored and assessed women's blood sugar to prevent gestational diabetes, hyperglycaemia or hypoglycaemia. This was in line with national recommendations (NICE *Diabetes in pregnancy: management from preconception to the postnatal period*). The service had two diabetic specialist midwives that supported women and were involved in development of guidelines relating to diabetes.

During inspection we reviewed the trust policies and guidance including 10 specific protocols and guidance related to the service and we noted they were generally up to date. However, staff found it hard to find some guidelines such as the postpartum haemorrhage (PPH) guideline on the system. Staff were unable to find the guideline for neonatal resuscitation and we were not sure if there was one. We did not see the resuscitation council algorithm in the clinical areas. The maternal resuscitation guideline we saw was out of date and due for review since July 2018.

On the Lindo Wing postnatal ward, the printed PPH guidelines on the trolley were out of date since 2016 and had an updated version on the intranet, which have not been printed out. This was escalated to staff and the guideline was removed immediately.

We also found some protocols on the intranet that had different version control dated 2015, 2016 and 2019 like the eclampsia protocol. Senior staff told us they recently transitioned into a new intranet which explained the different versions of guidelines and why staff might have found it hard to search for new protocols and guidelines.

Following the inspection, the trust provided us with the above guidelines which showed they were all up to date. We saw that the neonatal guidelines also had links that directed staff to the Resus Council UK website for specific guidelines such as paediatric basic and intermediate life and the newborn life support. The service also had a newborn life support flow chart to guide staff on resuscitation.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff used special feeding and hydration techniques when necessary.

The service made adjustments for patients' religious, cultural and other dietary preferences.

Patients' nutrition and hydration needs were identified, monitored and met and indicated on patients' record. Women and babies had access to dietary and infant feeding specialists when needed to including the Lindo Wing. The service had breastfeeding support workers and volunteers that help support women with feeding and babies nutrition.

Staff supported and advised women on breastfeeding their babies, including positioning and attachment, and hand expression during the antenatal and postnatal period. The average breastfeeding rate for the period of February 2018 to January 2019 at birth and discharge was 80%. The highest compliance was achieved between August and October 2018 between 90% to 93%. The Lindo Wing breastfeeding rate for the same period was 75%. The trust reported they were unable to differentiate between breastfeeding initiation rates and the breastfeeding discharge rates in their data extraction. The trust told us they had identified an issue with the data on the breastfeeding rate figure in November 2018 which was corrected and they had continued to support women with breastfeeding. The hospital had plans to improve the milk kitchen and breastfeeding areas on the maternity wards in February 2019.

Babies with tongue-tie, a condition that affects their feeding, were referred to a complex breastfeeding and tongue-tie assessment clinic where the doctor could divide the tongue-tie during a procedure if required. This meant that women and babies received timely intervention when feeding was complicated by tongue-tie.

Women were offered light refreshments such as biscuits, sandwiches, water and hot or cold drinks during labour, after delivery or caesarean section. During inspection, we observed staff offering women a drink of their choice and biscuits. There were also hot meals available to women admitted on the inpatient wards.

Women and babies at risk of hypoglycaemia were regularly monitored following delivery to ensure they were well and their blood glucose levels were maintained within the normal range. We observed the maternity wards had hypoglycaemia box which contained dextrogel, glucose juice and glucose-tablets which were given to patients during diabetic emergencies. Women with pre-existing or gestational diabetes were referred to a dietician with advice given on diet to help control blood sugar levels and weight, in line with national guidance (*NICE Diabetes in pregnancy: management from preconception to the postnatal period*).

Staff monitored women's hydration levels during labour and post-delivery and if necessary these were corrected with oral or intravenous hydration techniques when indicated using the fluid chart, in line with national guidance.

Women were given advice on fasting before their elective caesarean section which was in line with national guidance (*OAA/AAGBI Guidelines for Obstetric Anaesthetic Services*).

Staff in antenatal clinic gave women advice on their nutrition and hydration including iron rich diet.

The service used a gestational related optimal weight (GROW) assessment tool which was a customised birth weight centile to plot baby's weight accurately including weight loss and gain. The weight centile result informed the health promotion and care plan of the baby. Nutrition advice and referrals were given based on the result of the baby's birth weight centile.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

The staff assessed and supported those unable to communicate using suitable pictorial assessment tools and gave additional pain relief to ease pain.

Women were provided with evidence-based care and information about the availability and provision of different types of analgesia. This was in line with national recommendations (OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services*, 2013). Pain relief and control was discussed with women during their birth plan appointment and women were able to choose their choice of pain relief.

During admission, staff assessed and managed women's pain level regularly on an individual basis. The delivery rooms and birth centre had birthing pools and stools which were used to ease pain. Women were offered massage, breathing and relaxation techniques, mobilisation and Entonox (a mixture of nitrous oxide and air) as part of the pain relief

Staff used various pain tools such as the numeric pain score or smiley face score to assess patient pain depending on the needs of patient. The smile face pain tool is used for patients with speech impairment and learning difficulties that may find it hard to describe their pain.

Pharmacological methods of pain relief such as 'gas and air', opioids (such as oral morphine) and epidural anaesthesia were readily available for women in the service. Women were also prescribed non-steroidal anti-inflammatory drugs (NSAIDs) post-operatively and during delivery to manage their pain.

During inspection we saw there was good anaesthetist cover which ensured women had timely access to pain management. Women we spoke with told us they had received good pain relief from staff and pain management options were discussed at the birth plan appointment.

National guidelines recommend that the time from which a woman requests an epidural to the time they are ready to receive one should not normally exceed 30 minutes; this period should only exceed one hour in exceptional circumstances (OAA/AAGBI *Guidelines for Obstetric Anaesthetic Services*, 2013). For the period of April 2018 and February 2019, the average waiting time for 95% of women was 10 minutes which showed the service was compliant and was within the national standards. There were 2 (5%) outliers at 30-40 minutes waiting time. The reasons for the delay included doctors were busy with another epidural, emergency within labour ward, pending blood results and major incident or emergency outside labour ward. The average waiting times during day time hours was 11 minutes and 54 seconds and 8 minutes and 18 seconds during the night shifts. There was no audit of wait times in the Lindo Wing as the service was bespoke to women's needs. An anaesthetist was on call 24/7 and all women were reviewed by an anaesthetist following delivery.

Between April 2018 and February 2019 all women having elective caesarean section (ELCS) received regional anaesthesia while 99.8% having emergency caesarean section (EMCS) had regional anaesthesia which was better than the national targets. Only two patients had a general anaesthetic (GA) during this time period, one at maternal request and one for a category 1 lower (uterine) segment caesarean section (LSCS). Eighty percent of women had epidural while the other patients for ELCS and EMCS received regional anaesthetic. The result showed that in less than 1% for GA, consultants had participated in a GA quality improvement project which ran for a year.

The 2016 epidural audit showed the epidural rate was over 50% and all women received their epidural in less than 10mins with the exception of one outlier at 32 minutes.

The trust maternity division carried out a pain audit in November 2018 which covered paediatric and maternity service (88%) and the Lindo Wing (12%). The audit covered pain assessment for adults (74%) and children (27%). The result showed that 85% of patient had at least one pain score in 24 hours, while 15% had no pain score. The result highlighted that 65% of patients were assessed as part of the clinical observation, poor prescription in 72% of cases, low as required medicines (28%) and the documented reason for moderate or severe pain. The target was met for having no more than mild pain. As a result of this audit the hospital had created a pain task and finish group to improve the pain assessment and provision in the WCC services.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The maternity service at St Mary's Hospital participated in various quality improvement initiatives, research, trials and regularly reviewed the effectiveness of patients care and treatment through local and national audits and used the findings to improve the service.

The maternity service maintained a local and regional clinical indicators, scorecards and governance dashboard which reported on activity and clinical outcomes. Performance was monitored for a range of outcomes such as deliveries, instrumental deliveries, caesarean section deliveries, still birth rate, neonatal death rate and the number of third and fourth degree perineal tears.

We reviewed the regional maternity dashboard from April 2018 to January 2019 submitted by the trust. The hospital was only meeting (green) their goals on 23 out of 36 outcomes. This included maternal mortality, maternal admission to ITU, third and fourth degree tears, women having personalised care and offered choice of birth setting, women booked by 12 weeks, normal and instrumental deliveries, women offered smoking cessation at booking, women with a named midwife, one to one care in labour, and post-partum haemorrhage. The trust was amber on seven indicators which included c-section (18.6%) and LSCS (7.2%) and red for four indicators which included continuity of care (7.1%), home births (0.4%) breastfeeding initiation rate (80%) and pre-term birth rate (12.9%) against their goals. We noted that performance on the continuity of care model was similar in the region and none of the trust had their target. Senior staff told us that most women that would or were at risk of having pre-term birth in the region had their babies in the trust due to the facilities and provision offered in the trust compared to other maternity service in the region, which was reflected in the dashboard.

The hospital also had clinical indicators which was reviewed for performance but did not have a RAG rating. We reviewed the performance between April 2018 and January 2019. The maternity service delivered 2,540 babies of which 14 were born before arrival at the hospital, which is lower among the region. In that period the service did not meet the trust target for breastfeeding initiation (BFI) with the rate being 79.2% against 83% target. The trust explained this was due to data quality issues which were being investigated. The trust BFI level 2 inspection was due in April 2019. The percentage of women seen before 12+ 6 week, excluding late referrals was 95%. In January 2019 this rate had dropped to 91.1% due to a process failure which was rectified and they were compliant as at February 2019.

In the same period there were 31.3% c-sections of which 18.3% (452) were emergency c-sections while 13% (322) were elective c-sections. The service reported 17.6% of women delivered in birthing centre, and there were 0.4% home births. There were 58.7% (1459) normal vaginal deliveries and 10% instrumental deliveries. From April 2018 to January 2019 there were 437 deliveries at the birth centre of which there were 195 (44.6%) primipara (single deliveries and multiple deliveries (55.4%). For the single deliveries, 31.3% had water births, 23.1% had land births and 20.3% had water in labour and land birth. For the multiple deliveries; 45.1% of women had water births, 38% had land births and while 16.9% had water in labour and land birth.

The service reported that four babies were born in the intrapartum areas in triage or cases where induced labour has progressed quickly in an antenatal area. The trust told us these were occasions where staff had decided it was safer to deliver the baby in these areas as opposed to transfer.

For the same period the rate of postpartum haemorrhages over 1.5 litres was 2.7% against the target of 2.8% or below. The other indicators reported in the same period are below:

- Number of bookings was 3,744
- % of women seen before 10+0 weeks excluding late referrals was 66.9%
- % of women seen before 12+6 weeks excluding late referrals was 95%
- % of late referrals less than 10+6 weeks was 20.5%

- % of late bookers was 14.2%
- (BC + HB) out of obstetric unit births (MLU & Home of unassisted vaginal births) 31%
- Number of Eclampsia: 0
- Number of Neonatal Deaths 2
- Consultant hours on labour ward: 98 hours

The service did not report significant delays in induction of labour within this period. In the last six months before the inspection, Lindo Wing had delayed elective inductions of labour and lower-segmented caesarean section (LSCS) on two occasions. This was due to high acuity on the labour ward.

For the period of 1 February 2018 to 31 January 2019 the Lindo Wing reported 847 deliveries of which 400 were normal delivery, 497 were c-sections and 27 were instrumental delivery. The Lindo Wing compared its LSCS rate with the trust NHS maternity service on a quarterly basis. Whilst there were higher proportion of elective LSCS, the emergency category 1 and 2 LSCS were comparative in the NHS. All unexpected term admissions to the neonatal unit were discussed at a neonatal and obstetric MDT and information on Lindo Wing was fed back to the Lindo Wing lead midwife. The rate of postpartum haemorrhages over 1.5 litres between December 2017 and December 2018 was between 0% and 2.4% which was better than the national standard of 2.8% or below. Their performance was fed back to the Imperial Private Healthcare (IPH) quality and safety committee and the women's, children's and clinical support (WCCS) (NHS side) divisional quality and safety committee meeting and risk group.

For the period of April 2018 to January 2019 the service reported 1.6% (40) third and fourth degree tears during the deliveries of babies. Following concerns raised by staff on the prevention and treatment of significant perineal trauma, an audit was carried out in 2018 to assess maternity staff views on perineal repair. The audit showed that staff were positive about the implementations of several policies on perineal tear and had recommended areas of improvement. This included: antenatal education on perineal massage, introduce a policy on 'fresh eyes' on complex perineal repairs, use of warm compresses on the labour ward and urgent training for all staff on perineal support in advance of anticipated roll out of Obstetric Anal Sphincter Injury (OASI) care bundle. Staff also recommended that managers should feedback to the named staff who performed a repair if a tear or complication occurred. The service planned to seek staff feedback in six months after implementation of the policies and recommendations. As a result of this audit the trust had introduced a quality improvement project on the prevention and treatment of perineal trauma.

The trust participated in the National Maternal and Perinatal 2017/18 audit. The result showed the electronic system was fully accessible by community midwives, over 95% of women had received one to one care in labour and the services met the number of planned postnatal community contact.

In the 2017 National Neonatal Audit St Mary's Hospital's performance in the two measures relevant to maternity services was as follows:

•Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?

There were 124 eligible cases identified for inclusion, 91.5% of mothers were given a complete or incomplete course of antenatal steroids. This was better than expected when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids. The hospital met the audit's recommended standard of 85% for this measure.

•Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?

There were 29 eligible cases identified for inclusion, 51.7% of mothers were given magnesium sulphate in the 24 hours prior to delivery. This was better than the national aggregate of 43.5%,

and put the hospital in the middle 50% of all units.

(Source: [National Neonatal Audit Programme](#), Royal College of Paediatrics and Child Health)

From April 2017 to March 2018 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections and emergency sections were both as expected.

Standardised caesarean section rate (April 2017 to March 2018)					
Type of caesarean	England	IMPERIAL COLLEGE HEALTHCARE NHS TRUST			
	Caesarean rate	Caesareans (n)	Caesarean rate	Standardised Ratio	RAG
Elective caesareans	12.4%	1,440	15.7%	98.7 (z=-0.1)	Similar to expected
Emergency caesareans	15.9%	1,561	17.0%	102.4 (z=0.2)	Similar to expected
Total caesareans	28.3%	3,001	32.7%	100.6 (z=0.1)	Similar to expected

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from April 2017 to March 2018, the table below shows the proportions of deliveries recorded by method in comparison to the England average:

Proportions of deliveries by recorded delivery method (April 2017 to March 2018)			
Delivery method	IMPERIAL COLLEGE HEALTHCARE NHS TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Total caesarean sections ¹	3,001	32.7%	28.3%
Instrumental deliveries ²	1,423	15.5%	12.4%
Non-interventional deliveries ³	4,749	51.8%	59.3%
Total deliveries	9,173	100%	100% (n=596,828)

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

¹Includes elective and emergency caesareans

²Includes forceps and ventouse (vacuum) deliveries

³Includes breech and normal (non-assisted) deliveries

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

As of December 2018, the trust reported no active maternity outliers. However, the local inspection team was following up action plans for puerperal sepsis and other specified puerperal infections (July 2017).

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

The Lindo Wing reported one still birth (0.11) in 2018.

In 2018 there were 44 bereavement cases in the maternity service which required 319 hours input by the bereavement midwives. Post mortem was offered for 20.5% of these cases. The bereavement cases were in relation to late miscarriage (15), still births (19), medical termination of pregnancy (9) and social team (1).

The trust took part in the 2018 MBRRACE perinatal mortality audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 6.70. Comparing this trust to others with similar service provision, this was worse than expected and was up to 10% higher than the average for the comparator group rate of 6.20. The MBRRACE data was not risk adjusted and none of the neonatal deaths were avoidable (complex congenital pathologies) and reflected the high risk population as a tertiary centre for fetal disease. However, at the time of the inspection there was no aspirational standard for this audit.

(Source: MBRRACE UK)

In response to MBRRAC-UKE perinatal mortality report the trust carried out a review of the neonatal mortality and stillbirth rates trends. The trust produced an action plan following the review. They identified 11 actions which, at the time of the inspection, were on track with allocated leads responsible for completing each action. The audit showed nine of the eleven actions had been completed and while the other two were in progress including neonatal implementation of the national perinatal mortality review tool (PMRT) to strengthen the review process in line with national guidance and invitation of the maternity to the newborn and infant physical examination (NIPE) quarterly meeting. The trust had implemented the growth assessment programme (GAP) and gestational related optimal weight (GROW) chart and used the RCOG guidelines on fetal movement to help reduce still the still birth rates.

The Saving Babies' Lives care bundle was covered within the maternity core specific training to improve staff knowledge and competency. The service had identified high still birth rate identified in the black and minority ethnic groups and midwives worked to improve community engagement with the groups and key stakeholders to improve patient outcome.

The MBRRACE 2016 audit showed the trust had still births which were up to 10% higher and the neonatal rate were over 10% higher than comparable level 3 units in UK. The audit showed that the majority of still births were complex cases and were not preventable. We reviewed the February 2018 outstanding action plan updates which showed that all actions had been completed which included risk assessment and surveillance of pregnancy for fetal growth restriction, raising awareness of reduce fetal movement, effective fetal monitoring and reducing smoking in pregnancy.

The trust neonatal intensive care units (NICU) also participated in the Vermont Oxford Network (VON) that risk adjusts and benchmarks key performance indicators (KPI) including mortality of 950 NICU around the world (containing outcome data on about 60,000 very low birth weight infants per year). The result showed that the trust performance against KPIs was comparable to other tertiary centres.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff were supported by their managers to maintain their professional skills and experience through internal and external training, study days and career progression.

Staff had access to internal and external training to ensure their competence and development. Staff told us courses were advertised and managers encouraged them to attend training. Study time was negotiable depending on the course.

Staff including the student midwives and junior doctors were given protected time to attend regular teaching and learning schedules in place for staff such as CTG weekly teaching meetings, SIMS training, away days, bereavement teaching sessions. For example, carers and staff such as consultants, midwives, sonographers and bereaved parents also attended a full bereavement study day which had included the use of actors to role play bereaved families. Staff spoke positive about the training and how it had given them insight on communication, breaking bad news, behaviour and compassion.

Staff were trained on the assessment of fetal growth and used gestational related optimal weight (GROW), conflict resolution, bereavement and NHS newborn and infant physical examination (NIPE) screening programme. The service had a dedicated NIPE midwife that worked one day per week. The NIPE midwife was looking to implement NIPE screening management and reporting tool (SMART) as a fail-safe system. The NIPE SMART is an IT used to identify eligible babies and record and manage local newborn NIPE screening pathways. Ten midwives had received training on NIPE and staff told us there were other midwives currently doing the NIPE training. Newly trained NIPE midwives were supported by a paediatrician and worked alongside them to gain confidence and competency.

The service had a list of all midwives who were trained and conducted NIPE and refreshers were also set up for these midwives to keep their skills current.

Midwives with high dependency skills staffed the high dependency unit (HDU) on the labour ward. Data provided by the hospital showed that 17 midwives had completed the HDU training. This was in line with the requirements of the Obstetric Anaesthetist Association, Maternity Enhanced Care guidance (2015).

Staff had attended study days on perinatal mental health and had an hour training with the mental health team and IAPT (Improving access to psychological therapies). The training included scenarios based on real life issues. Staff told us they found this helpful in identifying and managing women with perinatal and postnatal depression. Senior staff told us as a result of the training staff were more competent in assessing patient perinatal mental health and there had been an increase in the number of referrals.

The midwives received breastfeeding training every two years and some midwives we spoke to had received training on assertiveness.

Student midwives (SMW) were involved in the simulation training as part of MDT and had received breastfeeding training via their university.

We saw that staff were actively involved in teaching within the service and externally. For example, the bereavement midwife participated in teaching student midwife at a nearby university.

Consultants had attended the RCOG training day, funded through the CTG safety stream work. The CTG teaching, skills and drills and sepsis management were included in all induction sessions for junior doctors.

The service offered a bespoke incidents training for senior staff and staff had received swab training as a result of recent never events. The service had plans to start the human factors training. Senior managers had received training on investigating incidents to improve their skills and competence in the daily reviews of incidents. The risk midwife was seconded to the Healthcare Safety Investigation Branch's (HSIB) with the aim to improve their knowledge and competency on investigating of maternity incidents.

The IT midwife trained colleagues on their electronic records if training had been identified from their appraisals, responded to email queries, corrected errors on system and attended weekly meeting for fetal link and data correction.

Three staff in the screening team had been trained to be genetic counsellors to improve competence and service provision in the service.

The PROMPT training was currently done across the North West London region and the trust had applied for funding to run sessions in the maternity services.

Midwives received support through the professional midwifery advocate (PMAs) which replaced the supervisors of midwives. All the previous supervisors of midwives had or were receiving the bridging programme for the PMA role. All midwifery staff in the trust were offered restorative clinical supervision and safeguarding supervision by the PMAs.

All maternity staff underwent a trust and maternity specific induction and orientation programme, which included mandatory and role specific training. The maternity specific induction included tour of the service area and teaching on topics such as breastfeeding, obstetrics and consenting to

mortem. Staff told us the induction and orientation for new starters was useful and well organised. Staff were given time to complete their mandatory training. Students and new midwifery staff were given supernumerary period and rotated in different maternity clinical area. The student midwives had opportunity to do their placement in all the maternity areas and neonatal unit.

Midwifery and medical staff we spoke to within the maternity service were up-to-date with their professional revalidation. Consultants and medical staff were involved in serious incidents investigation and this formed part of their appraisal and revalidation process. Midwives told us the PMA and other senior staff supported them with revalidation. This meant the service had appropriate measures in place to ensure all midwives and doctors were up-to-date and fit to practice.

All midwives were trained to give BCG vaccination which meant midwives vaccinated their own patients. Two midwives were trained to give whooping cough and flu vaccines and were based in the antenatal clinic. There were three immunisation midwives across sites and the trust had secured a training package by the Public Health England to train more midwives.

The head for anaesthesia had completed a course to be a mentor for junior colleagues.

The service had a competency based pack to assess staff competence and development. For example, there was a theatre clinical competency pack for midwives and scrub nurses in the service.

Sonographers and antenatal screening co-ordinator attended staff meetings and held teaching sessions with staff.

All staff underwent a trust induction and orientation programme, which included mandatory and role specific training. Staff told us that they had two weeks of induction, three weeks supernumerary and orientation as new starters and had found them useful and well organised. Bank and agency staff were inducted at the start of their shift in the maternity wards. There was a local induction checklist which was completed by agency, bank and medical locum staff.

The majority of midwives could work anywhere in the maternity service which ensured their skills and competence were up to date.

The service offered a bespoke one year preceptorship programme and staff were assigned for six months on the labour ward, three months on the postnatal ward and three months at the birth centre or community. Staff told us the preceptorship programme attracted newly qualified midwives who were mainly student midwives to apply for jobs in the service. Preceptorship programme included administration of intravenous (IV) antibiotics to babies. Staff were required to witness five antibiotics and observe five antibiotics being given before being signed off to administer neonatal IV injections to ensure their competence.

All trust staff received annual appraisals, during which any concerns or support needed in relation to professional and/or clinical competency could be raised and actions identified as appropriate. From November 2017 to November 2018, 95.9% of required staff within maternity at St Mary's Hospital received an appraisal compared to the trust target of 95% and hospital average (92.1%) within this period. The breakdown by staff groups can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met? (Yes/No)
NHS Infrastructure Support	2	2	100.0%	Yes
Support to doctors and nursing staff	51	49	96.1%	Yes
Qualified Nursing Midwifery Staff	117	112	95.7%	Yes
Total	170	163	95.9%	Yes

(Source: Routine Provider Information Request (RPIR) – Appraisals tab)

There was a good system in place for the annual appraisals through the electronic systems. For doctors the revalidation team sent an email as they were coming close to their revalidation and the divisional director was informed if requirements were not met. Staff told us where poor performance

was identified the senior managers worked with HR department to support staff and process was put in place for the staff capability and training package.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

The maternity service multidisciplinary team (MDT) worked together with external multi professionals and hospitals to improve patient care and outcome. Doctors, midwives, midwifery support workers and other healthcare professionals supported each other and were involved in assessing, planning and delivering women's care and treatment.

The maternity staff worked jointly with a number of specialities including physicians, psychologists, paediatricians and perinatal mental health team to deliver effective care and treatment. We saw there was good liaison and collaborative working among the obstetrics, safeguarding and perinatal mental health team.

The perinatal mental health team worked well with caseload midwives and ran weekly clinics in the centre. Since the last inspection, the trust had employed an additional staff for the perinatal mental health team and there were now two designated staff members. The team worked with caseload midwives to capture women that lived out of the local area who were vulnerable to ensure continuity of care. The perinatal mental health team had a caseload of 150 women in the trust and held one clinic per week on each site. The perinatal mental health team had good links with consultants who had special interest in mental health.

There was good multidisciplinary working in the fetal medicine unit (FMU) and the midwives worked well with doctors and counsellors in the diagnosis, support and delivery of care. Staff were proud of the radio fetal ablation as it made a difference to women. Ablation which is also known as catheter ablation, is a treatment that aims to control or correct certain types of abnormal heart rhythms.

The midwifery teams had daily handovers on the labour ward between changes in shifts (twice daily) where each woman was discussed at the handover and the lead midwife from the out-going shift briefed the on-coming staff about each woman including any mental health needs they might have. We observed one of the morning midwives handover. The team used electronic board which had real time information for patients' allocation and staff could discuss patient fetal monitoring using the fetal link. The handover was detailed with good interaction between staff. Allocation was done according to skill mix and midwives were able to choose if this improved the continuity of care for women. 'Fresh eyes' buddies (discussed above) were allocated at hand over and entered onto Cerner.

The medical handovers took place four times a day on the labour ward. The medical handover used a structured approach at the handover with a senior midwife present to discuss plans for each woman. We observed a morning medical handover that took place at 8am which the labour wards coordinator attended and presented to the obstetrician and anaesthetic team. Medical handover took place four times daily at 8am, 1pm, 5pm and 8.30pm. The antenatal and postnatal ward had daily ward round which was attended by MDT staff. We observed that midwifery and medical staff respected each other, share relevant information, focused on safety and was able to challenge each other.

The handovers were used as a teaching opportunity for staff. Other MDT meetings in the maternity service included CTG, safeguarding meeting and bereavement meetings to discuss complex cases. For example, the bereavement midwife hosted an MDT meeting every three months and where other staff such as the Chaplin, faith workers, porters, and clinical staff could attend and discuss on-going cases and any concerns.

There was a cross site telephone safety huddle over the phone twice daily which was led by the consultant midwife or senior managers. The safety huddle covered staffing and any patient concerns

in each area. At the evening huddles, shifts that needed to be escalated to the bank and agency staff office for the night shift or next day were reviewed and approved at this meeting.

The caseloads midwives cared for vulnerable women including learning disabilities, safeguarding and mental health. They worked with other MDT teams such as safeguarding and perinatal mental health to ensure a care plan was in place by 34 weeks on the electronic records. This ensured all staff involved in the patient care were aware what was on the plan as well as continuity following discharge into the community. During inspection we saw that during labour, midwives were able to see patients care plan. If a woman was under the care of the perinatal mental health team, an alert was put on the electronic system with access to the care plan and notes entry highlighted in red to ensure ease of access.

The community midwives worked collaboratively with other MDT staff. They received emails from all areas in the trust, had access to the trust portal and were able to get real time information of patients and make referrals.

Community staff and caseload midwives reported good communication and relationship with their hospital colleagues and other professionals and agencies, such as health visitors, GPs, local authority safeguarding team, family nurse partnership, social services and the perinatal mental health team. We saw that staff involved health visitors on all high-risk cases and gave written and verbal handover on discharge. GP's and health visitors were informed by telephone and/or fax of events such as still births or neonatal loss, if it was an early loss.

In the Lindo Wing, the consultants and midwives would liaise with the patient's GP and other professionals such as perinatal psychiatrist, private counsellors, health visitors and social services following booking, intrapartum if any complication and delivery. Staff would also contact the GP if a still birth occurred or mental health and safeguarding issues were identified.

All MDT staff we talked with spoke highly of each other and focused on collaborative care to improve care and patient outcomes. Staff including the midwives and support staff told us they were treated as professional equals by other MDT staff. Medical staff listened to midwives' opinions which helped inform joint decision of plan of care. Staff felt the implementation of GAP improved communication among doctors, midwives and sonographers. Specific comments from staff included "great team work and relationship with the consultants and doctors", "team work is excellent in the service".

There were various joint MDT clinics in the service. For example, in the FMU the service held a joint cardiology and obstetric clinic twice a week. Staff in FMU also held weekly joint clinics with specialist such as the neonatologist, urologist and neurologist. There was a one stop shop in FMU which was a combined in-house screening service that enabled women to have their screening and tests carried out and have the result the same day.

The service also held recurrent miscarriage clinic in the hospital once or twice a week depending on acuity. This was a joint clinic by the consultants and bereavement midwives. The maternity diabetic clinic was a joint clinic with obstetrician and specialist midwife.

Seven-day services

There was seven days a week, 24 hours access in the maternity service, with the exception of the day assessment unit, antenatal clinic, ultrasound and FMU.

Access to the medical support was available seven days a week. Dedicated consultant cover was from 8am to 8.30pm with on-call arrangements in place out-of-hours.

Anaesthetic cover was available for emergencies on labour ward and the maternity service 24 hours a day, seven days a week in line with the national recommendations.

There was 24-hour access to a dedicated obstetric theatre, and the theatre team was also available 24 hours a day, seven days a week.

There was 24-hour access to the triage and diagnostic service, seven days a week.

The Lindo Wing (Imperial Private Healthcare) was open seven days a week, with 24-hours access for emergency antenatal care, intra-partum, nursery, postnatal care and postnatal community service.

The hospital pharmacy services which included the aseptic services was available Monday to Friday from 8am to 7pm and 9am to 1.30pm at weekends. Outside these hours, a resident pharmacist based at another nearby trust hospital was available for clinical queries and urgent supplies for all trust sites. The trust had a medicines helpline for patients to receive advice relating to their medicines and they received approximately 150 calls a month.

Health promotion

The midwifery and medical staff supported women that accessed the maternity service to live healthier lives and manage their own health, care and wellbeing.

The hospital had achieved the United Nations International Children's Emergency Fund (UNICEF) baby friendly initiative level 1 accreditation. This meant the trust had a policy in place, a plan for staff training and was committed to support mothers to breastfeed, whilst also supported parents who chose to bottle feed. Breastfeeding information was displayed throughout the maternity service, including percentage of breast feeding mothers. Midwifery staff gave breastfeeding support and advice to mothers both in the hospital and community. Women we spoke to told us staff had supported them with breastfeeding and feeding their babies in their preferred method such as bottle feeding and how to prepare bottle and formula feed.

The service held a daily breastfeeding and discharge talk on the postnatal ward which also covered other health promotion and safety information. The Lindo Wing also held regular parent craft (education classes; breastfeeding and baby massage) and health promotion class for women. Data received from the trust showed 133 women and their loved ones had attended the parent craft classes for the period of September 2017 to September 2018 in the Lindo Wing. Women we spoke to spoke highly of this service and we noted good attendance of women.

Staff gave health promotion advice to women on various topics which was evident on patients' records reviewed. This included advice on gestational diabetes, alcohol, smoking cessation, flu vaccines, breastfeeding, constipation, sleep, healthy eating, vitamin D, sudden infant death syndrome (SIDS), high body mass index, fetal movement monitoring, sleeping, and Bacillus Calmette–Guérin (BCG) vaccine. Other health promotion advice also included dental care, free prescription, care of self and baby, pelvic floor exercise to prevent tear, wound hygiene, and emotional well-being.

Staff assessed patient smoking status and offered smoking cessation advice before sign posting them for support in their local community. Between April 2018 and January 2019, 2.2% of women were known to be smokers at time of delivery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

Staff understood their responsibilities regarding consent and the Fraser guidelines and Gillick competence were explicit, and informed women about the risks and benefits of obstetric procedures, such as caesarean section. Fraser guidelines refer to a legal case which found that doctors and nurses are able to give contraceptive advice or treatment to under 16-year olds without parental consent. The Gillick competence is used in medical law to establish whether a child (16 years or younger) is able to consent to his or her own medical treatment without the need for parental permission or knowledge. Staff were familiar with the trust policy relating to the application of consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

We saw midwifery and medical staff asking for consent before they provided care or treatment such as administration of medicines, pregnancy scan and obtaining blood samples. From the notes reviewed we saw signed consent forms of women before procedures and treatments.

We observed staff obtained consent from women before carrying out a female genital mutilation (FGM) examination, before caesarean section and for early help referral.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

At the time of our inspection, staff we spoke to told us there were no patients receiving treatment that were subject to the Mental Health Act 1983 (MHA). Staff knew the correct process on how to refer patients to the mental health and perinatal mental health teams when required. Midwives told us that it was extremely rare to have a woman attend the service or deliver at the hospital who was under section under the Mental Health Act.

Staff had good understanding of Mental Capacity Act (MCA) and we saw examples of good MDT working and support with women that had capacity issues and where safeguarding issues were identified. For example, staff had liaised with their legal team and made representation at court of protection for a woman with capacity to ensure their safety. Staff had worked with the woman and her loved ones through the legal process before being transferred to a mother and baby unit.

Staff confirmed they had had training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). MCA and DoLS data was included in the mandatory training module on consent. Data provided by the trust showed that the maternity service had exceeded the trust target of 85% for mandatory training: 98% of maternity staff had undertaken consent training.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Patients were treated and cared for with compassion, respect and dignity. Feedback from patients and their relatives were positive. Staff were observed speaking to patients and families in an appropriate and caring way. We saw staff introduce themselves by first name and job title.

During inspection we observed staff had name badges. Patients knew their midwives and staff that were involved in their care. We saw a thank you card where a patient named six members of staff in her complimentary feedback and spoke highly of the compassionate care they delivered.

We saw many positive comments in the newsletters, letters and thank you cards. This included “compassionate”, “kind staff”, “excellent- 5 stars”, “lots of support and patience provided”, “huge thank you for all your help and support during child birth”, “thanks for your support, don’t think we would have done it without you”. “Your calm and belief that we can do it natural was very irreplaceable”, “midwives are like family”, “after care and feedback was great as well as answering any feedback or questions”, “staff check on us through the day, really supportive”, “everything was so good and brilliant”, “staff did great job with us”, “everyone was wonderful, I cannot stress how fantastic the staff were”.

We saw that curtains were used in all the patients’ room in the maternity service to maintain patient confidentiality when required and during handovers and ward rounds. Women told us that staff always maintained their privacy and dignity. We observed there was a check-in kiosk in place in the antenatal clinic which promoted patient confidentiality by ensuring they could self-check-in without going to the receptionist and confirming their personal details with other people present.

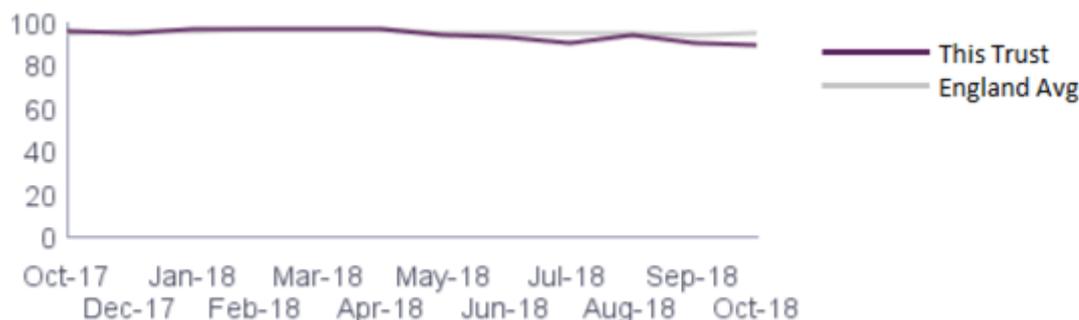
In order to improve the continuity of care the service had caseloads to support vulnerable women and recently introduced the continuity of care model for low risk women, which promoted a trusting relationship and patient-centred care.

We saw several examples of good and outstanding care by staff which included compassionate care during and post caesarean section. Staff supported, empowered and offered compassionate care to a woman and her birth partner throughout the procedure. In the recovery, we observed staff being kind and giving reassurance to the woman post operation. The named midwife was observed calling the neonatal unit where the baby was transferred to check how baby was doing and gave feedback to mum in a caring and reassuring manner. We noted this helped reduced the mother's anxiety and made her smile.

We observed a consultation at the female genital mutilation (FGM) clinic. We observed good care and support by the specialist FGM midwife and health advocate, they maintained patient dignity and respect during the consultation and talked to her in a compassionate and sensitive manner. The woman thanked them for making her feel calm and maintaining her dignity.

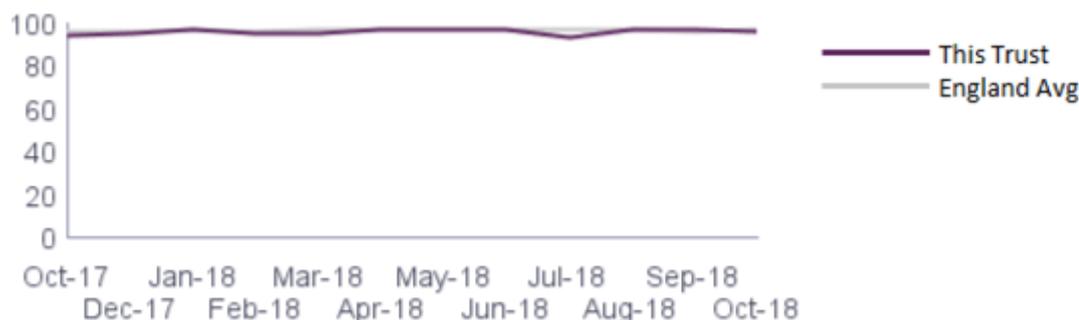
Friends and family test performance (antenatal), Imperial College Healthcare NHS Trust

From October 2017 to October 2018, the trust's maternity Friends and Family Test (antenatal) performance (% recommended) was similar to the England average. In the latest period, September 2018, performance for antenatal declined and was 90%, compared to the England average of 95%.



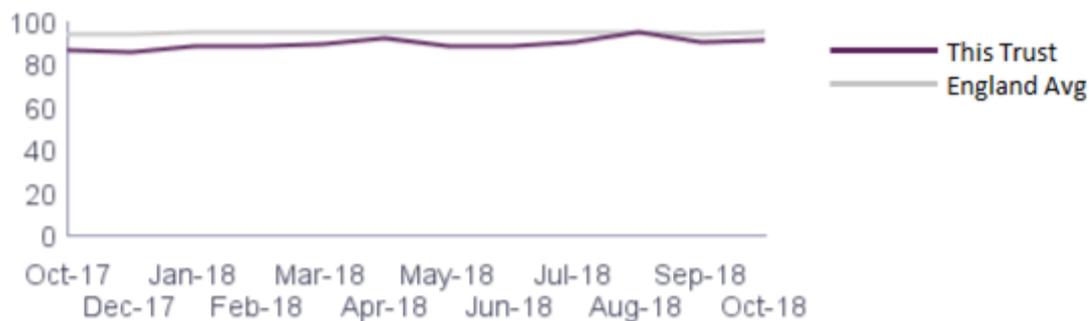
Friends and family test performance (birth), Imperial College Healthcare NHS Trust

From October 2017 to October 2018, the trust's maternity Friends and Family Test (birth) performance (% recommended) was similar to the England average. In the latest period, September 2018, performance at the trust was 96% compared to the England average of 97%.



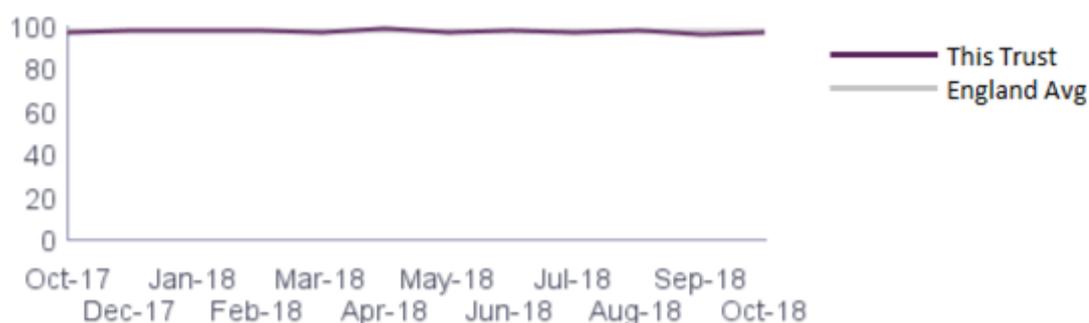
Friends and family test performance (postnatal ward), Imperial College Healthcare NHS Trust

From October 2017 to October 2018, the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was slightly worse than the England average. In the latest period, September 2018, performance at the trust was 91% compared to the England average of 95%.



Friends and family test performance (postnatal community), Imperial College Healthcare NHS Trust

From October 2017 to October 2018, the trust's maternity Friends and Family Test (postnatal community) performance (% recommended) was similar to the England average. In the latest period, September 2018, performance at the trust was 97% compared to the England average of 98%.



(Source: NHS England Friends and Family Test)

Women were given a feedback form to complete at discharge at the birth centre about their experience in the service. During the inspection we reviewed 60 birth centre satisfaction survey forms seen in the unit for the period of October 2018 to February 2019. We noted that 98% of women rated the service as excellent on the overall quality of service received while 2% rated the service as good. There was no negative feedback and all comments were highly positive on their experience, staff compassion and care received.

The trust performed better than other trusts for one question and similar to other trusts for the remaining 18 questions in the CQC maternity survey 2018. The question that scored better than other trusts was "If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?".

Area	Question	Score	RAG
Labour and birth	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	8.9	About the same
	During your labour, were you able to move around and choose the position that made you most comfortable?	7.6	About the same
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	9.2	About the same
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.9	Better
	Did the staff treating and examining you introduce themselves?	9.1	About the same

Staff during labour and birth	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	7.3	About the same
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	8.4	About the same
	If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time	8.6	About the same
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.3	About the same
	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	8.6	About the same
	Thinking about your care during labour and birth, were you treated with respect and dignity?	9.3	About the same
	Did you have confidence and trust in the staff caring for you during your labour and birth?	9.0	About the same
Care in hospital after the birth	Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?	7.2	About the same
	Looking back, was there a delay in being discharged from hospital?	4.9	About the same
	Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?	7.4	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	8.0	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	8.5	About the same
	Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?	8.3	About the same
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	8.6	About the same

(Source: CQC Survey of Women's Experiences of Maternity Services 2018)

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff provided patients and their loved ones with compassionate care and emotional support to minimise their distress. Staff treated and involved women and their loved ones as partners in assessing and meeting their emotional and social needs, which was understood as being crucial in patient-centred care. Women in vulnerable and emotional circumstances had access to specialist service and support which included bereavement, psychologist, social services, psychiatrist, chaplaincy and perinatal mental health.

We observed staff providing emotional support during care and procedures such as delivery, FGM consultation, caesarean operation and breastfeeding.

Staff provided ongoing assessment of women's mental health and well-being from the antenatal to the postnatal period. Staff also worked collaboratively with other professionals such as social workers where women were identified as vulnerable or with mental health needs. Staff also had access to the safeguarding midwife.

The maternity service offered 'improving access to psychological therapies' (IAPT) and other counselling therapies for women. Women had access to genetic counsellors and thalassaemia/sickle cell counsellors in the screening services following diagnosis.

Counselling was also offered to women that experienced traumatic birth or post-traumatic stress disorder (PTSD) with leaflets given. Women were signposted to other agencies in the community for further support such as birth trauma resolution. The intervention and support given to women focused on techniques to help them relax and reduce symptoms of panic and anxiety and dissolve negative emotions attached to the memory of births.

The FGM team included FGM midwife, health advocate, psychotherapist and social workers, who offered emotional and holistic support to women. Staff understood the psychological and emotional trauma that women faced and their anxiety about birth. The team offered follow-up appointments for women following the procedure to ensure they were emotionally stable and staff were available to answer any further questions to reduce their anxiety. The counsellors called the women the following day and the midwives called a week after the procedure to ensure women were well and did not experience emotional stress.

Bereaved women were also supported in a number of ways which included a regular bereavement clinic which was run by the bereavement midwife to support women who had experience child loss. Bereaved women and their families could access six sessions of PETAL (for baby loss and trauma) counselling facilitated by the PETAL team. The clinic was run three times a week and the team contacted women within 72 hours of the referral.

Bereaved women were signposted by the bereavement midwife to faith groups for additional emotional and spiritual support and offered free weekend retreat to couples following a loss of a baby. There were several bereavement support leaflets available for women and their relatives following death of a baby which covered emotional support that was available in the hospital and community. The service had bereavement and breaking bad news rooms in the FMU which was used for counselling and offering support for women and their loved ones.

The maternity service had two bereavement midwife champions in the hospital who received training to support colleagues, women and their families.

Midwifery staff we spoke to at FMU told us they were involved and provided emotional support for women from diagnosis to treatment or feticide (late termination of pregnancy for fetal abnormalities).

The service had caseload midwives that provided on-going emotional support and cared for vulnerable women and their families which include domestic violence, asylum seekers and still births.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Women and those close to them were treated as active partners in the planning and delivering of their care and treatment. We saw that the medical staff, midwives, including specialist midwives, and other professionals were committed to working with women and their loved ones in the delivery of care. Women were given appropriate information and encouraged to make decision about their birth choices, pain relief and care.

From our observations, patient feedback and patient records, we noted that women were involved in their decision making and given choice of birth. On the patients records reviewed we saw that staff documented the views of women and their relatives.

Staff involved women's loved ones or birth partners in the care of women and their newborn babies. Birthing partners could attend deliveries including caesarean section deliveries and were able to sit beside their partner and support them throughout the procedure. Birth partners were also involved in comforting, massaging and cutting of the baby's umbilical cord at birth. Women birth partners we spoke to told us they felt welcomed and listened to.

We observed some clinical consultations and procedures. We observed clear instructions and good interaction with a woman and her birth partner during an emergency caesarean procedure. Staff ensured the woman and birth partner knew what was happening during the procedure and answered their question.

At the FGM clinic we saw that staff engaged well with the patient and used FGM board to show and explain different categories of FGM to aid her knowledge and understanding about the diagnosis and procedure if indicated. Women that attended the FGM clinic were also encouraged to bring their partners and were included in health promotion around FGM in order to safeguard their children.

The FGM health advocate discussed the clinic and the deinfibulation process (reversal) before the clinic appointment to reduce anxiety as some women might find it upsetting and difficult. The health advocate would answer questions from women and their relatives before the appointment and would go through the process with them on the day of their appointment before seeing the FGM team. Women told us they found this useful as it prepared them on what to expect which reduced their anxiety.

Women and staff we spoke to told us women were not rushed during their appointments. Women told us staff answered all the questions they and their families had. We saw that staff gave written information to support information given verbally.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

The maternity service was planned and delivered care in a way that met the diverse needs of the local and surrounding population. The patients' needs and preferences were considered and acted on to ensure services were delivered to meet those needs. Staff tried to arrange patient antenatal appointments together for the same day to meet patients' commitments such as work.

The service worked closely with stakeholders including their commissioners, neighbouring trusts, North West London (NWL) network, and the local maternity system (LMS) to improve maternal and neonatal safety across the clinical network as laid out in Better Births, Saving Babies' Lives and Maternal and Neonatal Health Safety Collaborative. Staff we spoke to reported good relationship with their commissioners and network.

The female genital team (FGM) team had contacted Brent local authorities and commissioners to work with them and plan service delivery as majority of the vulnerable women who accessed the service lived in their locality. FGM clinic were held weekly on both maternity trust sites and saw an average of 300 women in a month for consultation and procedures. The service had two FGM health advocate that were Arabic and Somalian speakers which helped in building rapport and trusting relationship with women identified with FGM.

The hospital had a private maternity service in the Lindo Wing. Staff told us women that accessed this service were often private, international, prominent patients. Women who paid through their insurance or had no recourse to public fund also accessed the service. The Lindo Wing had a maximum of two elective caesarean section scheduled in the morning daily to meet the service delivery.

As part of the Lindo service planning, provisions were made for airport concierge, nursery and child minding services for women during their appointment or child birth.

Antenatal and postnatal care was provided and easily accessible to pregnant women and mothers. Care delivered was tailored to meet the needs of women and the local community in line with the NICE guidance on antenatal care. The service had introduced evening and Saturday's appointments, and the private postnatal community service to meet the diverse needs of the patient population. Women could access maternity services via their GP, self-referral, local children's centre or by contacting community midwives directly. Women were able to tour the maternity unit in advance of giving birth.

As part of the postnatal follow up, care and discharge process to the community services discharge letters were sent to women's GPs, health visitors, family nurse partnership and community midwives following discharge from the hospital, to facilitate continuity of care. This was in line with best practice and national guidance.

Community midwives made daily home visits to women with mental health needs after they had delivered. For most women the daily visits lasted for 10 days. For women with mental health needs or other social needs, the daily visits continued for 28 days in total before discharge to their health visitor for continuity of care. The community team worked flexible hours to cover patient needs.

The Lindo Wing offered postnatal community follow-up service to women in the local area for up to 10 weeks or a three week intense support package at home. The private patients had access to the Lindo community midwife and consultant during the postnatal ward period following their discharge home.

Women were given an informed choice about where they gave birth, in conjunction with consideration of their potential risk. Midwifery-led care was offered to women with an uncomplicated pregnancy and included a home birth or delivery in the birth centre, in line with the NICE antenatal care guidance. Women with a previous medical condition or had experienced previous complications in pregnancy or labour, were advised to have their baby on the labour ward, which was obstetric-led.

The maternity service had birthing pools in the birth centre and labour ward which meant women could use water for labour and/or birth if they wished.

The trust website could be translated to 103 languages from different ethnicity and continents including European, Asian and African. The languages included Turkish, Polish, Japanese, Greek, Swahili, Yoruba and Urdu, amongst others. The trust's website contained blogs, questions and answers, specific maternity topics and link to external resources such as NICE. The website also had information on hospital location and directions, visiting times, places to eat, wi-fi and chaplaincy service. The maternity section of the trust website covered information such as service pathways and provision, self-referrals, interpreting service, FGM clinic, perinatal mental health and how to self-refer, screening information, pregnancy tips, choosing trust, ask your midwife, your pregnancy, giving birth, perinatal referral, postnatal care, meet the team with names and pictures of consultants, referrals and special midwives. The website also included information on the North West London (NWL) mum and baby app which was created by midwives in the NWL network for women to explore local maternity services, track appointments and care notes which was available to download on mobile phones and other electronic devices.

The trust website also directed women to the private health care website for the maternity service in Lindo Wing and how they could upgrade to this service. Women that accessed the Lindo Wing were given list of consultants and their expertise at booking which enabled them to choose consultant that would manage their care.

Maternity helpline was available 10am to 5.30pm Monday to Friday which was manned by a midwife to ensure direct and easy access to maternity related information. Women's partners were able to stay with them throughout their admission and stay overnight. The maternity service also accommodated partners of either gender in the unit.

Meeting people's individual needs

The service took account of patients' individual needs.

The needs and preferences of patients were taken into account when delivering and coordinating services, including those who were in vulnerable circumstances or had complex needs. Care and treatment was coordinated with other services and providers, to ensure the needs of women and their families were met.

The maternity service had wheelchair access to the wards and antenatal clinic, ensuite rooms with bed, fridge, accessible toilets and showers which were suitable for people with reduced mobility. The service also had hearing loops for people with hearing impairment. The antenatal and postnatal ward had a designated room that was spacious and adapted to use for women with disability.

The maternity services had birthing balls, birthing pools and stool to promote comfort of women in labour. The birth centre and Lindo Wing had a relaxed, cosy and homely feel. Women spoke highly about the environment and how it had a homely feel and met their needs.

At the last inspection, we were concerned about the poor signage navigating to different parts of the maternity service. During this inspection we saw improvement in the service and our concerns had been addressed.

The service ran various joint clinics which met women's needs and prevented them from having separate appointments.

The maternity service had arrangements in place to support women with complex needs such as learning disabilities, diabetes, sickle cell, HIV, mental health, blood disorder, genetic disorder, hepatitis B, previous c-section and high BMI. There were caseloads and specialist midwives dedicated to support vulnerable women with complex needs including teenage pregnancy. Staff told us the caseload team expanded provision to include drug abuse. Women with a learning disability were also under the care of the learning disability consultant. Staff told us they had few women with a learning disability and the general learning disabilities team would also support the midwives, consultant, safeguarding and mental health team as necessary. The team would assist with communication aids and the support worker assistant helped with developing the care plan.

There was a 'vulnerability- high risk' flagging system on the patient electronic records to alert staff of patient identified with learning disability and which also informed the case midwives of patient activity.

For the period of 1 November 2017 to 3 December 2018, the trust reported 247 admissions for people with a learning disability. In this period the trust reported 1,453 attendance of patient with learning disability of which 33% were children 17 years and below for the maternity services.

Interpreter services were available for women for whom English was not their first language. These were provided face-to-face or via a dedicated telephone translation service. There was also access to sign language interpreters for people with hearing and speech difficulties. We saw evidence that interpreters were used in the service and also identified from booking. We observed two handovers and a team theatre brief and noted that women translational needs were discussed and arrangements put in place. For the period of April 2017 to April 2018 the trust fulfilment rate for all interpreting requests was 99% for all translation requests for all services.

Women had a choice of meals, which took account of their individual preferences, respecting cultural, nutritional and personal choices.

There was a one stop shop which was a combined in-house screening service for antenatal women in the FMU which enabled patients to have their screening and tests carried out and have the result the same day.

There were effective bereavement care provisions in place to support women and their families from their initial loss, throughout their time in hospital and return home. The bereavement midwife also signposted women and their loved one to a free weekend retreat following their loss when required. The bereavement midwife engaged with women who accessed the service and had also worked with stakeholders, charities, hospices, MPs to improve the service and meet the needs of women.

The service had two bereavement rooms in the labour ward and postnatal ward which had cold cots that cooled a baby and ensured bereaved parents had time with their baby. The bereavement rooms were well furnished and all relevant facilities were provided within the room and room was designed to give it a homely feel and not too clinical. Women and their families could spend as much time as they like with the baby in the bereavement room.

A memory box was provided to women who have suffered a loss at no extra cost, we were informed this was previously provided at an extra cost. The service had two types of memory boxes they could give to women. The smaller memory box was given to women for the deceased babies under 24 weeks gestation and included items such as teddy bear, angel, tea light candle, tag, roulette game pack, book and scroll. The larger box were for deceased babies over 24 weeks and contained photo frame pack, two teddy bears, scroll, angel, book and remembrance card. Bereavement families were also given a black and white picture with a USB stick of their deceased baby as keep sake. The memory box included photographs and hand and foot prints in line with national recommendations (*Sands Stillbirth: how professionals can make a difference*, 2015). The boxes could be stored on the labour ward until the family was ready to take it home.

There was a Muslim pack given to women and families which contained a prayer book, diary, gift of hope, leaflets, journals, poems, prayers and Imams helpline with prayer. Staff told them an imam was available seven days a week to support family and ensure the deceased was buried in a timely manner in accordance with the Muslim rite.

The service provided Jewish families a Jewish leaflet through the Chana organisation. The Jewish organisation also supported and counselled families with funeral if the deceased family were from a Jewish faith.

All bereaved families were provided with the SANDS (stillbirth and neonatal death charity) pack which contained 12 leaflets on various topics such as father's leaflets, for the family and saying goodbye to your baby.

Staff signposted siblings of the deceased to the Child Bereavement UK charity hub counselling and support.

The service covered the burial and cremation service of deceased babies over 24 weeks gestation and offered multi-faith service, burial and cremation. The bereavement midwife had arranged a multi-faith memorial service on 15 June 2018 for their locality for recently bereaved women and families.

The birth centre had a calm homely feel. The rooms had birth stools and two birth pools that could be used during delivery to aid comfort. The rooms also had pull down beds which could create more space if the women decided to walk around the room during labour. The birth centre had implemented continuity of care model and involved women from booking till the postnatal period which met women's needs and helped to develop a trusting relationship.

The trust had a chaplaincy service, which provided spiritual care and religious support for patients, partners and relatives as needed. Multi-faith options were available. Staff told us there was chaplaincy support for a number of religions that reflected their population.

The hospital had a chapel, multi-faith room and a Muslim prayer room for all women and visitors which met their diverse spiritual or religious needs.

The service allowed 24 hours visiting time for one person per women. Other relatives were required to visit during the visiting hours of 3pm to 8pm on the antenatal and postnatal ward.

During inspection we saw examples of where the FGM health advocate had supported women. For example, a woman had gone into labour during a clinic appointment and her birth partner was not present. The FGM health advocate supported the woman during delivery and also took care of the woman's child till the child's father arrived in the unit. The health advocate also supported and escorted women from the hospital bus-stop if they found it difficult to locate the unit or anxious about the appointment. The health advocate supported women and stayed with them during their clinic appointments before they went home.

Women that accessed the FGM clinic were assessed and offered holistic support that met their needs. We saw that MDT staff worked well together to address the women's needs such as housing support, offering free exercise, computing or swimming classes with support of local organisations and charities. Women we spoke to were happy about the classes and support provided by the FGM team.

The service offered a bespoke community service and women had the opportunity of having some of their postnatal appointment at home or in the clinic if no safeguarding concerns were identified.

The service commenced the continuity of care project on 14 January 2019 as part of the better birth initiative, which ensured women saw the same midwives to improve their experience in the service. One of the women's feedback form reviewed during inspection showed that the woman had visited the birth centre thrice before delivery; introductory class with her birth partner and two final appointments with the same midwife. The visit had been reassuring and meant she knew where to go when she came to the hospital during labour.

The Lindo Wing offered bespoke one to one classes for women and their loved ones as part of the parent craft educational and health promotion classes. Data received from the trust showed that 12 (9%) women and their loved ones had accessed one to one session for the period of September 2017 to September 2018.

Staff told us the North West London region had increased the caseload midwives' cases to 416 and the model staff created had been shared in the region which ensured shared learning within the network.

Access and flow

Women could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Women accessed the maternity services via their GP, local children's centre or by direct referral. Patients could also self-refer to the service by the phone or completing a booking form on-line.

Women could telephone the labour ward, birth centre and triage directly, 24 hours a day, seven days a week. Women could telephone the maternity helpline Mondays to Friday from 10am to 5.30pm.

Women were referred to the day assessment unit and fetal medicine unit (FMU) through self-referrals, midwives, GPs and ward referrals for on-going surveillance such as blood pressure or cholestasis through scheduled appointment.

The day assessment unit was opened 7.30am to 8pm, Monday to Friday. Women accessed the service through a referral for interventions such as postnatal wound review, follow-up of medical conditions in pregnancy and reduced fetal movement. Staff also saw women with recurrent appointments such as CTG, scan, BP monitoring and bloods.

Women could access triage through the telephone triage, appointment or attend the unit. The majority of women were admitted to the maternity service via triage, some directly to the labour ward or through the birth centre pathway. Triage accepted women from 20 weeks gestation and covered areas such as induction of labour and assessment around reduced fetal movement, bleeding, preterm labour, emergency ill health, cough and temperature. Triage assessed and monitored women with reduced fetal movement at night when the maternal day assessment unit (MDAU) was closed. Outpatient inductions were done in triage and inpatient inductions took place on the antenatal ward. The pre-op blood was done in triage and anti-D was completed on the labour ward.

Patients that accessed the Lindo Wing went through their booking office where patients were given the list of consultants' details from which they choose their preferred consultant. Following this, women would contact their chosen consultant secretary and do their booking and receive their first appointment. Women were seen for their first appointment with the consultant for up to an hour with clinical investigation carried out. The women were seen by the midwives at 28 weeks for comprehensive assessment and registered on the electronic system if not completed at booking while the delivery was consultant led. Women were under the care of consultant and midwives post birth and if they accepted they were seen by the postnatal community service for follow-up. Since the introduction of the Lindo community midwifery service, staff had delivered care to seven patients on the postnatal community pathway.

Women had timely access to all the maternity services including the theatre for elective and emergency procedures. There were no issues identified during inspection around access and flow to the labour wards, triage, recovery and theatres. There were also no issues around patient waiting to be seen in the FMU, day assessment unit and antenatal clinics during inspection.

The Lindo Wing had two elective caesarean (ELCS) daily while the NHS maternity side had two to three ELCS with a dedicated team for ELCS. There was a separate team to cover emergency caesarean which meant the elective procedures continued and were not cancelled during an emergency. Staff told us that cancellations rarely happened, however they would rebook if needed. If a caesarean section was cancelled, this was invariably due to high clinical activity or acuity resulting in a significant delay to the elective list, and could otherwise result in a woman being fasted until mid-late afternoon. If significant delays to the elective caesarean section list were anticipated, the option of postponing was always discussed with the woman and her birth partner. In 2018, 18 (4.3%) elective caesarean sections were cancelled on the scheduled day and of which 14 (78%) were rescheduled to the following day, two (11%) were rescheduled for the next working day (Monday) and while two (11%) were carried out within two days. The trust reported no adverse clinical outcomes and complaints received regarding postponing caesarean sections.

There were few delays in the recovery as they had four beds. When we inspected there was only one woman in the unit and one waiting for a transfer. We noted that the staff had cared for three women in recovery that day, two women were already transferred to the postnatal ward and they were expecting a woman from the theatre.

When we visited the birth centre at night they had a postnatal patient who had given birth earlier in the day. Staff told us they had four discharges earlier in the day.

There were no concerns identified with women antenatal appointments. Between April 2018 and January 2019, the hospital reported that 70% of women were seen before 10 weeks and while 95% were booked by 12+ 6 weeks (excluding the late referrals) with scans and follow up appointments made on clinical need basis. For the same period there was 21% late referrals of women over 10+6 weeks and 14.2% booked late to the service.

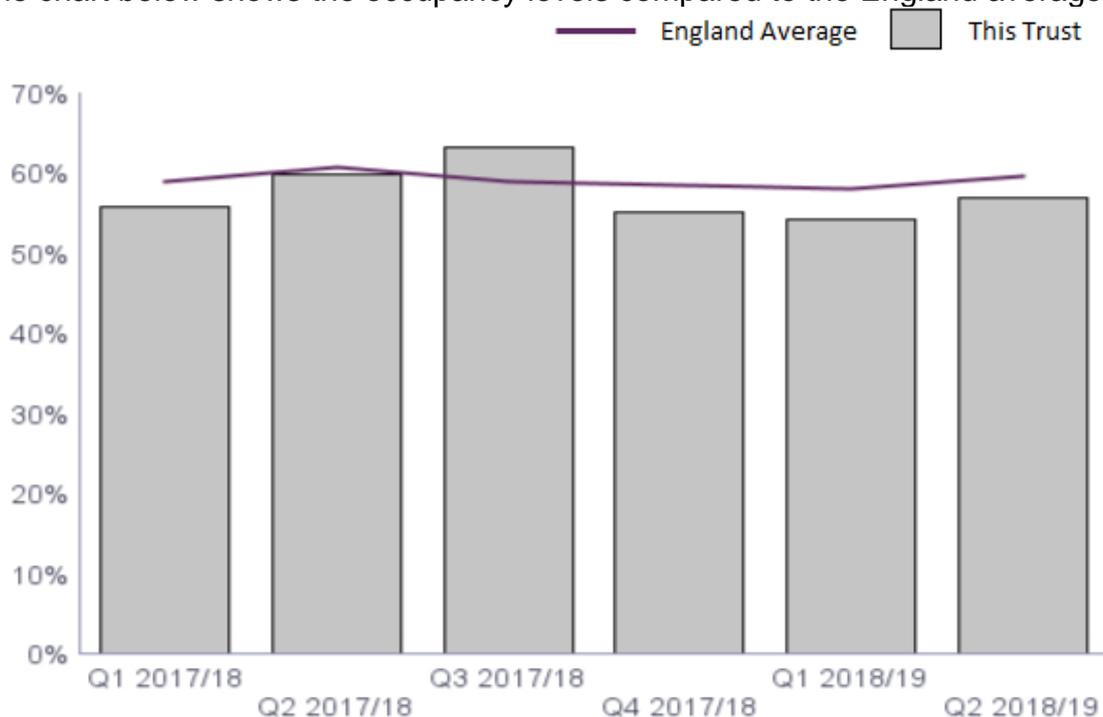
There was no formal audit of waiting times within the antenatal clinic, although real time waiting times were written and updated regularly on boards for women to be kept informed. Lindo Wing did not audit antenatal waiting times due to the nature of private patients where the appointments were timed with the patient and consultant with no delays.

The trust said there was no formal audit of triage waiting times as women were seen in order of clinical priority. The triage was co-located and close to labour ward which meant staff were available to review women based on clinical needs. Any concerns over delays that could cause clinical harm were reported as an incident. The trust reported that no significant concerns had been raised in the last 12 months. At the time of the inspection the triage pathway was under review in the antenatal 'big room', where analysis were underway for triage waiting times and improving the prioritisation and flow of patients.

Women repeatedly told us that they had good access to the hospital and did not experience prolonged delays to be seen.

From April 2017 to September 2018, the bed occupancy levels for maternity were lower than the England average, with the exception from October 2017 to December 2017, where bed occupancy was higher with 63.2% compared to the England average of 59.0%. In the latest quarter from July 2018 to September 2018, bed occupancy was 56.8% which was better compared to the England average of 59.6%.

The chart below shows the occupancy levels compared to the England average over the period.



(Source: NHS England)

For the period of February 2018 to January 2019, the average length of stay on the postnatal ward was 2.4, 1.0 at the birth centre and 2.6 days on the Lindo Wing. The figure for the Lindo Wing reflect the women choice on their preferred length of stay.

For the period of 1 August 2017 to 1 October 2018 the service reported the number of women who were in labour in their planned delivery environment of home or a midwife-led unit and had to be transferred to obstetric-led care before birth, median time taken to transfer below:

Planned delivery location	Total number of women in labour in planned delivery environment	Number of those having to be transferred	% of women transferred before birth from planned delivery environment
Intrapartum transfers to Delivery suite from home (no. labouring at home and intending on a homebirth) SMH	2618	5	3
Intrapartum transfers to Delivery suite from MLU (no. labouring at home and intending on a homebirth) SMH	368	71	197

Staff told us that the did not attend (DNA) rate has improved in the FGM clinic due to text reminder and telephone follow-up by the FGM health advocates.

Lindo Wing never had to close and if there was any issue around flow or emergency women would be diverted to the general labour ward.

The Lindo Wing had one readmission (0.1%) with puerperal sepsis in the last 12 months

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

There were processes in place to ensure complaints were dealt with effectively. Information was provided to patients on how to report concerns and make a complaint. Information on the patient advice and liaison services (PALS) was available on the maternity unit. PALS provided advice and support to women (and those close to them) who wished to raise a concern or complaint. This was an improvement from the last inspection.

Informal complaints were dealt with by staff immediately. Women and their partners were offered resolution clinics to address complaints. The service captured complaints directly from patients and also through PALS, feedback, surveys and Friends and Family Test (FFT) results.

From November 2017 to October 2018, there were 84 complaints about maternity, with 83 of these closed. The trust took an average of 36.5 working days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be closed within 40 working days.

There were 45 complaints reported for the service at St Mary's Hospital, with main themes relating to clinical treatment (17), patient care (10) and values and behaviours (10). Lindo Wing complaints were 1% and mostly related to estate issues, the environment and conflicting advice.

One complaint relating to failure to obtain appropriate consent in the maternity service had been open for 41 working days at the time of inspection.

There had been 29 complaints referred to the PHSO or ombudsman and of which eight were upheld and six were partially upheld for the period of 18 January 2018 to January 2019.

We saw examples of complaint responses and saw that responses were detailed, the duty of candour observed where appropriate and women were also invited for a face to face meeting if they also preferred.

We saw examples of improvements made to the service as a result of patients' complaints and feedback. Following improvement made to the bereavement including counselling provision made to bereaved families there had been a significant reduction in complaints from bereaved parents. Staff told us they now received lots of compliments from the bereaved families and the bereaved mothers had now formed a group network.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The Lindo Wing has not had any complaints referred to the PHSO in the last 12 months.

The Lindo Wing was the only NHS private patient unit to subscribe to Independent Healthcare Sector Complaints Adjudication Service (ISCAS), an independent complaints service. The trust reported that no complaints had been taken to this service.

Number of compliments made to the trust

From November 2017 to October 2018 there were 10 compliments within maternity at St Mary's Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The maternity service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The maternity service which was referred to as the maternity directorate was under the division of women's, children's and clinical support (WCCS) and had a clear management structure with defined lines of responsibility and accountability.

The maternity directorate was led by the clinical director, interim general manager, head of midwifery and consultant midwife. They reported to the divisional director of WCCS within the WCCS division wide structure triumvirate. The other leaders in the WCCS division wide structure included the divisional director of operation and divisional director of nursing. The WCCS and maternity triumvirate were responsible for the St Mary's Hospital and the Queen Charlotte's and Chelsea Hospital (QCCH) and worked cross site. The head of midwifery would report to the divisional director of nursing on governance around midwifery staff.

The maternity leadership team was supported daily by lead midwives, obstetric lead, matrons, managers, specialist midwives and head of speciality for fetal medicines and screening. The community midwives had a community manager that was in charge of the two teams in the service. Since the last inspection all band 7 midwives had responsibility for different roles. The leaders including the specialist midwives were competent in their roles and completed various leadership courses and training.

The Lindo Wing private maternity unit leadership structure was within a different division from WCCS and was under the Imperial Private Healthcare (IPH) division. The Lindo Wing was led by the lead midwife who reported to the IPH divisional director of nursing, divisional director, clinical director, lead obstetrician and site lead. The lead midwife reported good support, accessibility and visibility from the IPH senior managers.

At the last inspection we had concerns that the divisional leaders did not have oversight of the problems within the service. During this inspection we met with the triumvirate who demonstrated knowledge of the service's performance, challenges they faced and actions needed to address them. During inspection we saw the leadership team seemed cohesive and worked well together to improve the service and care provision. This was an improvement from the last inspection.

The leadership team had direct access to the WCCS triumvirate and trust board, reported good support and felt the trust had an interest in maternity. We saw from the minutes of board meetings that the trust board had oversight of the maternity service and received a presentation on the performance of maternity service. The trust non-executive directors (NEDs) had assigned areas and feedback to executive team. The board including the NEDs had visited and engaged with the maternity services through the board visits, open CEO forums, regular executives walkarounds and the health and safety walkabouts. Staff knew who their leaders including the divisional and clinical directors were.

At the last inspection, we identified there was lack of visibility of the executive and senior management team in the clinical areas. Staff told us the senior leaders and local managers were visible, accessible and approachable. Staff told us they were invited to the leadership forum and the chief executive had visited the department. Medical staff told us the medical director was a good leader, treated people well and was fair.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

The trust vision was to be a world leader in transforming health through innovation in patient care, education and research. We saw that the trust vision, values and strategy were discussed at band 7 meetings and team meetings. The Lindo Wing staff had participated in the trust's current programme of work relating to values and behaviours.

The 2018-19 maternity clinical and safety strategy were clinical outcomes, safety, patient experience, training, staff wellbeing and research. The strategy focused on continuous improvement on the care provided to women during pregnancy, childbirth and their postnatal care. The strategy also focused on current and relevant challenges. The service had created better pathways such as the ward accreditation programme and postnatal discharge pathway to achieve their strategy. This was an improvement from the last inspection.

At the last inspection, we had concerns that staff were not aware of their directorate vision and strategy. During this inspection we saw that the service had a team away day in October 2018 to develop and agree on the strategy of the service. We saw that various multidisciplinary (MDT) staff had attended the away day. The maternity strategy was also shared with staff through their newsletter after it was developed. During inspection staff we spoke to were aware of their vision and strategy and understood their role in achieving them. This was an improvement from the last inspection.

The trust medicines optimisation mission was to improve the use of medicines and the health of patients by delivering safe, effective, patient focused pharmacy services. This formed the basis of the hospital pharmacy transformation plan which underpinned their medicines optimisation work. The medicines optimisation main strategy was to increase the use of their clinical skills and deliver care closer to patients and to work collaboratively with nursing and midwifery staff to improve medicines safety and management.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There was a high level of staff satisfaction across all disciplines and equality groups.

Staff we spoke with had a strong commitment to their job and were proud of the team working, continuity of care, positive impact to patient care and experience, and improvements they had made to the service since the last inspection.

The MDT staff described good teamwork within the division and gave examples of good team working and support on the wards between staff of different disciplines and grades. Staff told us that in the service staff were treated equally and there was no hierarchy in how they were treated as part of the MDT staff. Specific comments from MDT staff included; "doctors do a good job and consultants buddy work well together", "proud of MDT colleagues as they work with and they genuinely care and want to give good service", "pleasant and caring midwives and doctors who genuinely care about our patients".

Staff were proud of each other, the continuity of care model and the use of caseload midwives to ensure continuity of care and improve service provision. Staff told us they enjoyed helping women through their birth journey and how the team work well in an emergency.

Staff told us that since the last inspection there had been improvement in communication with managers, senior staff and consultants.

Staff including student midwives and junior doctors felt well supported, respected and valued by their colleagues and senior managers.

Several staff we spoke to had been working at the trust for years, this ranged from 11 to 43 years. Staff felt it was easy to progress and be promoted and we saw evidence of progression of staff since they had been employed in the service.

The trust had a freedom to speak up guardian and champions. Details of the speak up guardian were displayed on posters on the ward and on the computer screen savers. Staff told us they knew their speak up guardian and champions and they would be confident to raise a concern with their managers and were confident this would be investigated appropriately.

The service celebrated staff and team success through the star of the month award and make a difference award. Patients and staff nominated staff or team for the make a difference awards and awarded were given a badge to wear. Information of this awards were displayed on the posters in the maternity unit.

The culture encouraged openness, honesty, positive culture of shared learning and improvement. Staff told us there was a no blame culture when incidents happened and the team supported each other. Staff were supported following serious incidents, Healthcare Safety Investigation Branch's (HSIB) investigations and never events through debrief and Schwartz rounds. We saw examples of support given to staff at the Lindo Wing following the death of one of their colleagues. Staff told us they had received counselling and debriefs which had helped restored staff morale in the service.

Staff told us they now had a safety and wellbeing support in place in the hospital since the Grenfell Tower incident and staff were aware and more focused on staff wellbeing.

The duty of candour was implemented in the service and we saw that cases that met the duty of candour threshold were reviewed and monitored at the governance meetings.

We saw that patients' compliments and positive outcomes were shared with staff in the newsletter with the aim of improving staff morale and engagement.

Majority of staff we spoke to were happy about working in the service and reported no bullying and harassment.

Staff at the Lindo Wing told us the unit was a small and close unit, which meant they knew each other and had good rapport. The medical and midwifery staff were proud of the Lindo community postnatal service and how it had grown and expanded from one community midwife who initially delivered the service.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

The maternity service had a clear systematic governance process to continually improve the quality of service provided to women. The arrangements for governance and processes were clear and operated effectively. Staff understood their roles and accountabilities.

At the last inspection we had concerns on the governance structure of the service however there had been improvements on the governance of the maternity service. The WCCS divisional director was a member of the trust board and provided assurance about the maternity service to the board. We noted the service now had oversight of serious incidents (SIs) and other governance issues. The service had done lots of improvements around investigation of SIs and involvement of families, and had trained appropriate staff on carrying out root cause analysis. SIs were now monitored by senior managers using a tracker for all SIs. This was an improvement from the last inspection.

At the last inspection we told the trust, they must implement the recommendations made in the Royal College of Obstetricians and Gynaecologists (RCOG) report from April 2017, 'Review of Maternity Services in the hospital. During this inspection, we noted that all actions on the trust wide action plan and maternity action plan had been completed. The actions included; parents are enabled to be active participants in SIs investigation, skills based bereavement training for clinical and non-clinical staff such as porters, update the bereavement pack, training for all investigators, duty of candour processes, adopt and use of pregnancy GROWTH chart, bereavement care and transfer to the mortuary.

The trust had an integrated quality performance framework. This involved the measurement of a number of core indicators, agreed annually, at different levels of the organisation. The indicators were split into CQC's five quality domains, safe, effective, caring, responsive and well-led. This fed the metrics that were included in the integrated quality performance reports (IQPR), which was reported at monthly trust board meetings. For example, patient safety incidents, staffing fill rates, infection prevention and control, medical devices management, mortality, sickness absence, bank and agency spend, FFT, national operational standards, in month variance to plan and cost improvement programme delivery.

The service sought reassurance through various governance meetings such as the monthly divisional quality and safety meeting, monthly risk management meeting, poor outcome risk meeting, weekly cross-site critical review meeting, Weekly Avoiding Term Admissions Into Neonatal units (ATAIN) meeting, monthly risk maternity meeting and the medical directors meeting. The service also had a cross site quality and safety meeting that was held every two months.

We reviewed various governance meetings and noted they were well attended by senior managers and MDT staff and covered areas such as incidents, staffing, risk register, risk management, complaints, information governance, clinical effectiveness and audits, investigations, quality performance indicators, complaints, reviewing of guidelines report, patient experience and medicines.

The maternity directorate committee fed into the divisional committees while the executives committee received reports from the divisional committees. Themes from incidents were reviewed at the directorate quality and safety committees before being added to the risk register if they met the threshold and fed through into the divisional quality and safety committees. The minutes of these meetings were reviewed at the trust quality and safety sub-group, chaired by the medical director which allowed trust wide themes to be identified, monitored and included in the safety improvement priorities as appropriate. Trust wide issues were monitored every month at executive level through the incident monitoring report which included actions to support improvement.

All patient safety incidents graded moderate and above were reviewed weekly in the risk maternity meetings and by the divisional management teams and then at the weekly panel chaired by the medical director, which allowed timely declaration of SIs as well as executive oversight of emerging safety risks and their mitigations.

The trust had a joint child and adult safeguarding committee and the membership included the named professionals, clinical divisions, CCG designated nurses and local authority (LA) safeguarding representatives. The deputy director of patient experience who was the senior safeguarding manager lead was on the LA safeguarding adults executive board. The trust board received annual reports for safeguarding and the quality and safety subgroup received safeguarding reports each quarter.

There were daily cross-site safety huddle where issues around staffing, acuity and access and flow were discussed and escalated.

Management of risk, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

The maternity service had clear risk processes and systems in place for managing performance and identifying and mitigating risks. There was a maternity dashboard and a systematic programme of clinical and internal audits, which were used to monitor risks and quality and to identify where action should be taken. The service used the North West London (NWL) maternity dashboard to identify trends and benchmark performance with other hospital in the region. The maternity audit programme was informed by national audits, incidents, complaints and clinical outcomes.

Incidents were reviewed at various governance meetings such as quality and safety, Avoiding Term Admissions Into Neonatal units (ATAIN) and perinatal mortality and morbidity meetings. Minutes of governance meetings and newsletters reviewed shows that SIs, complaints and quality audit updates were discussed and shared with staff. Actions taken to reduce recurrence and improve service provision were detailed. Any potential serious incidents were escalated appropriately.

At the last inspection we were concerned that the maternity risk register did not reflect all risks identified by us when we inspected. During this inspection, there had been improvement in the management of risks in the service and managers had oversight on the risks. The maternity service had arrangements in place for identifying, recording and managing risks. The divisional risk register included a description of each risk, with mitigating actions and assurances in place. An assessment of the likelihood of the risk recurring, possible impact and those responsible for review and monitoring were highlighted on the risk register. We saw that all risks were reviewed and updated on a regular basis. There were 33 risks for the trust maternity directorate in the divisional risk register which were reviewed at the quality and safety meetings. We reviewed the maternity and corporate risk registers during inspection. The two risk registers contained risk relating staffing, implementation of electronic system, risk of abduction, risk of lift breakdown, implementing the General Data Protection Regulation (GDPR), impact of development in Paddington to the hospital, inconsistency in cleaning provision, increase violence to staff and risk of medicine safety been negatively affected due to poor adherence to the trust policy. The service had mitigated the risk of violence to staff by installing additional CCTV and swipe access to the maternity services.

Staff we spoke to had good understanding of the risks and the service used a multidisciplinary approach in managing risk. During inspection, we saw posters of the top risks in the service which included estate issues, lift break downs and security issues with difficult patients and relatives (violence and aggression).

The service had dedicated risk team that worked cross site in the hospital and QCCH. The team reviewed incidents daily to identify risks that needed to be added to the risk register. The risk team provide an update on risk management to staff through newsletters, attendance at staff team meetings and bi-monthly meetings where on-going risk and death investigation were discussed.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The service had clear performance measures such as key performance indicator (KPI), local and national audits which were reported and monitored. These included the MBRRACE((Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) UK audit, maternity safety thermometer, maternity dashboard, Friends and Family Test (FFT) results and social media. Performance results were discussed at divisional and board level to improve care and patient outcome.

The maternity dashboard parameters had been set in agreement with the CCG and a traffic light system was used to flag performance against agreed thresholds. The dashboard performance was reviewed regularly by the senior staff at various governance and risk management meetings. The service also used score cards and harm free care reports to monitor their performance.

Fetal link were used in the service to monitor the foetus heart beat and ensured rapid escalation if there were abnormalities.

During inspection we observed staff treated patient identifiable information in line with General Data Protection Regulations (GDPR).

The trust had a major investment programme in place to implement the electronic patient record. The trust was announced as a Global Digital Exemplar by NHSE in 2016/17 and was awarded £10m over two years to make further advances. The trust was working in partnership with another

NHS provider to implement the existing system across both organisations to better serve the population of North West London.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. The service obtained and acted on people's views and experiences to shape and improve the services and their experience. We saw evidence during inspection that service user feedback was sought to inform changes and improvements to service provision.

The service engaged well with the stakeholders and was actively involved with the North West London (NWL) Local Maternity System (LMS) meeting. A representative from the trust attended the monthly North West London Local Maternity System (LMS) meeting. The meeting was attended by other trusts and clinical commissioning groups as well as any other relevant stakeholders such as local GPs, NHS England, local authority representatives. The agenda always included regional updates while the remaining items of the agenda varied from meeting to meeting. For example, the group discussed London Maternity Quality standards, shared GP care, sustainability and transformation plans, or learning from serious incidents. At September 2018 meeting the trust shared a serious incident report with the group, and learnings around it. The group had also discussed the midwifery led criteria and the regional Mum and Baby app for the period of October to December 2018.

The maternity service had a functioning Maternity Voices Partnership (MVP) which was launched in April 2018 and, at the time of the inspection, had met four times. The service was actively involved in their regional MVP which provided a forum for service users, CCGs and health professionals to work collaboratively to plan and improve maternity service provision in the region. The group's aim was also to improve quality and patient experience within the maternity service. The service had engaged with women and the public on the 'better births' and other projects through displayed banner and meetings across the local areas. We reviewed the May and July 2018 meeting minutes. The meetings focused on how the group should be run and group's priorities but they also included discussion around audits and birth story of a service user.

The Lindo Wing did not have a MVP group but has plans to develop this in future. However, all parents were asked to provide feedback with regards to the parent education sessions. The trust was planning a parent reunion in the summer 2019 which they hoped would provide the opportunity to hear women's feedback to improve the service. The friends and family feedback was requested on discharge from the Lindo Wing as a means to hearing women's voices. The lead midwife also did regular ward rounds to speaking to women and loved ones about their experience at the Lindo Wing.

Local and senior managers were visible on the ward, which provided patients and staff with the opportunity to express their views and opinions. Staff displayed letters and thank you cards of positive feedback about the service on the noticeboards.

Patients were also invited to attend the 'antenatal big room' meeting and receive feedback around pathways, access and flow and their experience.

The service had engaged with staff to seek their ideas and opinions on developing their strategy during an away day in October 2018.

The specialist bereavement midwives actively engaged with women and stakeholders to receive feedback and improve provision to the service. They had engaged with charities such as CHANA, Poppy's fund, friends of St Mary and remember my baby to improve bereaved women and their families experience and receive on-going support in the community.

The bereavement midwife had also engaged with local MPs and attended their political parties meeting quarterly where bereavement group issues and provisions were fed to MPs. Staff told us this had triggered the works of SANDS to standardise the bereavement care provision across UK.

The bereavement midwives had initiated a midwife forum across UK and engaged with other midwives to improve bereavement service and provide support network for members. There were approximately 120 members in this group and they held 13 forums as at 28 January 2019. The group worked closely with SANDS to improve bereavement service nationwide. Staff told us NHS England had contacted them and were looking at using the bereavement forums as expert group to improve bereavement provision in the region.

The bereavement midwives engaged with the maternity bereavement experience measure (MBEM), this had involved visiting Muslim families and engaging with a local mosque to improve Muslim families' experience.

The trust had three staff networks for staff engagement which included the women network, LGBT (lesbian, gay, bisexual, and transgender) network and BAME (black, Asian, and minority ethnic) network. One of the Lindo's senior midwifery staff who joined the BAME network won an aspiring leader award.

The IPH which included the Lindo maternity service had a staff survey in 2018 which showed a completion rate of 75%. In response to the staff survey the Lindo Wing now engaged with the trust recognition awards. The Lindo team won the bi-monthly making a difference award for their team efforts in bringing together the postnatal package and the parent education sessions for women.

The Lindo Wing staff held bi-annual time out team days meeting which was a full day event. The maternity service also engaged with staff through regular team meetings and newsletters.

The female genital mutilation (FGM) health advocates engaged and worked with women that had accessed the service who now campaigned against FGM in the local region and the UK.

Following the end of the Early Adopters Programme, the Maternity Transformation Team were hosting an NWL maternity celebration event in March 2019 and staff and patients could attend to celebrate the programmes achievements and work towards planning the next steps for maternity transformation.

The service sought patients feedback about their birth experience through birth reflection meetings and debriefing service.

At every public trust board meeting women were invited to present and share their story and feedback about the service received.

The 2018 "Our Voice' engagement survey" received 3,164 staff responses which was an increase of 357 from 2017. The overall engagement has improved in the national survey for the last three years. The overall engagement score has increased from a position of 'lowest 20 per cent' in 2015 to 'above Average' in 2017. The trust local survey results indicate relative consistency in the engagement score (78%) across the trust in 2018. The result showed positive findings on staff satisfaction with the quality of work and care they can deliver, quality of appraisals and training, learning and development. Staff were clear about the values and behaviours expected of them at work (95%) and clear about their own objectives (93%). The areas of improvement that was highlighted in the national and local staff survey included staff experiencing discrimination, bullying and harassment, staff working extra hours, senior leadership communication and visibility, estate and facilities, IT systems and effectiveness, enough time to complete work, staff health and wellbeing, career progression and witnessing potentially harmful errors, near misses or incidents. However, a new question in the trust local survey showed that 92% of staff felt they knew the processes to report any concerns they had on errors or incidents.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

There was a strong culture and focus of continuous learning, innovation, research and improvement in the service to improve patient outcomes. Staff and management were committed to improving services by learning from when things went well and making changes in practice through shared learning, external reviews, promoting training, research and innovation.

The trust was part of the Imperial College Academic Health Science Centre in partnership with two other NHS trusts and colleges, and one of the 11 academic health science centres in the UK.

Since the last inspection the Lindo Wing had introduced the postnatal community midwifery service for women in the local area as part of a visiting scheme to ensure continuity of care, provide support and improve their postnatal experience and outcomes. The unit had also introduced the day assessment unit and parent craft for private women who accessed the service.

Since the last inspection the service had introduced the continuity of care model on 14 January 2019 to improve women's experience to ensure women were seen by the same staff. The birth centre now had a daily clinic and was looking at booking women from 10 weeks and combined screening. This meant woman categorised as low risk and given birth at the birth centre would have their antenatal appointment in the unit and get familiar with the environment and staff. The unit had introduced booking on Saturdays and evening appointment on Mondays in order to accommodate women's family and work life balance and improve the did not attend (DNA) rate. Staff told us since the implementation of this model they had performed better than their target on the number of women to be seen and women were excited about this change.

As part of the continuity of care model the service was trying to set up a multiple births team that would cover women care from the antenatal to postnatal period across both maternity sites.

The female genital mutilation (FGM) team had received an award in 2017 from The Royal College of Emergency Medicine (RCEM) for the holistic support and compassionate care given to women.

The Lindo Wing Lotus team had received a postnatal visiting initiative award for a making a difference to the women who had accessed the service.

The service was involved in several quality improvement programmes to improve service provision which were displayed on the wards. This included discharge pathway, hand hygiene, venous thromboembolism (VTE), triage and prevention and treatment of perineal trauma.

Other safety improvement work streams in the trust for 2018/19 addressed the most frequently occurring clinical risks reported by staff. This included abnormal results, recognising and responding to the very sick patient, safer surgery, fetal monitoring, safer medicine, positive patient confirmation and reducing falls with harm.

In 2017, the trust was recognised by NHS England as a leader in the adoption of digital technologies to improve patient care and one of 16 global exemplars of acute care.

The service had set up an outpatient induction of labour (OPIOL) pathway for women in their first pregnancy several years ago but uptake had not been very successful. This had led to the service currently reviewing their induction of labour pathway to improve efficiencies, reduce clinical risk and improve patient experience. The service had plans to relaunch the additionally offered OPIOL to women in their second / third pregnancies. This service was being supported by the maternity day assessment unit and they offered patient education sessions on OPIOL.

The maternity services had introduced the 'antenatal big room' which used a 'big room' and QI to improve the antenatal pathway across areas such as communication, maternity self-referral process, vaginal birth after caesarean section pathway and the quality and safety in emergency and urgent obstetric services in the triage and day assessment.

The trust had introduced the Sepsis 'big room' meetings to improve the care for patients with sepsis including reducing unwarranted variation in identification of sepsis, reduce time from sepsis alert to antibiotics and increasing the update of sepsis treatment plans. Improvements made by the 'big room' included trust-wide roll out of sepsis alert on the patient records.

The service had fetal monitoring safety stream that aimed at reducing the number of incidents relating to misinterpretation of CTG results through introduction of new software (fetal link),

education and training and introducing 'fresh eyes' as a second check to interpret CTG. Since the launch of the fetal link the trust told us there had been no CTG incidents in the services.

The trust was leading on a number of national and international studies to identify fetal growth restriction, examining the feasibility and value of ultrasound in labour, research in partnership with the Institute of Cancer Research and Cambridge University to offer non-invasive fetal surgery for twin-twin transfusion in 2020.

The service was an early adopter site within the NWL maternity network.

Services for children and young people

Facts and data about this service

The main base for children's services at Imperial College Healthcare NHS Trust is at St Mary's Hospital (SMH), with some activity also at Queen Charlotte & Chelsea Hospital (QCCH) and Hammersmith Hospital (HH).

The hospital continues to provide emergency, non-elective and elective inpatient services for infants, children and young people.

The trust provides paediatric care from birth through to transition into adult services, combining integrated community services with secondary hospital care and 29 specialist commissioned services that include a paediatric intensive care unit (PICU), acute general paediatrics, a paediatric emergency department, diabetes, infectious diseases, clinical haematology and bone marrow transplant (BMT), neurology, allergy, rheumatology, nephrology and dermatology.

The surgical specialties include: ENT (ear, nose and throat), urology and ophthalmology. In addition, the trust collaboratively works with adult divisions in major trauma, plastics and vascular services. It also provides level 2 and level 3 neonatal critical care at SMH and QCCH.

Ambulatory services (outpatient and day-case) are also provided at SMH and QCCH. At HH this is the David Harvey unit; at SMH there is paediatric outpatients, a paediatric short stay unit and a paediatric haematology day unit. SMH also provides paediatric inpatient beds on PICU, Great Western ward and Grand Union ward.

(Source: Routine Trust Provider Information Request (RPIR) – Context acute)

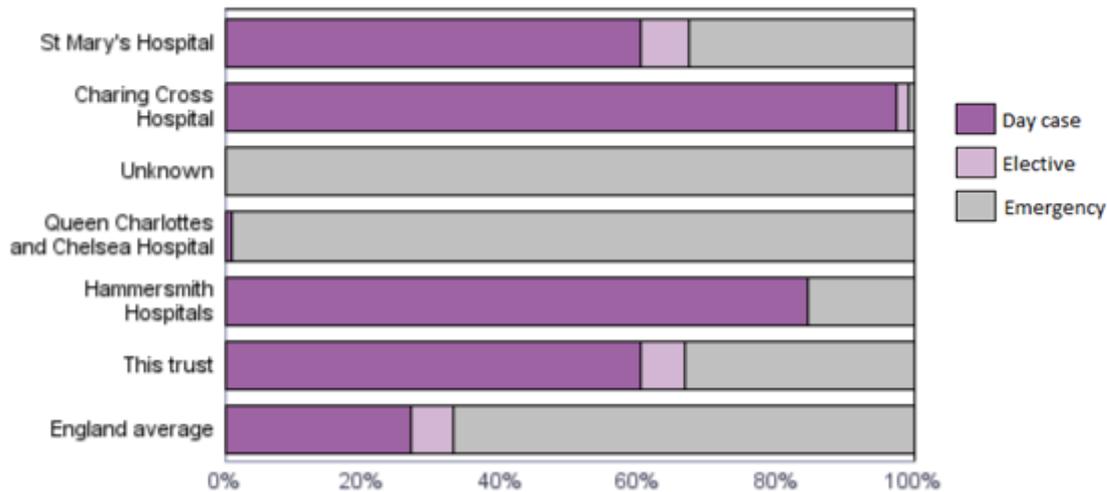
The trust has 115 inpatient paediatric beds across the two main sites:

- St Mary's Hospital: 91 beds are located within nine wards/units, with an additional five sofas and one isolation cubicle at the paediatric haematology day unit.
 - Queen Charlotte's and Chelsea Hospital: 24 beds are located within the neonatal intensive care unit (NICU)
 - Hammersmith Hospital: There are no inpatient paediatric beds at Hammersmith.
- (Source: Routine Trust Provider Information Request (RPIR) – Sites tab)*

The trust had 12,454 activity spells from August 2017 to July 2018.

Emergency spells accounted for 33% (4,137 spells), 60% (7,498 spells) were day case spells, and the remaining 7% (819 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from August 2017 to July 2018, Imperial College Healthcare NHS Trust.



Total number of children’s spells by Site, Imperial College Healthcare NHS Trust.

Site name	Total spells
St Mary's Hospital	11,853
Charing Cross Hospital	343
Unknown	139
Queen Charlottes and Chelsea Hospital	106
Hammersmith Hospitals	13
This trust	12,454
England Total	1,125,448

(Source: Hospital Episode statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

Although the service provided mandatory training in key skills to all staff, not all staff had completed it.

Staff received mandatory training on a rolling annual programme which was provided through a mix of practical sessions and e-learning. Topics included: venous thromboembolism, medicines management, health and safety, infection prevention and control and blood transfusion.

The trust set a target of 85% for completion of mandatory training. Nursing staff met this target for all except one module. However, there were several modules for which medical staff were slightly below the target.

St Mary’s Hospital children’s services department

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at St Mary’s Hospital for qualified nursing and midwifery staff in children and young people’s services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Consent	199	201	99.0%	85%	Yes
Invasive Procedures Policy	198	201	98.5%	85%	Yes
Conflict Resolution	197	201	98.0%	85%	Yes
Equality and Diversity	197	201	98.0%	85%	Yes
Moving and Handling Level 1	197	201	98.0%	85%	Yes
Venous Thromboembolism	196	201	97.5%	85%	Yes
Medicines Management	195	201	97.0%	85%	Yes
Health and Safety	193	201	96.0%	85%	Yes
Fire Safety Awareness	192	201	95.5%	85%	Yes
Infection Prevention and Control Level 2	191	201	95.0%	85%	Yes
ANTT	190	201	94.5%	85%	Yes
Blood Transfusion	189	201	94.0%	85%	Yes
Duty of Candour	47	50	94.0%	85%	Yes
Information Governance	177	201	88.1%	85%	Yes
Resuscitation Level 2	173	201	86.1%	85%	Yes
Moving and Handling Level 2	122	160	76.3%	85%	No

In children and young people's services the 85% target was met for 15 of the 16 mandatory and statutory training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at St Mary's Hospital for medical staff in children and young people's services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Moving and Handling Level 1	81	88	92.0%	85%	Yes
Resuscitation Level 2	81	88	92.0%	85%	Yes
Equality and Diversity	80	88	90.9%	85%	Yes
Health and Safety	79	88	89.8%	85%	Yes
Conflict Resolution	78	88	88.6%	85%	Yes
Infection Prevention and Control Level 2	76	88	86.4%	85%	Yes
Blood Transfusion	74	88	84.1%	85%	No
Invasive Procedures Policy	74	88	84.1%	85%	No
Fire Safety Awareness	73	88	83.0%	85%	No
Medicines Management	72	88	81.8%	85%	No
Consent	71	88	80.7%	85%	No
Information Governance	70	88	79.5%	85%	No
Duty of Candour	68	86	79.1%	85%	No
ANTT	68	88	77.3%	85%	No
Venous Thromboembolism	67	88	76.1%	85%	No

In children and young people's services the 85% target was met for six of the 15 mandatory and statutory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at St Mary's Hospital for doctors in training in children and young people's services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Infection Prevention and Control Level 2	104	112	92.9%	85%	Yes
Blood Transfusion	102	112	91.1%	85%	Yes
Conflict Resolution	102	112	91.1%	85%	Yes
Equality and Diversity	102	112	91.1%	85%	Yes
Moving and Handling Level 1	102	112	91.1%	85%	Yes
Resuscitation Level 2	102	112	91.1%	85%	Yes
Health and Safety	101	112	90.2%	85%	Yes
Consent	100	112	89.3%	85%	Yes
Nasogastric Tube Placement	99	112	88.4%	85%	Yes
Fire Safety Awareness	97	112	86.6%	85%	Yes
Information Governance	97	112	86.6%	85%	Yes
Invasive Procedures Policy	97	112	86.6%	85%	Yes
Medicines Management	97	112	86.6%	85%	Yes
Venous Thromboembolism	96	112	85.7%	85%	Yes
ANTT	93	112	83.0%	85%	No

In children and young people's services the 85% target was met for 14 of the 15 mandatory and statutory training modules for which doctors in training were eligible.

Safeguarding

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

The trust had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. Staff we spoke with knew how to escalate safeguarding concerns.

Female genital mutilation (FGM) was part of the level 2 and level 3 safeguarding training. Staff were provided with guidance on identifying FGM or children at risk of FGM. Reports could be made directly to the trust safeguarding team, followed by a comprehensive referral to the police and children's social care.

The trust safeguarding team consisted of a named nurse, a named midwife, two safeguarding midwives, a lead CNS for safeguarding children, three CNSs for safeguarding children and two safeguarding administrative staff.

A joint safeguarding committee met quarterly, and reported to the children's directorate quality and safety meetings, where there was representation from sites across the trust. The trust safeguarding team attended the local safeguarding children board sub-groups and board meetings.

The trust set a target of 85% for completion of safeguarding training.

St Mary's children's services department

A breakdown of compliance for safeguarding training courses as at February 2019 for qualified nursing and midwifery staff in the children and young people's services at St Mary's Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults Level 2	190	201	94.5%	85%	Yes
Safeguarding Children Level 3	184	201	91.5%	85%	Yes

In children and young people's services at St Mary's Hospital, the 85% target was met for both of the safeguarding training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for safeguarding training courses as at February 2019 for medical staff in the children and young people's services at St Mary's Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Children Level 3	84	88	95.5%	85%	Yes
Safeguarding Adults Level 2	76	88	86.4%	85%	Yes

In children and young people's services at St Mary's Hospital, the 85% target was met for both of the safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as at February 2019 for doctors in training in the children and young people's services at St Mary's Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Children Level 3	106	112	94.6%	85%	Yes
Safeguarding Adults	98	112	87.5%	85%	Yes

In children and young people's services at St Mary's Hospital, the 85% target was met for both of the safeguarding training modules for which doctors in training were eligible.

It was unclear how managers were assured that staff complied with the training requirements for level 3 safeguarding. The safeguarding consultant nurse told us they completed four hours of face-to-face training every three years, and that the remaining training was done through staff appraisals. However, staff and managers we spoke said this was not a routine part of their annual appraisals.

Cleanliness, infection control and hygiene

The service had processes in place to control infection risk. However, we found areas where there was a risk of cross-infection.

The hospital had an infection prevention and control (IPC) policy and IPC team. Clinical areas had IPC link nurses who acted as the link between clinical areas and the wider infection control

team. Their role was to increase awareness of infection control issues and motivate staff to improve practice. Staff received mandatory training relating to IPC as part of their rolling training requirements. At the time of the inspection, 95% of nurses at SMH had received IPC training.

We observed a cross-infection risk where some staff were going through the back corridor that separated the day surgery unit and Westway ward without washing their hands. There were signs up reminding staff to wash their hands. However, we observed that staff (including clinical and domestic staff) regularly went through from one ward to the other without washing their hands or using sanitising gel.

Staff told us that cleaning was sometimes not completed to the required standard. We saw a cleaning audit of Grand Union ward, which showed a compliance rate of 77% in January 2019, which was below the trust target of 80%. However, staff said that when they escalated concerns to senior nurses they were addressed promptly.

We saw that equipment on the wards was clean and labelled with green 'I am clean' stickers to let staff know at a glance which pieces of equipment and surfaces were ready to use. Information on hygiene audits was displayed on the wards' quality and safety board. For example, we saw that Grand Union ward scored 100% for sharps compliance and hand hygiene, and 77% for the cleaning audit for January 2019.

We saw the children's directorate scorecard, which showed that services met the trust target for hand hygiene compliance in 11 out of 12 months from October 2017 to September 2018.

Staff we observed on the neonatal intensive care unit (NICU) and paediatric intensive care unit (PICU) followed appropriate hand hygiene techniques. In January 2019, PICU showed 96.2% compliance with standards in the hand hygiene audit and 94.9% compliance in the most recent weekly cleaning audit carried out by the IPC team. There were sufficient handwashing facilities in both areas and antibacterial hand gel available at the entrance and in bed spaces. Personal protective equipment (PPE) was available for staff to use.

There were systems for ensuring that the play room and toys were cleaned on a regular basis.

In the CQC Children and Young People's Survey 2016 the trust scored 8.5 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Environment and equipment

The service mainly had suitable premises and equipment and looked after them well. However, some areas required improvement.

The service faced challenges with the condition of the estate, with one of the biggest risks being legionella and pseudomonas in the water. Staff told us regular flushing was undertaken and filters were used in areas such as neonates where there was a high count. We saw that this was included on the divisional and directorate risk register, which stated that remedial works were carried out wherever positive samples were obtained. Testing was ongoing.

During the last inspection in 2014, we identified issues with the environment in the PICU. At this inspection, we found that the environment had improved, and there was now appropriate bed spacing. However, the lack of isolation facilities continued to present a risk to infection prevention and control. The service had acknowledged this as a risk and included it on their risk register.

Controls in place to mitigate the risk included: grouping patients with infectious diseases in one area of the ward and working closely with the hospital's IPC team to identify and address any immediate IPC concerns. The PICU matron told us that any patients undergoing a bone marrow transplant who were at high risk of infection were nursed by PICU staff in the separate 2-bedded high dependency unit (HDU). The HDU was on the same floor as the PICU but separated by a corridor and located on Grand Union ward.

Although the PICU matron told us there had been no reported incidents of hospital acquired infection, we were concerned that the controls in place were insufficient to reduce the risk of cross-infection. For example, during the inspection, we saw that a patient with influenza A was in a bed next to a patient with MRSA. There was a curtain separating the two patients and a trolley set up with PPE at each bed space, as well as signs that stated, "Enhanced Isolation Precautions" at the end of each bed. However, there were no physical barriers preventing patients, staff or visitors from moving into or between the bed spaces.

We found issues with the availability of emergency equipment on the PICU. The intubation and difficult airway trolley was kept on the main PICU. The HDU had its own resus trolley but did not have a separate intubation and difficult airway trolley or a defibrillator. The PICU matron told us they were already aware of this risk and that there were plans in place to provide this equipment to the HDU within the next week. However, we were also told that there had been a recent patient safety incident relating to a delay in care due to equipment not being readily available. Although we were told that the patient came to no harm in this case, it demonstrated the potential risk this issue presented to patient safety. The PICU matron told us the mitigation for this was that each bed space had "airway connections".

There was only one defibrillator to be shared between Grand Union ward, PICU and the haematology day unit, and one shared between Westway ward and the day surgery ward. This presented a risk if one was required in an emergency.

There had been limited improvement to the environment of the Grand Union ward since our last inspection. Managers told us that the ward would be refurbished after the work on the PICU was completed, and could not be done before due to management of patient flow. They said a business case had recently been submitted for these improvements.

Staff told us there was a lack of suitable space on Great Western ward for patients with mental health needs. Patients were having to stay in a shared bay due to lack of side rooms which was disruptive for other patients. The trust had a new policy on MRSA which said they didn't need to use a side room as patients were grouped in a bay. These helped free up side rooms but there were still not enough.

Grand Union ward had 14 beds, all of which were cubicles. This meant that the risk of infection for immune-compromised patients (such as those undergoing bone marrow transplant) was minimised. We saw that each room had appropriate equipment, including oxygen and suction, and lockable drug storage. There were four en-suite rooms which were allocated to bone marrow transplant patients as a priority.

We saw evidence that staff checked the resuscitation trolleys on a daily, weekly and monthly basis and replaced any items after use. We saw that portable equipment we sampled had been recently serviced and labelled to indicate the next review date.

The service was in the process of making improvements to the environment for services on the sixth floor (paediatric outpatients, child development centre and paediatric haematology day unit) to make it more child-friendly. We saw that children were involved in developing the project. The

outpatient department had renovated the reception area since our last inspection. Improvements included a lower reception desk and brighter décor.

Children were seen in non-paediatric areas, including the fracture clinic and sexual health services. We visited the imaging department and saw that there was a dedicated space in the waiting area for young children with toys available.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient.

Staff used the paediatric early warning score (PEWS) tool to assess patients and identify deterioration. The service audited the use of PEWs in the detection of and timely response to deterioration in children. An audit of Great Western ward in June 2018 found that overall, there was good compliance in recording observations. It noted that there was good communication between the medical and nursing team and the medical consultant presence on the unit was good. However, it found that 25% of parameters were incompletely recorded, with blood pressure being the most frequently missed.

There was a PICU outreach team who supported staff on the wards with making decisions about escalation. The PICU matron told us this had helped reduce unnecessary re-admissions to the PICU as staff on the wards were able to look after patients with support on the wards.

Staff used the Shelford Group Safe Nursing Care Tool to monitor patient acuity. Patient acuity was assessed three times each day on Great Western ward.

There was a sepsis protocol in place and staff received additional education days on sepsis awareness.

We saw a protocol for identifying sepsis and fever in bone marrow transplant, oncology, immunocompromised and paediatric haematology patients. There was also a clinical guideline document for sepsis in PICU, including the recognition of the early signs of sepsis. A new sepsis tool had been introduced in the paediatric emergency department two weeks before inspection and there were plans to roll this out on the wards.

Staff had access to mental health support and could request a registered mental health nurse (RMN) for children who required one-to-one supervision. There were currently no RMNs employed directly by the trust, so the service used bank and agency nurses. Managers told us they were often not trained in paediatric mental health. We noted that “inadequate psychology provision” for children and young people within children’s services was on the directorate risk register and there were ongoing discussions with commissioners regarding liaison psychiatry provision.

There was a risk assessment tool in place for children at risk of suicide and self-harm.

In the CQC Children and Young People’s Survey 2016 the trust scored 7.6 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was about the same as other trusts.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.6 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Nurse staffing

The service usually had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, staff told us there were sometimes shortages.

Staff told us that staffing levels were one of their biggest concerns and that often the nurse in charge had to take on a clinical role when they should be supernumerary. On Grand Union ward, there were no permanent health care assistants, with reliance solely on bank staff.

Staff said there was a shortage of play specialists and medical students often helped out providing distraction activities for children undergoing treatment.

During the previous inspection, we found that the NICU was not meeting national staffing standards (British Association of Perinatal Medicine). Senior leaders told us the service was still not meeting the requirement but that significant improvements had been made in this regard. They said had completed a lot of work on safe staffing, including developing a safe staffing standard operating procedure (SOP). They told us that the introduction of cross site working, where nurses were moved between sites as required, meant that the service was usually adequately covered. They commented that there was a shortage of children's nurses nationally, but that the trust had done a lot of work on recruiting, including a 'grow your own' project aiming to upskill their own staff. They had seen a reduction in incidents being reported in relation to safe staffing.

The trust reported their nursing staffing numbers below as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
Cross site	3.0	2.0	66.7%
Hammersmith Hospital	5.0	4.5	90.2%
St Mary's Hospital	218.0	190.6	87.4%
Total	226.0	197.1	87.2%

(Source: Routine Provider Information Request (RPIR) - Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 16.2% in children's services. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) - Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 10.6% in children's services at St Mary's Hospital. This was lower than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 4.6% in children and young people's services at St Mary's Hospital. This was higher than the trust target of 3%. During inspection, managers told us that sickness rates could be high, particularly for the neonatal unit, as there was a low threshold for staff to call in when ill to reduce infection risk to patients.

St Mary's Hospital

From October 2017 to September 2018, the trust reported 49,035 (14.5%) bank hours and 35,244 (10.4%) agency hours at the trust were filled by qualified nurses in services for children and young people. There were 10,134 hours that were over-filled by bank/agency staff.

A ward breakdown is shown below:

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Grand Union	47,371	9,026	19.1%	6,823	14.4%	Over-filled by 3,463	Over-filled by 7.3%
Grand Union Nursing	46,504	1,501	3.2%	0	0.0%	3,440	7.4%
Great Western ward / Paediatric short stay unit	45,938	12,765	27.8%	10,092	22.0%	Over-filled by 20,379	Over-filled by 44.4%
Paediatric Allergy (Clinical nurse specialist)	15,344	316	2.1%	107	0.7%	1,587	10.3%
Paediatric Haematology (Clinical nurse specialist)	13,775	0	0.0%	0	0.0%	4,128	30.0%
Paediatric Safeguarding (Clinical nurse specialist)	1,980	0	0.0%	0	0.0%	1,980	100.0%
Paediatric Haematology Day Care	7,817	895	11.5%	3,417	43.7%	Over-filled by 858	Over-filled by 11.0%
Paediatric Outpatients Department	11,734	274	2.3%	416	3.6%	8,628	73.5%
Paediatric Site Practitioner Team	8,980	2,024	22.5%	0	0.0%	248	2.8%
PCCS	74,355	17,958	24.2%	14,075	18.9%	Over-filled by 5,787	Over-filled by 7.8%
Westway Ward	7,646	250	3.3%	130	1.7%	477	6.2%
Winnicott baby unit	56,525	4,027	7.1%	186	0.3%	Over-filled by 135	0.2%
Total	290,598	49,036	16.9%	35,246	12.1%	Over-filled by 10,134	Over-filled by 3.5%

During the same period, the trust reported 8,197 (16.3%) bank hours and 2,081 (4.1%) agency hours were filled by nursing assistants in services for children and young people. There were 347 (0.7%) hours that were not filled by bank/agency staff.

A ward breakdown is shown below:

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Grand Union Nursing	18,965	2,076	11.0%	0	0.0%	89	0.5%
Great Western ward / Paediatric short stay unit (SSU)	8,098	2,406	29.7%	1,650	20.4%	Over-filled by 2,282	Over-filled by 28.2%
Paediatric Haematology Day Care	1,940	2,141	110.4%	72	3.7%	Over-filled by 1,251	Over-filled by 64.5%
Paediatrics Outpatients Department	11,728	1,360	11.6%	359	3.1%	4,272	36.4%
Westway ward	1,588	100	6.3%	0	0.0%	13	0.8%
Winnicott baby unit	8,053	115	1.4%	0	0.0%	Over-filled by 494	Over-filled by 6.1%
Total	50,371	8,197	16.3%	2,081	4.1%	347	0.7%

The trust confirmed that the over-establishment reflects actual v planned for months where the actual was greater than the planned (i.e. over established due to specialising, enhanced care, etc.). The trust reported that bank staff usage is mainly attributed to vacancies.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

There was 24/7 on-site cover provided by paediatric specialist registrars (SpRs), with week day twilight shifts and overnight shifts seven days a week, as well as an on-site PICU SpR. The SpRs were supported by a paediatric site practitioner at all times, as well as the paediatric emergency department nursing team.

There was a paediatric emergency department consultant on site until 8pm every day, and then on-call out of hours. There was an attending general paediatric consultant, who did twice daily ward rounds, and was on site until 8pm.

There was on-call provision for consultants in NICU, PICU, paediatric clinical haematology and paediatric infectious diseases. There was on-call paediatric surgeon for major trauma, 24 hours, seven days a week. There was a consultant anaesthetist on call at all times to support children's services across the hospital.

The trust reported their medical staffing numbers below for St Mary's Hospital as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
Cross site	6.3	1.4	21.4%
St Mary's Hospital	108.6	106.5	98.0%
Total	114.9	107.9	93.9%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 3.6% in children’s services at St Mary’s Hospital. This was lower than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 2.5% in children’s services at St Mary’s Hospital. This was lower than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 0.2% in children and young people’s services at St Mary’s Hospital. This was lower than the trust target of 3%.

From November 2017 to October 2018, the trust reported no locum hours and 16,845 (4.8%) agency hours were filled in children’s services. There were no hours that were not filled by locum/agency staff.

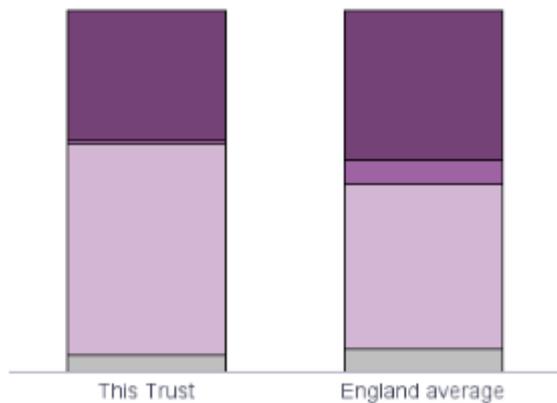
Site/Ward	Total hours available	Agency Usage	
		Hrs	%
PICU - consultants	19,718	451	2.3%
PICU - Juniors	52,416	987	1.9%
NICU - consultants	40,976	2,232	5.5%
NICU - juniors	89,856	3,312	3.7%
Haematology - consultants	12,480	132	1.1%
Haematology - juniors	9,984	1,457	14.6%
Allergy - consultant	14,352	598	4.2%
General - consultants	33,571	3,636	10.8%
General - juniors	69,114	3,556	5.2%
General Surgery - consultants	9,984	375	3.8%
Paediatric Audiology	0	109	N/A
Total	352,452	16,845	4.8%

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In September 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

Staffing skill mix for the 148-whole time equivalent staff working in children’s services at Imperial College Healthcare NHS Trust

	This Trust	England average
Consultant	36%	42%
Middle career^	1%	7%
Registrar Group~	58%	45%
Junior*	5%	6%



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

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

Records were part electronic and part paper-based. PEWS scores, for example, were paper based. Staff told us the service planned to start using an electronic version of this tool in the next few months.

We saw that the electronic patient record contained a checklist which included safety and orientation, weight, allergy and nutritional screening. There was a mental health behavioural chart for patients with a mental health condition. Records we reviewed were completed appropriately including risk assessments.

We saw that safeguarding alerts were flagged on the electronic record system. The electronic records clearly indicated patients with enhanced needs, such as learning disabilities This was also the case if a patient had an allergy. The electronic system would flag up if a healthcare professional attempted to exit the patient records without first inputting the weight and allergy status of a patient.

Discharge letters were generated for GPs and forwarded to other relevant health professionals. The discharge nurse coordinator, hospital school, and family liaison team assisted sharing of patient information to relevant community agency to assist care and safeguarding.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

We saw that medicines were all stored securely. Controlled drugs were seen to be stored securely and appropriate records were maintained. We found that emergency medicines and equipment were available and the trust checklists were completed daily. In the NICU, we saw that although the fridge temperatures were being monitored action was not being taken in accordance with the trust policy where the readings were out of range. When this was raised an additional check was carried out which established that the thermometer was giving an incorrect reading and action was then taken.

On NICU, we saw that where people were prescribed medicines that required additional monitoring that this was documented as being completed.

We saw that there was a current version of the BNF for children available and staff could also access the online version of this.

The service uses an electronic prescription and administration records system. The records were completed and notes were made when any non-administration had taken place.

Anti-microbials were seen to be reviewed in line with the Trust policy

The PICU use a different system for prescribing and administration and there was a system in place for the handover of information when a child moves from the unit to ensure continuity of prescribing.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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 we spoke with were aware of how to report and record safety incidents and near misses and knew how to use the trust's electronic reporting system.

Staff we spoke with said they heard about incidents they had reported directly by email and discussions with their line manager. They also heard about incidents and learning via a monthly report and in meetings such as the daily safety huddles and were able to give examples. The service held quarterly mortality and morbidity meetings. Staff we spoke with were aware of the principles of the duty of candour and said that it was followed in the event of an incident as required.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January 2018 to December 2018, the trust reported no incidents classified as never events for children's services.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in children's services which met the reporting criteria set by NHS England from January 2018 to December 2018.

The four types of incidents reported at St Mary's Hospital were:

- Sub-optimal care of the deteriorating patient meeting SI criteria with two (33.3% of total incidents)
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with two (33.3% of total incidents)
- Treatment delay meeting SI criteria with one (16.7% of total incidents)
- Apparent/actual/suspected self-inflicted harm meeting SI criteria with one (16.7% of total incidents)

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

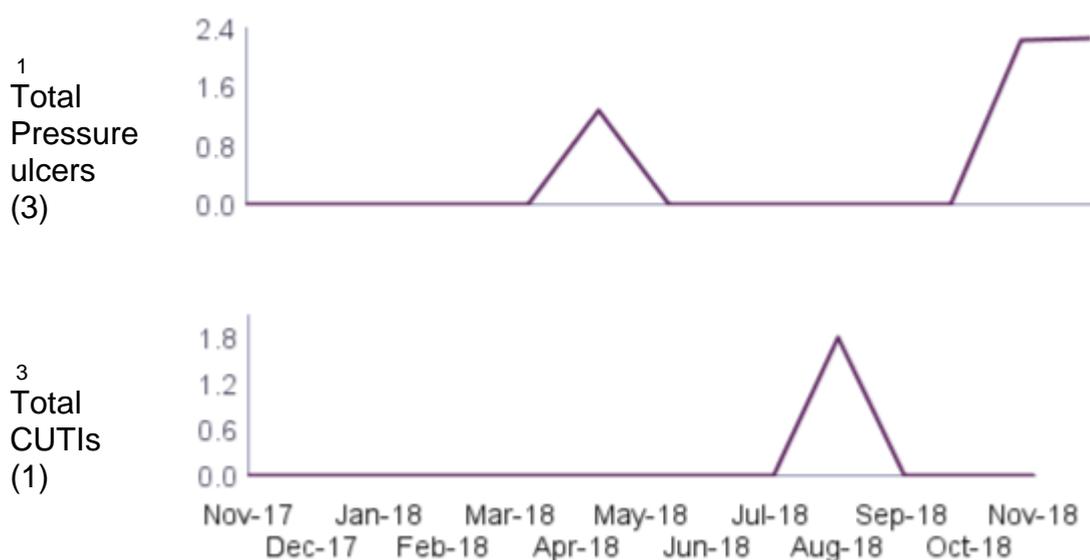
The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported three new pressure ulcers, no falls with harm and one new urinary tract infection in patients with a catheter from November 2017 to November 2018 for children's services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Imperial College Healthcare NHS Trust



1 Pressure ulcers levels 2, 3 and 4

2 Falls with harm levels 3 to 6

3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

We reviewed a sample of trust policies and saw they were up to date and based on national policy, including guidelines published by both the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH). For example, the policy titled, 'Fever - Management of Children under 5 years of age with fever' was based on NICE

guideline 160 (2013) Feverish Illness in Children, and NICE quality Standard 64 (2014) Feverish Illness in Children.

Policies were available to all staff on the electronic intranet system and staff demonstrated they knew how to access them.

The adult and paediatric audiology services were in the process of preparing for 'Improving Quality In Physiological Diagnostic Services' (IQIPS) accreditation.

St Mary's was accredited as a level 2 paediatric oncology shared care unit (POSCU) and was currently engaged with the acute lymphoblastic leukaemia and lymphoma (UK ALL) trial. This was a trial for the treatment of paediatric acute lymphoblastic leukaemia in the UK.

The trust process for reviewing and confirming compliance with NICE guidelines was managed through the clinical audit and effectiveness group, which met monthly and had representation from the clinical divisions, the safety and effectiveness team, the office of the medical director, the nursing directorate, the therapies department, pharmacy and the improvement team. The group reported to the quality and safety subgroup of the trust executive quality committee.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Records we reviewed showed that patients nutritional needs were routinely assessed. Staff said they had access to support from the dietitian when required, and there was a dedicated dietitian for haematology patients.

The nutrition and dietetics department provided support for babies across both of the neonatal units within the trust. They contributed to the 'integrated family delivered care' project, which included parent teaching around diet and breast milk. They also contributed to the clinical guidelines development group to ensure appropriate nutritional input to various guidelines.

Age appropriate nutrition was provided and there were spaces for mothers to breast feed.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients we spoke with said their pain was well managed and that staff asked them about their level of pain. A pain rating scale using face symbols was used for pain rating in children of age three and older. In the neonatal unit staff used the neonatal infant pain scale, faces, legs, activity, cry, consolability (FLACC).

A pain audit was conducted for children's services in November 2018. There were six questions for the patients to answer; they were requested to score their pain on moving at the time of the audit, using a verbal pain rating score of 'none', 'mild', 'moderate' or 'severe'. The Wong-Baker faces pain rating scale was also used for younger children. Audit report findings were similar across the trust, finding the need for greater accuracy in nurse reporting of pain scores on the electronic patient record and that levels of uncontrolled pain needed to be reduced. There was a

'pain task & finish' group looking at these issues and there were representatives from children's services in the group.

The trust told us that paediatric pain was managed by the paediatric site practitioner team (24/7 service), with support from paediatric anaesthesia and general paediatrics. 'Patient controlled analgesia' and 'nurse controlled analgesia' infusions for acute pain in children and young people were managed by the paediatric team at St Mary's Hospital. Acute pain training had been incorporated into the induction for junior doctors and into nursing away days. Additional specialised training in pain had been undertaken by several senior nurses.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The service had recently undergone a quality improvement project to improve theatre pathways. Staff told us the result was that over 90% of patients were now getting from the ward to theatre in 15 minutes, instead of the previous 30 to 60 minutes.

Results from the neonatal 'integrated family delivered care' project (May 2017 to June 2018, 100 families), showed that babies' length of stay had reduced from an average of 78 days to 61 days. The average baby's gestational age at discharge had also reduced. Babies were able to go home when they were able to feed independently, and on average this had reduced from an average of 74 days to 47 days. This indicated that, because of increased parental involvement, babies were ready for discharge earlier and therefore able to go home sooner.

The data below shows that in the 2015/16 diabetes audit St Mary's Hospital performed similar to the England average.

The proportion of patients receiving all key care processes annually was 87.2%, which was a positive outlier, compared to a national aggregate of 35.5%. The previous year's score was 90.4%.

HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The average HbA1c value (adjusted by case-mix) at the trust was 66.1%, which was within the expected range, compared to a national aggregate of 68.3%. The previous year's score was within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 66.5, which was about the same as the previous year's median, which was 65.5.

(Source: National Paediatric Diabetes Audit 2015/16)

The data shows that, from May 2017 to April 2018, no specialty at the trust had six or more children aged under one readmitted following an elective admission. The trust had a similar percentage of patients aged 1-17 years old readmitted following an elective admission compared to the England average.

Emergency readmissions within two days of discharge following elective admission among the under 1 age group, by treatment specialty (May 2017 to April 2018)

There were emergency readmissions after elective admission at Imperial College Healthcare NHS Trust among patients in the under 1 age group from May 2017 to April 2018. However, no treatment specialty reported six or more readmissions.

Emergency readmissions within two days of discharge following elective admission among the 1-17 age group, by treatment specialty (May 2017 to April 2018)

Specialty	Imperial College Healthcare NHS Trust			England
	Readmission rate	Discharges (n)	Readmissions (n)	Readmission rate
Paediatric clinical haematology	0.9%	1,750	16	1.3%
Paediatrics	1.1%	929	10	0.9%

The data shows that from May 2017 to April 2018 no specialty at the trust had six or more children aged under one following an emergency admission. The trust had a lower percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (May 2017 to April 2018)

Specialty	Imperial College Healthcare NHS Trust			England
	Readmission rate	Discharges (n)	Readmissions (n)	Readmission rate
Paediatrics	0.7%	2,317	16	2.8%

No other specialty at the trust had six or more readmissions

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

From June 2017 to May 2018, the trust performed similar to the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma.

The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for epilepsy.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (June 2017 to May 2018)

Long term condition	Imperial College Healthcare NHS Trust			England
	Multiple admission rate	At least one admission (n)	Two or more admissions (n)	Multiple admission rate
Asthma				
Under 1	-	-	-	8.6%
1-17	14.0%	121	17	16.1%
Diabetes				
Under 1	-	-	-	16.7%
1-17	*	32	*	13.0%
Epilepsy				
Under 1	*	*	*	32.9%
1-17	23.6%	55	13	27.4%

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with '*'.
 (Source: Hospital Episode Statistics, provided by CQC Outliers team)

In the 2017 National Neonatal Audit St Mary's Hospital's performance in the four measures relevant to children and young people's services was as follows:

- **Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5°C-37.5°C?**

There were 64 eligible cases identified for inclusion. Of these, 60.1% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

This was within the expected range when compared to the national aggregate where 61.0% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

The hospital did not meet the audit's recommended standard of 90% for this measure.

- **Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?**

There were 314 eligible cases identified for inclusion. Of these, 98.6% of these cases had a first consultation with parents by a senior member of the neonatal team within 24 hours of admission.

This was a positive outlier when compared to the national aggregate where 90.5% of cases had the first consultation within 24 hours of admission.

The hospital did not meet the audit's recommended standard of 100% for this measure.

- **Do all babies <1,501g or a gestational age of <32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP)**

There were 78 eligible cases identified for inclusion. Of these 96.1% of babies with a weight of <1,501g or a gestational age of <32 weeks at birth received the appropriate ROP screening.

This was within the expected range when compared to the national aggregate, where 94.2% of cases received the appropriate ROP screening.

The hospital did not meet the audit's recommended standard of 100% for this measure.

- **Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age?**

There were 18 eligible cases identified for inclusion. Of these, 73.7% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age.

This was in the middle 50% of units when compared to the national aggregate where 61.2% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age.

The hospital did not meet the audit's recommended standard of 100% for this measure.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Nurses we spoke with told us that training provision was good. One gave an example of the training provided to care for bone marrow transplant patients, which included infection control and infusion training. Mentoring was available to staff and nurses could apply for additional training courses, such as HDU training.

The service had clinical practice educators whose role was to develop the nursing workforce by supporting staff career progression and ensuring high quality patient care through enhanced clinical skills and teamwork. A clinical practice educator we spoke with told us they ran 'back to the floor' sessions for senior nurses and had different consultants or senior nurses come in to teach at these. For example, during our inspection, there was a consultant speaking about jaundice. A senior nurse could relieve a nurse on the ward, so they could complete training.

New nurses were rotated through the different areas of services for children and young people, which gave them a wide range of experience and skills.

Nursing revalidation is the process by which registered nurses are required to demonstrate on a regular basis that they are up to date and fit to practice. The trust was actively supporting the nursing staff throughout the Nursing and Midwifery Council (NMC) revalidation process, as well as with competency assessments and further training.

There was cross-site working in the neonatal service (St Mary's Hospital and Queen Charlotte's Hospital), with a consultant rota to provide care at both sites. Leaders told us this was a big improvement since last inspection in 2014. They said the service was seamless, as they had daily contact via videoconferencing and could transfer babies easily.

The trust told us that 100% of PICU medical staff were APLS trained. In general paediatrics, all shifts were covered by medical staff with accredited APLS training. Specialist registrars (SpRs) were 100% compliant. The paediatric site practitioner team provided 24-hour cover across children's services and were 100% compliant with APLS training. The paediatric resus team were all APLS trained. Furthermore, 69% of PICU nursing staff shift leaders were EPLS / APLS trained, with 40% of band 6 nurses on Grand Union ward trained and 100% of shift leaders Great Western ward trained too.

From November 2017 to November 2018, 96.1% of required staff within children's services at St Mary's Hospital received an appraisal compared to the trust target of 95%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met? (Yes/No)
Qualified Healthcare Scientists	4	4	100.0%	Yes
Qualified Allied Health Professionals	5	5	100.0%	Yes
Other Qualified Scientific, Therapeutic, Technician Staff	4	4	100.0%	Yes
Support to Scientific, Therapeutic, Technical Staff	4	4	100.0%	Yes

Qualified Nursing and Health Visiting Staff	201	195	97.0%	Yes
Support to doctors and nursing staff	18	16	88.9%	No
NHS Infrastructure Support	18	16	88.9%	No
Total	254	244	96.1%	No

(Source: Trust Provider Information Request – Appraisal tab)

Multidisciplinary working

Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

We saw numerous examples of excellent multidisciplinary team (MDT) working between different groups of staff. There was a weekly MDT safety meeting on each ward, in which staff discussed different topics each week. During the week of inspection, there was a discussion on incidents (including medicines incidents) and the booking of follow-up appointments. Staff in attendance included student nurses, matron, nurses, consultants and a pharmacist. We saw good interactions between staff of different levels.

There was a weekly MDT meeting for bone marrow transplant patients on Grand Union ward. Staff discussed various things, including inpatients and outpatients, as well as their school and educational needs.

Senior sisters, including those from both paediatrics and neonates, met weekly to discuss ideas or present potential projects, and were connected to other sites via video conferencing.

The service had developed strong working links with local GPs through continuation of the 'Connecting Care for Children' initiative, designed to assist in the integration of child healthcare across primary, secondary and tertiary services.

In the CQC Children and Young People's Survey 2016 the trust scored 8.5 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Seven-day services

A consultant paediatric anaesthetist was available on site during working hours, Monday to Friday. Out-of-hours cover was provided via a dedicated on-call paediatric consultant anaesthetist. All specialties had access to senior paediatric advice 24 hours a day.

There was a neonatal outreach team, which was established in September 2018, in order to facilitate early discharge from the neonatal unit and offer outreach care at home. The team provided a seven-day outreach service to facilitate early discharge from inpatient neonatal care. The neonatal outreach team was comprised of one Band 7 lead nurse, two Band 6 specialist nurses and two Band 6 lactation specialist nurses.

Patients had access to allied healthcare professionals, such as physiotherapists, outside of normal working hours, including weekends. Staff were able to access radiology services 24 hours per day, with urgent electronic reporting available overnight.

The ear, nose and throat on-call consultant was available to support complex paediatric cases and support the PICU, especially for complex airway cases.

Staff on the wards told us play specialists were only available three days a week due to lack of resourcing.

Health promotion

The service supported patients to be involved in their own care. We saw there were health promotion leaflets available and there were information boards around the wards and outpatient department displaying health promotion material.

Senior leaders told us about the 'care information exchange' which was a phone application ('app') used by carers and patients to access records. They said the app could be used by doctors to say whether patients needed to attend hospital, and that it reduced hospital visits, gave patients more control over their care, and allowed them to share information more easily with both GPs and carers.

The unit had continued the 'Connecting Care for Children' initiative that we observed at the time of the last inspection. One of the main aims of the scheme was to empower patients and their parents/carers to self-manage their own care, reducing unnecessary presentations or admissions to services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

We saw that consent was appropriately recorded in patient records we reviewed. Staff we spoke with demonstrated a good understanding of consent processes.

The trust had a policy on consent, which included guidance on the treatment of young children. It stated that where a child is admitted, clinicians should discuss with their parent(s) what routine procedures will be necessary, and ensure that clinicians have their consent for these interventions in advance. If parents specify that they wish to be asked before particular procedures are initiated, clinicians must do so, unless the delay involved in contacting them would put the child's health at risk. It further stated that only people with 'parental responsibility' were entitled to give consent on behalf of their children and that clinicians must be aware that not all parents have parental responsibility for their children.

Other CQC Survey Data

The trust performed about the same as other trusts for all of the five questions relating to effectiveness in the CQC Children and Young People's Survey 2016.

CQC Children's Survey questions, effective domain, Imperial College Healthcare NHS Trust

Question Number	Question	Age group	Trust score	RAG
21	Did you feel that staff looking after your child knew how to care for their individual or special needs?	0-15 adults	8.3	About the same
9	Did staff play with your child at all while they were in hospital?	0-7 adults	8.1	About the same

19	Did different staff give you conflicting information?	0-7 adults	8.0	About the same
33	During any operations or procedures, did staff play with your child or do anything to distract them?	0-15 adults	8.0	About the same
54	Did hospital staff play with you or do any activities with you while you were in hospital?	8-11 CYP	6.3	About the same

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff were kind and caring towards patients and took the time to listen to children and explain what was happening.

We observed caring interactions on the PICU where staff were crouched down to the child's level and making eye-contact, whilst explaining about the medicine they were about to be given.

A teenage bone marrow transplant patient we spoke with on Grand Union ward was very positive about their experience. They said the play specialist was "great" and checked in with them daily, and had got them a games console to use in their room.

A parent we spoke with on Great Western ward said staff were welcoming and attentive.

In NICU, a mother of twins we spoke with said all nurses had been very helpful and they felt they could ask them questions. Another mother commented that they felt empowered by staff to take care of their baby. Another mother said that all staff were responsive and "lovely".

The service performed well in the Friends and Family Test, with an average of 95% of respondents saying they would recommend the service (October 2017 to October 2018).

The trust performed about the same as other trusts for all of the 10 questions relating to compassionate care in the CQC Children and Young People's Survey 2016.

CQC Children and Young People's Survey 2016 questions, compassionate care, Imperial College Healthcare NHS Trust

Question Number	Question	Age group	Trust score	RAG
10	Did new members of staff treating your child introduce themselves?	0-7 adults	8.9	About the same
14	Did you have confidence and trust in the members of staff treating your child?	0-15 adults	8.7	About the same
22	Were members of staff available when your child needed attention?	0-15 adults	8.2	About the same
42	Do you feel that the people looking after your child were friendly?	0-7 adults	9.0	About the same
43	Do you feel that your child was well looked after by the hospital staff?	0-7 adults	9.0	About the same

44	Do you feel that you (the parent/carer) were well looked after by hospital staff?	0-15 adults	7.9	About the same
58	Was it quiet enough for you to sleep when needed in the hospital?	8-15 CYP	6.2	About the same
64	If you had any worries, did a member of staff talk with you about them?	8-15 CYP	7.9	About the same
74	Do you feel that the people looking after you were friendly?	8-15 CYP	9.3	About the same
75	Overall, how well do you think you were looked after in hospital?	8-15 CYP	8.9	About the same

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Emotional support

Staff provided emotional support to patients to minimise their distress.

There was a family liaison service to provide support to families of children using the service. Parents and patients we spoke with said they felt well supported by staff. The trust told us that psychologists were involved in communication with children during their hospital attendance in specialist services.

Within the psychology contract with a local community NHS trust, psychologists provided emotional support to parents with parent groups and individual face to face sessions. Weekly support sessions for PICU parents and staff were available from the external psychologists.

The service had a family room which could be used for discussions with families and carers including breaking bad news. There was a chaplaincy service and a bereavement service.

The trust performed about the same as other trusts for all of the five questions relating to emotional support in the CQC Children and Young People's Survey 2016.

CQC Children and Young People's Survey 2016 questions, emotional support, Imperial College Healthcare NHS Trust

Question Number	Question	Age group	Trust score	RAG
7	Was your child given enough privacy when receiving care and treatment?	0-7 adults	8.7	About the same
29	If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?	0-15 adults	8.4	About the same
45	Were you treated with dignity and respect by the people looking after your child?	0-7 adults	9.1	About the same
65	Were you given enough privacy when you were receiving care and treatment?	8-15 CYP	8.7	About the same
67	If you felt pain while you were at the hospital, do you think staff did everything they could to help you?	8-15 CYP	8.3	About the same

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

One bone marrow transplant teenage patient we spoke with told us they had been informed and involved in their discharge planning. They said their pain was well controlled and that staff listened to them.

The neonatal service used an 'integrated family delivered care' model that encouraged parental education and involvement in their babies' care. The programme was supported by a competency book for parents, which was developed by the neonatal team and subsequently rolled out across the North West London perinatal operational delivery network. They had also developed a free mobile phone app, which provided a range of educational material for parents.

There were processes to ensure information was provided in a child-friendly way. The paediatric diabetes team had child-friendly starter packs for children and young people of all ages. The play team worked with children during procedures and consultations, and the trust told us that psychologists were involved in communication with children during their hospital attendance in specialist services. There were child-friendly videos on the trust website regarding procedures and roles within CYP services.

The trust performed about the same as other trusts for all of the 20 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People's Survey 2016.

CQC Children and Young People's Survey 2016 questions, understanding and involvement of patients, Imperial College Healthcare NHS Trust

Question Number	Question	Age group	Trust score	RAG
11	Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	0-15 adults	9.1	About the same
12	Did members of staff treating your child communicate with them in a way that your child could understand?	0-7 adults	7.7	About the same
13	Did a member of staff agree a plan for your child's care with you?	0-15 adults	9.0	About the same
15	Did staff involve you in decisions about your child's care and treatment?	0-15 adults	8.2	About the same
16	Were you given enough information to be involved in decisions about your child's care and treatment?	0-15 adults	8.8	About the same
17	Did hospital staff keep you informed about what was happening whilst your child was in hospital?	0-15 adults	8.4	About the same
18	Were you able to ask staff any questions you had about your child's care?	0-15 adults	9.0	About the same
31	Before your child had any operations or procedures did a member of staff explain to you what would be done?	0-15 adults	9.2	About the same
32	Before the operations or procedures, did a member of staff answer your questions in a way you could understand?	0-15 adults	9.2	About the same
34	Afterwards, did staff explain to you how the operations or procedures had gone?	0-15 adults	8.3	About the same
39	When you left hospital, did you know what was	0-15	8.0	About the same

Question Number	Question	Age group	Trust score	RAG
	going to happen next with your child's care?	adults		
41	Do you feel that the people looking after your child listened to you?	0-7 adults	8.5	About the same
59	Did hospital staff talk with you about how they were going to care for you?	8-15 CYP	8.6	About the same
60	When the hospital staff spoke with you, did you understand what they said?	8-15 CYP	8.7	About the same
61	Did you feel able to ask staff questions?	8-15 CYP	9.4	About the same
62	Did the hospital staff answer your questions?	8-15 CYP	9.2	About the same
63	Were you involved in decisions about your care and treatment?	8-15 CYP	6.3	About the same
66	If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?	12-15 CYP	N/A	N/A
69	Before the operations or procedures, did hospital staff explain to you what would be done?	8-15 CYP	9.4	About the same
70	Afterwards, did staff explain to you how the operations or procedures had gone?	8-15 CYP	8.9	About the same
72	When you left hospital, did you know what was going to happen next with your care?	8-15 CYP	7.6	About the same

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

However, there were some areas for improvement. For example, there was limited provision for adolescent patients on the wards and in paediatric outpatients.

There was no dedicated space for adolescents on the wards or in the paediatric outpatient department. However, there was free Wi-Fi available for patients to use and play specialists could provide computer tablets and games consoles for adolescents when required. There was a working group underway focussing on how to make improvements for adolescents, called the 'adolescent big room'. This was a coached weekly meeting that aimed to bring together people, data and patient stories to drive improvement and was facilitated by a paediatric consultant with a special interest in adolescent care and a non-clinical coach.

There was a dedicated adolescent transitional HIV service, called the '900 clinic'. The trust stated that "the HIV transitional care service is fully comprehensive, compliant with NHS guidance, is well published in medical literature including service user satisfaction, developed the national [Children Living with HIV and AIDS] and [British HIV Association] transitional care HIV guidelines... Staff members and patients give national and international lectures on transitional care. There is a less than 1% loss to follow up 1-year post transition to adult care".

The trust had a standard operating procedure (SOP) regarding the admission of adolescents to adult inpatient wards. The document related to young people generally between the ages of 16 and 18. but included young people who were slightly younger or older than 18 years in appropriate circumstances, such as the case of a significant disability. The trust stated that each

case was always considered on its own merits. The process of admission was illustrated in the SOP. All attendances to the emergency department required notifications to be printed, with appropriate review and action by the safeguarding team. This was designed to highlight children who were admitted to adult wards. However, the trust said work was underway for daily reports of the admissions to be generated to the team so the process was quicker.

Significant work had gone into improving facilities for relatives of patients on the PICU since the last inspection. There was a new large relative's lounge area, which included comfortable seating and a kitchen area with facilities to store and make food and hot drinks. There was also a small dedicated quiet room where staff could speak confidentially to parents. Staff told us there was some accommodation provided off-site for parents who had children staying in the PICU, and that nearby hotels could be paid for by the charity.

There was now on-site accommodation for parents whose babies were in the neonatal unit. This was an improvement since the last inspection. The accommodation was also used for 'rooming in', where babies would be moved into the room where the parents were staying. This allowed parents the opportunity to be involved in their child's care and enabled staff to provide support. This facilitated improved discharge processes.

The teaching team at St Mary's were part of an external local community hospital school. They provided education on a daily basis for all children aged between four and 18, either in a classroom or at their bedside. As well as a broad academic curriculum, they also offered an arts curriculum including art, music, poetry and writing. The team liaised with a pupil's home school if a longer stay in hospital was required.

The trust performed better than other trusts for no questions, worse than other trusts for two questions, and about the same as other trusts for the remaining 15 questions relating to responsiveness in the CQC Children and Young People's Survey 2016.

The two worse performing questions were: 'Did your child like the hospital food provided?' and 'Did the hospital change your child's admission date at all?'

CQC Children and Young People's Survey 2016 questions, responsive domain, Imperial College Healthcare NHS Trust

Question Number	Question	Age group	Trust score	RAG
4	For most of their stay in hospital what type of ward did your child stay on?	0-15 adults	9.9	About the same
5	Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?	0-15 adults	8.4	About the same
25	Did you have access to hot drinks facilities in the hospital?	0-15 adults	7.8	About the same
26	Were you able to prepare food in the hospital if you wanted to?	0-15 adults	3.9	About the same
28	How would you rate the facilities for parents or carers staying overnight?	0-15 adults	7.4	About the same
55	Was the ward suitable for someone of your age?	12-15 CYP	8.0	About the same
8	Were there enough things for your child to do in the hospital?	0-7 adults	7.5	About the same
24	Did your child like the hospital food provided?	0-7 adults	4.6	Worse
37	Did a staff member give you advice about caring	0-15	8.5	About the same

	for your child after you went home?	adults		
38	Did a member of staff tell you who to talk to if you were worried about your child when you got home?	0-7 adults	8.1	About the same
40	Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?	0-15 adults	7.4	About the same
56	Were there enough things for you to do in the hospital?	8-15 CYP	6.7	About the same
57	Did you like the hospital food?	8-15 CYP	6.2	About the same
71	Did a member of staff tell you who to talk to if you were worried about anything when you got home?	8-15 CYP	7.1	About the same
73	Did a member of staff give you advice on how to look after yourself after you went home?	8-15 CYP	8.3	About the same
2	Did the hospital give you a choice of admission dates?	0-7 adults	4.9	About the same
3	Did the hospital change your child's admission date at all?	0-7 adults	8.0	Worse

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Meeting people's individual needs

The service took account of most patients' individual needs. However, there were issues with psychiatric support for patients with a mental health condition.

The service employed bank registered mental health nurses (RMNs) for children who had a mental health condition and required support. However, staff said they often had issues with accessing RMN cover. Mental health provision was provided by a local trust's child and adolescent mental health service (CAMHS) team. Staff said there was often a long wait to get children CAMHS beds outside of the trust. The lack of onsite psychiatric multi-disciplinary support for paediatric patients was on the directorate risk register.

There was play provision for young children, including dedicated play areas, toys and screens showing children's entertainment.

There was a kitchen available for the use of bone marrow transplant patients, and patients had their own cupboards allocated.

Parents of children staying on Grand Union and Great Western wards told us there were limited facilities for them to make food and refreshments.

There was a 'what matters to me' board in Grand Union ward and patients were given a pack on admission to fill out their likes and dislikes. However, it was not clear what was done with this information.

There was no children's learning disability nurse and no standard learning disability hospital passport. However, staff we spoke with said they made required adjustments for children with a learning disability and they were in the process of developing a passport. They also ensured these children had access to play specialists. Many staff had Makaton training. This a system that uses signs and symbols to aid communication.

In sexual health services, there was a specialist nurse team and the trust said children were fast tracked to see them.

On the PICU, patient's individual needs were highlighted to staff via a board at the end of each patient's bed. The board allowed staff to see, at a glance, the patient's likes and dislikes and respond accordingly.

Staff told us that they sometimes had difficulty getting play specialists to attend the PICU due to limited resourcing, but that staff were very experienced at supporting children on the unit.

The neonatal outreach team provided a range of services including; supporting complex discharges and supporting parents at home, education and teaching for parents and families.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Patients primarily accessed the PICU services via escalation from one of the wards or the emergency department. Only a small number of patients were pre-booked surgery cases. Patients were also occasionally admitted from the children's acute transport service. The trust told us all PICU admissions had to be accepted by both the attending consultant and the nurse in charge.

Staff said the main admission route to Great Western ward was via the paediatric emergency department and that admissions were organised by the site practitioner. They also had admissions from the haematology day unit and received transfers from other hospitals.

The trust told us elective admissions were usually surgical (ENT / general surgery) and were discussed in advance with the PICU team. Some unplanned admissions came from within the trust, in the case of a collapse or deterioration on a ward, a high PEWS score, a PICU consultation request from another team, or via the paediatric emergency department, or were an unplanned surgical admission.

The majority of unplanned admissions came in via a retrieval team for children who required level 2 or 3 care and needing to be transferred to the PICU from another organisation.

For bed management purposes, the hospital had their own paediatric site practitioners providing cover 24 hours a day, seven days a week. They had close links with site management teams at other sites across the trust and dialled into the four daily bed management calls. Senior leaders told us this was a big improvement since the last inspection.

The trust ran a service called Providing Assessment and Treatment for Children at Home (PATCH), which was a nurse-led hospital at home service for mild to moderately unwell children.

Senior leaders told us the service usually met trust referral to treatment (RTT) targets. We saw the RTT data for October 2017 to October 2018 on the paediatric scorecard which showed that the 18-week target for incomplete pathways had been met each month except for three instances. However, these instances were only very slightly below the target (1%).

From October 2017 to September 2018, the trust's neonatal bed occupancy was higher than the England average for five months of the 12-month period.



Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

We saw that information was available for patients and parents on how to make a complaint, including leaflets and posters which provided contact details of the service senior staff.

From November 2017 to October 2018, there were 25 complaints about children's services. The trust took an average of 33 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 40 working days.

At St Mary's Hospital, there were 20 complaints (80%), with main themes relating to values and behaviours and clinical treatment.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From November 2017 to October 2018 there were four compliments within children's services at St Mary's Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. However, staff survey results showed signs of disconnection with senior management.

The service was led by a divisional clinical director, a divisional director of operations and a divisional director of nursing. Services for children and young people had board representation via the divisional director for the division of women, children and clinical support. There was also a children and young person's non-executive director who sat on the board.

The same leadership team covered all sites, which the leaders told us helped to ensure shared learning. There were site specific matrons and ward managers, who came together at the directorate meetings ensuring joined up services across the trust.

Senior leaders told us there was a seamless multidisciplinary multi-site service for neonates, with one head of service covering both sites.

Our discussions with senior leaders and service managers demonstrated that they were passionate and committed to delivering good care across the trust.

Staff we spoke with said they felt well supported by their line managers. They said they were approachable and visible and they felt able to go to them for support.

Some staff said that senior leaders were visible, but commented that not all staff on the ward would know who they were.

The NHS staff survey 2017 results showed that 67% of participants of the women's, children's and clinical support division felt that immediate manager took a positive interest in their health and well-being. The majority (88%) knew who their senior managers were, however, only 35% thought that senior managers tried to involve staff in important decisions.

Survey results for the children's directorate showed that only 25% of participants thought that communication between senior management and staff was effective and only 13% felt that senior managers acted on staff feedback. Both results were worse than organisational average. Actions taken in response included global emails to be used to share changes and ask for comments and additional monthly staff team meetings.

Vision and strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust paediatric services vision was: 'Children's health for life'. The overall strategy for children's services was to live the trust values, build their services in collaboration with local partners, improve the environment, train their teams and give children access to new and innovative treatments.

The children's strategy document provided by the trust stated that the strategy included the following:

- Live the values of the trust - be kind, collaborative, expert and aspirational.
- Build services in collaboration - continue to innovate and develop as a provider of specialised and secondary children's health care, including looking after the sickest children, and working closely with all other children's services in north west London.
- Improve the environment - create a modern and welcoming place for staff to work, and children and families to receive health care.
- Train teams for the future - continue to train and build a committed, innovative and enthusiastic multidisciplinary children's work force for the future.
- Give children access to new and innovative treatments - build on research, and increase opportunities for children to be involved in clinical trials, making optimal use of the Children's Clinical Research Facility (CCRF).

Culture

Managers and staff including nurses and doctors promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff we spoke with of all levels spoke highly of the culture within their teams and within the wider trust. Staff told us there was an open culture, and some commented that the team was like “one big family” and that they learned a lot from each other.

Senior leaders told us that staff faced challenges with the state of the facilities, due to the ageing estate, but that they were proud that they were still passionate, innovative, trying to do their best, and delivering outstanding care.

There was a focus on improving child health outcomes embedded in the culture of the service.

There was an up-to-date whistleblowing policy, which outlined how to escalate any concerns. Two ‘Speak Up’ guardians had also been introduced in October 2016.

Governance

There were arrangements in place for governance and risk management.

In September 2016, the trust had restructured the existing corporate safety and effectiveness team, the divisional governance leads, patient safety managers and administration teams to form a safety and effectiveness hub. This allowed for centralised oversight around use of resources and caseload distribution based on demand across the divisions.

Senior leaders told us that the structure of the executive committees was emulated at divisional and then directorate level, which helped to ensure a ‘ward to board’ flow of information.

There was a quality and safety subgroup within children’s services which reported into the trust quality and safety committee. The division also had site oversight meetings with the executive team, where issues relating to risk and performance could be picked up. Directorate meetings fed into frontline safety huddles too, and vice versa, which senior leaders said ensured that learning came to them from the frontline.

The service held regular governance meetings, where good practice was shared across sites. There were monthly divisional meetings, as well as the monthly CYP directorate committee and the monthly CYP quality and safety meeting. The monthly directorate quality and safety meeting was chaired by the clinical director or the head of nursing and included direct updates from service regarding quality, incidents, complaints, risks, risk register updates, IPC, and safeguarding. The agenda also included: people and education update/staff engagement, peer reviews, audits, guidelines, policies, medicine management, estates/equipment, core skills and statutory and mandatory training, and review of key performance indicators (KPIs). There were monthly neonatal mortality and morbidity meetings and separate paediatric mortality and morbidity meetings.

We found issues relating to governance with the trust safeguarding team. There was no central log for child safeguarding cases. The safeguarding consultant nurse lead told us that the safeguarding leads or the staff involved took the lead on individual safeguarding cases. This meant that there was a risk that issues could be missed. A member of the safeguarding team attended the Local Safeguarding Children’s Board and shared learning with the wider team through email.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

We saw the divisional and directorate risk registers and saw that risks identified on inspection were identified on these. The divisional risk register included high level risks such as: the lack of comprehensive adolescent transitional services within some specialities across the trust, and the pseudomonas and legionella water risk within children's services. Senior leaders also emphasised the challenges relating to the environment due to the aging buildings. The directorate risk register contained 138 risks and included a summary of the risk, the last review date and the date the next review was due. The risk of cross-infection on PICU was listed and it was stated that this was ongoing until the new unit was completed. However, the trust had interim controls in place.

There was a head of risk nurse for children's services and one for neonatal services, who attended the directorate risk meetings.

Senior leaders told us that since the last inspection the trust had appointed two more paediatric surgeons to address a previous risk. The hospital was a major trauma centre but previously only employed two of their own surgeons and used additional surgeons from a network. They now had a total of four paediatric surgeons, who were also part of the network.

Information management

Most aspects of patient records were electronic. The service was working towards making more aspects of records electronic, such as the paediatric early warning score tool.

The intranet was available to all staff and contained links to current guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and the information contained within.

All staff had access to their work email, where they received organisational information on a regular basis, including clinical updates and changes to policy and procedures.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Patient experience was monitored via the friends and family test (FFT) and through informal feedback mechanisms such as the 'what matters to me' feedback, where patients could write or draw their likes and dislikes. We saw a variety of 'thank you' letters and cards, as well as 'you said, we did' boards. The 'Connecting Care for Children' (CC4C) project aimed to make children and parents partners in their care. There was also a paediatric diabetes home care team patient satisfaction survey.

The trust told us there were local listening sessions provided regularly to parents and patients by the matrons. There was a diabetes parent focus group which was parent-led, and a parent group which had recently commenced in Grand Union. There was also a paediatric sickle cell forum and a paediatric allergy family forum.

The trust gave examples of improvements that had been made based on feedback from patients and their families or carers. On Great Western ward the parents' kitchen had received a lot of negative comments historically. Staff raised money with the help of a charity to provide basic food and drinks, such as bread, tea and coffee. In response to more feedback, PICU parents were now

provided with psychology, play and family liaison support within 12 hours of admission. More privacy screens had been bought for breast feeding mothers. Additionally, sensors had been put in place to reduce noise levels in paediatric critical care areas. Paediatric outpatient improvements included: improving appointment letters with the addition of a patient leaflet, adding patient leaflets in waiting areas, and better communications around wait times.

Staff told us about the trust's a 'make a difference' award system which they and patients could nominate staff for in recognition of outstanding practice, achievement or innovation.

In October 2018 the trust ran an event "Shaping the future of St Mary's Paediatric Department", to involve staff, patients and families in discussing and sharpening the future of St Mary's children's services. It was held on a Saturday and the trust said it was well attended by patients, families including children and young people, and staff.

The 2018 "Our Voice' engagement survey" received 3,164 staff responses which was an increase of 357 from 2017. The overall engagement had improved in the national survey for the last three years. For the staff friends and family test, which asks whether staff would recommend the trust as a place to work and as a place for treatment, results showed that 77% of staff in the women's, children's and clinical support division would recommend the trust. This was close to the trust average of 78%.

The response rate for the NHS staff survey 2017 for the WCCS division was 38.7% which was slightly below the trust average of 41%. This was an improvement on the response rate from the previous year. The divisional final engagement score was 3.75 against a national average of 3.79 and an organisational average of 3.84.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The 'connecting care for children' (CC4C) model of care was established and managed by the general paediatric team and aimed to connect all involved professionals, to encourage shared learning, a 'whole person' approach to care, and increase parent and professional confidence in how child health services fit into primary care. The trust told us it resulted in better outcomes for children, through coordinated care management, multi-disciplinary teams, and assessment and treatment in the right setting.

This had been recognised through a recent Health Service Journal (HSJ) award in October 2018. And the lead for CC4C at the trust was awarded an OBE for this work. The approach led to reductions in outpatient appointments, emergency attendances and hospital admissions, and a similar model had now also been introduced for adults, following its success.

The 'integrated family care programme' in neonatology won an HSJ Award in July 2018 for innovation. A PICU consultant had recently received a HSJ award for innovative practice regarding paediatric simulation training.

The trust was a member of the North West London Sickle Cell and Thalassemia (NWLST) Clinical Network. The network oversaw the safe and effective delivery of care of haemoglobinopathy patients in the North West London region and aimed to promote clinical excellence by removing barriers to shared care, through common clinical management guidelines and improved working between local and specialist teams.

The service ran a paediatric asthma and wheeze 'big room'. They used a flow coaching approach and aimed to improve the recognition and management of asthma and wheeze in children and young people, with an initial focus on implementing an electronic asthma management plan. The

trust said the final round of ICT testing was underway and in the meantime, improvements in care planning were being audited via paper records.

The trust ran a service called Providing Assessment and Treatment for Children at Home (PATCH), which was an innovative nurse led hospital at home service for mild to moderately unwell children, preventing admissions and attendances and working with CCGs and GPs to explore direct referrals to prevent ED attendances. The trust told us the first phase of the pilot reduced admissions via the emergency department and attendances, making a cost saving projected c£300k per year. They said they had received “overwhelmingly positive” feedback from families and professionals and that the service provided patient-centred care, improved confidence in family self-care, and improved collaborative working across the urgent care paediatric pathway locally and across London.

Charing Cross Hospital

Imperial College Healthcare NHS Trust was formed on October 1, 2007 by merging St Mary's NHS Trust and Hammersmith Hospitals NHS Trust and integrating with the faculty of medicine at Imperial College London.

The trust has 12 registered locations and employs almost, 11,000 staff. The registered locations are:

- Queen Charlottes and Chelsea Hospital
- Western Eye Hospital
- Hammersmith Hospitals
- Northwick Park Renal Centre
- Ealing Renal Satellite Unit
- St Charles and Hammersmith Renal Centres
- West Middlesex Renal Centre
- Brent Renal Centre
- Charing Cross Hospital
- St Mary's Hospital
- Hayes Renal Centre
- Watford Renal Centre

The trust has an estimated range of population served is between 1,500,000 and 2,000,000 people.

- The trust has a total of 1004 inpatient beds spread across various locations
- 534 outpatient clinics per week.
- 297 day case beds.
- 38 Children's beds.
- No dedicated End of Life Care beds.
- 52 inpatient wards.

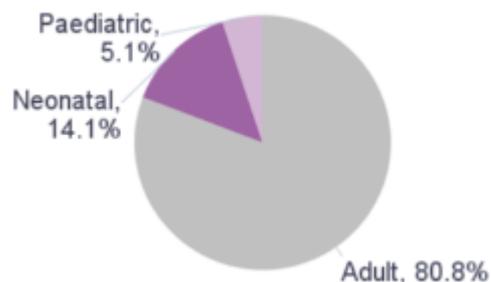
Critical care

Facts and data about this service

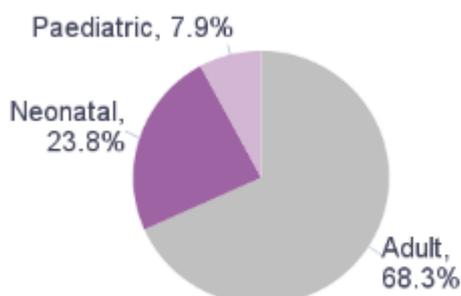
The trust has 107 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Imperial College Healthcare NHS Trust and England:

This trust



England



(Source: NHS England)

Critical care services are provided at the St Mary's, Charing Cross and Hammersmith hospitals sites.

There is an intensive care unit (ICU) at each of the sites delivering level two and level three care. There are speciality differences within each of the units, reflective of the configuration of services provided at each site.

St Mary's has a major trauma centre, covering north west London. Charing Cross is a tertiary referral centre for neurosciences. At Hammersmith Hospital there are two separate ICUs: cardiothoracic ICU and the general ICU.

In addition, the Charing Cross site and St Mary's hospital sites have acute respiratory units (ARUs), which provide non-invasive respiratory support for a defined patient population. There is also a renal unit at the Hammersmith Hospital site which provides level two care for this speciality group.

There is critical care outreach service provision at St Mary's, Charing Cross and Hammersmith Hospital, which is a combined service with resuscitation.

(Source: Routine Provider Information Request (RPIR) – Context acute)

The adult intensive care unit at Charing Cross Hospital cares for critically ill individuals from the local population and also those referred from other regions for specialised care. Specialties include major head and neck reconstructive surgery, plastic surgery, urology, complex ear, nose and throat (ENT) surgery, neurosurgery and neurology. Neurosurgery patients form the largest part of the case mix.

The intensive care unit at Charing Cross Hospital is set across the 11th floor and is split into two units: 11 North and 11 West. The service is commissioned to 24 beds (with 26 physical bed spaces), and offers both intensive and high dependency care for adults with immediate life-threatening medical and surgical conditions (planned and emergency). The service at Charing Cross Hospital is designed to accommodate patients with level two and level three care needs and can accommodate up to 14 level two patients and 10 level three patients. Level two care describes patients requiring more detailed observation or intervention. This includes support for a single

failing organ system or post-operative care, and those 'stepping down' from level three care. Level three care refers to patients requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multiple organ failure.

There is a practitioner-led outreach and resuscitation team providing support seven days a week from 8am to 8pm. The team comprises nurses and physiotherapists who work with staff on the wards to ensure the early detection of the deteriorating patient and follow up patients who have been discharged from intensive care.

The service also has a five-bedded acute respiratory unit (ARU) on the ground floor within the trust's acute medical unit which provides non-invasive respiratory support for level two patients only. The ARU is managed by the medicine directorate with oversight and input from the critical care directorate and team of doctors.

We visited the two intensive care units: 11 North and 11 West on the 11th floor and the acute respiratory unit on the ground floor of Charing Cross Hospital over three days during our announced inspection on the 26 February to 28 February 2019.

We reviewed nine patient care records and observed care provided. We spoke with 10 relatives and carers, two patients and 43 members of staff including nurses, consultants, junior doctors, physiotherapists, pharmacists, dietitians and administrative staff. We also reviewed the trust's performance data and looked at trust policies for critical care.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff. However mandatory training compliance levels for doctors in training did not meet trust targets. Band 7 nurses led teams of nurses within the critical care service and ensured mandatory training was completed and up to date. Staff were able to access the electronic learning management system to check their completion and sign up to courses. The lead nurse for the site also monitored mandatory training completion rates which were collected in a dashboard for the unit.

The trust provided a structured induction and mandatory training programme for staff. Staff working in critical care, including staff on the acute respiratory unit, received additional training courses specific to critical care. Courses specific to critical care included modules in intensive care unit medicines, sepsis, ventilators and intravenous therapy (IV) competency. The critical care outreach and resuscitation team delivered non-invasive ventilation (NIV) and tracheostomy training for the staff working on the acute respiratory unit.

Staff working on the intensive care units and acute respiratory unit also completed a critical care competency workbook. We saw competency workbooks for staff working on the acute respiratory unit which were signed off by the critical care outreach and resuscitation team.

Mandatory training was delivered through face-to-face sessions and online courses. Staff received protected time to complete training courses. Critical care staff received seven and a half hours of protected time every three years and an additional three and a half hours for extra e-learning annually. Temporary (agency) staff had a local induction which included orientation on

the wards and a checklist which the nurse in charge kept so that when the agency staff worked on the ward again a record of their competencies was available. Nursing staff, including agency nursing staff, told us the induction process was very thorough.

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at Charing Cross Hospital for qualified nursing and midwifery staff in critical care services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Duty of Candour	12	12	100.0%	85%	Yes
Infection Prevention and Control Level 2	105	106	99.1%	85%	Yes
Invasive Procedures Policy	105	106	99.1%	85%	Yes
Nutrition	105	106	99.1%	85%	Yes
Consent	104	106	98.1%	85%	Yes
Moving and Handling Level 1	104	106	98.1%	85%	Yes
Equality and Diversity	103	106	97.2%	85%	Yes
Health and Safety	103	106	97.2%	85%	Yes
Medicines Management	103	106	97.2%	85%	Yes
Conflict Resolution	102	106	96.2%	85%	Yes
ANTT	100	106	94.3%	85%	Yes
Fire Safety Awareness	99	106	93.4%	85%	Yes
Blood Transfusion	98	106	92.5%	85%	Yes
Resuscitation Level 3	96	106	90.6%	85%	Yes
Information Governance	94	106	88.7%	85%	Yes
Moving and Handling Level 2	93	106	87.7%	85%	Yes

In critical care services the 85% target was met for all 16 mandatory and statutory training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at Charing Cross Hospital for medical staff in critical care services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
ANTT	10	10	100.0%	85%	Yes
Consent	10	10	100.0%	85%	Yes
Duty of Candour	10	10	100.0%	85%	Yes
Equality and Diversity	10	10	100.0%	85%	Yes
Health and Safety	10	10	100.0%	85%	Yes
Infection Prevention and Control Level 2	10	10	100.0%	85%	Yes
Invasive Procedures Policy	10	10	100.0%	85%	Yes
Moving and Handling Level 1	10	10	100.0%	85%	Yes
Venous Thromboembolism	10	10	100.0%	85%	Yes
Blood Transfusion	9	10	90.0%	85%	Yes
Medicines Management	9	10	90.0%	85%	Yes

Resuscitation Level 2	9	10	90.0%	85%	Yes
Conflict Resolution	8	10	80.0%	85%	No
Information Governance	8	10	80.0%	85%	No
Fire Safety Awareness	7	10	70.0%	85%	No

In critical care services the 85% target was met for 12 of the 15 mandatory and statutory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at Charing Cross Hospital for doctors in training in critical care services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Conflict Resolution	22	27	81.5%	85%	No
Infection Prevention and Control Level 2	22	27	81.5%	85%	No
Equality and Diversity	21	27	77.8%	85%	No
Health and Safety	21	27	77.8%	85%	No
Invasive Procedures Policy	21	27	77.8%	85%	No
Moving and Handling Level 1	21	27	77.8%	85%	No
ANTT	20	27	74.1%	85%	No
Blood Transfusion	20	27	74.1%	85%	No
Consent	20	27	74.1%	85%	No
Fire Safety Awareness	20	27	74.1%	85%	No
Information Governance	20	27	74.1%	85%	No
Nasogastric Tube Placement	20	27	74.1%	85%	No
Medicines Management	19	27	70.4%	85%	No
Resuscitation Level 2	19	27	70.4%	85%	No
Venous Thromboembolism	19	27	70.4%	85%	No

In critical care services the 85% target was met for none of the 15 mandatory and statutory training modules for which doctors in training were eligible. The directorate leadership were aware of the low compliance rates in mandatory training modules for doctors in training and we saw in meetings minutes that this had been discussed at the monthly directorate board meeting. However, it was unclear how the leadership planned on increasing compliance levels.

In the previous inspection, basic resuscitation training levels were found to be low on the intensive care unit. During this inspection we found that all nursing staff working in critical care services, including on the acute respiratory unit, had completed immediate life support training as a requirement in their core competencies as per national guidelines; training compliance rates for immediate life support training (resuscitation level three) was 90.6% which was better than the trust target of 85%. Basic life support training with an automated external defibrillator (AED) (resuscitation level two) compliance rates were 90% for medical staff which was better than the trust target of 85%. Doctors in training compliance rates for resuscitation level two was 70.4% which was lower than the trust target of 85%. The critical care outreach and resuscitation team held teaching sessions for basic life support and work to get all staff throughout the hospital proficient in basic life support was ongoing.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Systems and processes protected patients from abuse, neglect, harassment and breaches of their dignity and respect. These were understood and followed by staff.

Staff were trained to level two in both adult and child safeguarding. All staff we spoke with demonstrated a good understanding of safeguarding vulnerable adults. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to make a referral. We were given examples of concerns they had identified and where referrals were made. Staff knew how to escalate concerns to the senior nurse and safeguarding team. Most staff we spoke with had good awareness and knowledge about female genital mutilation (FGM) which was part of mandatory safeguarding training.

Safeguarding information was flagged within a patient's record within the electronic patient record system. In a sample of records we reviewed, we saw that a safeguarding referral had been made and was appropriately flagged within the patient's electronic record.

We reviewed the trust's adult safeguarding policy which was available on the trust intranet. The policy detailed individual responsibilities and processes for reporting and escalation of concerns. There was a poster on the wall in the acute respiratory unit next to the nurse's station with relevant telephone numbers and contact details of safeguarding leads. We also saw a safeguarding flowchart on the staff information board in the administrative offices area of the 11th floor which informed staff of step by step actions when making a safeguarding referral and numbers to call. The board also displayed the latest safeguarding newsletter from the trust's safeguarding team.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as at February 2019 for qualified nursing and midwifery staff in critical care services at Charing Cross Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults Level 2	104	106	98.1%	85%	Yes
Safeguarding Children Level 2	103	106	97.2%	85%	Yes

In critical care services at Charing Cross Hospital, the 85% target was met for both safeguarding training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for safeguarding training courses as at February 2019 for medical staff in critical care services at Charing Cross Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Children Level 2	10	10	100.0%	85%	Yes
Safeguarding Adults Level 2	9	10	90.0%	85%	Yes

In critical care services at Charing Cross Hospital, the 85% target was met for both safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as at February 2019 for doctors in training in critical care services at Charing Cross Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults	22	27	81.5%	85%	No
Safeguarding Children Level 2	21	27	77.8%	85%	No

In critical care services at Charing Cross Hospital, the 85% target was met for neither of the two safeguarding training modules for which doctors in training were eligible.

Between November 2017 to October 2018 the critical care service trustwide made 13 safeguarding referrals to the relevant local authority.

Patients aged 16 or 17 were admitted to the intensive care unit at Charing Cross Hospital. Data provided by the trust showed that from December 2018 to February 2019, five young people of this age were admitted to the hospital's intensive care unit. When patients aged 16 or 17 were admitted to the intensive care unit, trust guidance on the admission of adolescents to inpatient wards was used. The guidance advised staff about ensuring that the young person is admitted to the department which best met their needs and to ensure that environmental and young person-centred needs are met such as educational resources.

Cleanliness, infection control and hygiene

The service controlled infection risk well. All clinical areas we visited on the intensive care units (11 North and 11 West) and acute respiratory unit were visibly clean and free of clutter. Wall mounted hand sanitisers were available in all areas including at the point of entry to the units and bed spaces.

Throughout our inspection all staff were observed to be 'bare below the elbows' and adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces. There was easy access to personal protective equipment (PPE), such as aprons, gloves (of different sizes) and face shields throughout the unit and at the entrances to side rooms which were used for patients with infections requiring isolation. We witnessed staff using PPE effectively.

We saw staff decontaminated their hands immediately before and after every episode of direct contact or care. This complied with guidance from the National Institute for Health and Care Excellence (NICE) QS61: infection prevention and control. We also saw the receptionist on the intensive care unit remind visitors to use the hand sanitisers before entering the bed bays.

Infection prevention control (IPC) was part of mandatory training and trust records showed a compliance rate of 96.6% for nursing staff which was better than the trust target of 85%. The compliance rate for medical staff was 85% which met the trust target. All nursing and medical staff we spoke with were able to articulate the IPC training they had received and most staff were able to identify the IPC link nurse for their area.

Hand hygiene audits had previously been ward-led; however, in May 2018, the trust implemented a new model for hand hygiene compliance auditing in order to improve the quality of audit data. The new model involved the trust's infection prevention and control team and divisional staff collecting hand hygiene data for compliance with the World Health Organisation (WHO) five moments for hand hygiene. This focused on five of the key moments when healthcare workers should perform hand hygiene. In May 2018, hand hygiene compliance under the new auditing

model was 53% for the intensive care units (11 North and 11 West) at Charing Cross Hospital. At the re-audit in November 2018, the compliance rate was 55%. During our inspection, quality and safety boards displayed a monthly hand hygiene audit result of 60%. To improve compliance rates on the intensive care unit, the critical care service had begun a quality improvement project on hand hygiene where there was a focus on moment one (before touching a patient) and moment four (after touching a patient) which were areas that the audit had identified required improvement.

The acute respiratory unit was based within the acute medical unit and so was audited together. Results in May 2018 showed a hand hygiene compliance rate of 64%. The compliance rate had significantly improved to 80% at the re-audit in November 2018.

IPC standard operating procedures were accessible by staff on the hospital intranet. We observed housekeepers working throughout the day following a schedule of cleaning tasks to maintain the cleanliness of the wards. Cleaning audits between August 2018 and January 2019 showed compliance rates of 98.6% for the intensive care units (11 North and 11 West) and 95.2% compliance for the acute medical unit which included the acute respiratory unit.

We reviewed patient areas across the intensive care units and the acute respiratory unit and found the waiting area, dirty utility rooms and store rooms to be visibly clean. Relatives we spoke with were satisfied with the level of cleanliness. We saw green 'I am clean' stickers being used to identify equipment that had been cleaned and ready for use. We inspected various items of equipment including a commode, blood pressure cuffs, a hoist, scales and found a good level of cleanliness. However, we found that keyboards used with computers at the bedside in 11 West had visible dust between the keys. We also found that trolleys containing disposables did not have dust covers which meant that dust could enter the drawers. We also checked a sample of toilets and shower rooms within the intensive care unit and acute respiratory unit and found them to be visibly clean.

Staff took precautions to identify patients at risk of infection. All patients were screened for methicillin resistant staphylococcus aureus (MRSA), vancomycin-resistant enterococcus (VRE), and carbapenemase-producing enterobacteriaceae (CPE) on admission to the intensive care unit and acute respiratory unit. MRSA screening compliance between August 2018 and January 2019 was 98% for the intensive care units which was better than the trust target of 90%. The screening compliance rate results for the acute respiratory unit which was measured with the acute medical unit and was 85%. This was below the trust target of 90% and was being managed by the divisional infection prevention control committee to increase compliance rates. There were no reported cases of MRSA and one case of Clostridium difficile in the reporting period in critical care services at Charing Cross Hospital.

There were three side rooms on the intensive care units (two on 11 North and one on 11 West) and one side room on the acute respiratory unit. Patients deemed to be an infection risk were isolated in a side room with en-suite facilities. This was in accordance with the trust infection control policy. Side rooms had an appropriate airflow system in place to ensure adequate ventilation, however during the time of our inspection, the negative pressure in the two side rooms on 11 North were not functioning and was not being used to accommodate patients with multi-resistant infections. The third side room located on 11 West was fully functioning. The two side rooms which were not functioning had been escalated to estates and had been placed on the risk register until they had been fixed.

Waste management was handled appropriately, with different colour coding for general waste, and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards.

Environment and equipment

The service had suitable premises and equipment and looked after them well. The entrance to the intensive care unit for both 11 North and 11 West had secure entry and buzzers to let visitors in. There were also additional doors separating bed bays from the main entrance and reception area. The entrance to the acute respiratory unit was through the entrance for the acute medical unit which also had secure buzzer entry. However, during our inspection, we saw some visitors tailgating into the intensive care unit and inspectors were also not challenged in the bed bay areas of the intensive care unit.

Medicines rooms were locked with a swipe card lock to prevent unauthorised entry. Linen cupboards and storage rooms were appropriately stocked and tidy.

There were two emergency trolleys covering 11 North and one emergency trolley on 11 West and one emergency trolley which covered the acute respiratory unit. We found that they were secured with a plastic snap lock so it was clear if someone had accessed the resuscitation equipment. Emergency trolleys were checked daily and a log was signed to confirm checks had been made. We checked various consumables, such as fluids and found that they were sealed and in date. There was also a difficult airway trolley on 11 North and 11 West.

We saw evidence that equipment had been serviced and calibrated regularly. We checked various items of equipment such as defibrillators, blood gas analyser, glucometer, infusion pumps and blood pressure monitors and found they had been safety tested. At our previous inspection we found there was only one defibrillator covering half of the intensive care unit. At this inspection we saw that there were now enough defibrillators cover both units.

Oxygen tanks were stored securely and were in date. We inspected three sharps bins on the intensive care unit and on the acute respiratory unit and found them to be correctly labelled and not filled above the maximum fill line.

At the last inspection we found that some equipment had been stored on top shelves requiring a step ladder to reach them. At this inspection we found that equipment stores were tidy and equipment was not placed on top shelves.

Bed space facilities conformed to Department of Health 2013 Guidelines for Critical Care facilities, Health Building Note 04-02. Every bed space had emergency equipment, a tracheostomy box as well as equipment needed for mouthcare, dressings and syringes. Bed spaces were clear and uncluttered allowing free movement for staff around the clinical area. There were designated side rooms available for patients who had a respiratory infection.

We checked the consumable equipment trolleys and found that all items we sampled were in date and packaging was intact, indicating it was sterile and safe for use in patient care. However, we found a dirty utility room on 11 North where there was an unlocked cupboard containing chlorine and chlorine releasing granules. This meant that anyone could have access to the substances and was not compliant with control of substances hazardous to health (COSHH) regulations. We notified the nurse in charge and the substances were immediately removed and placed in a locked cupboard in the dirty utility room on 11 West.

We viewed the relatives' waiting room which was spacious and equipped with a television, water fountain and chairs. However, we found that some of the seat pads of the chairs were ripped. We found that the fridge in the kitchen was not displaying the correct temperature and was faulty. We pointed this out to the nurse in charge who notified the maintenance team who came on the same day and rectified the problem.

Critical care services were supported by dedicated technologists who managed the medical equipment on the unit and conducted some minor maintenance. Routine maintenance was

completed by the trust's estates department medical engineers. All equipment was logged on an asset register which identified when the equipment required servicing or replacement. Two types of ventilators were in use on the intensive care units. This had been risk assessed and to mitigate the risk, technologists and nurse educators ran equipment training sessions so staff were familiar with the different types of ventilator. There was a plan to standardise equipment such as the ventilators once the machines required replacing.

We found that desk fans were being used to cool a blood gas analyser in the dirty utility room on 11 West as the room it was kept in got too hot and would cause the machine to malfunction. This had been reported to estates and was on the health and safety risk register. We were told that the estates maintenance team were working to reduce the temperature of the room at the time of our inspection.

At our last inspection we found that fire doors had been propped open. At this inspection we found that all fire doors were closed. However, we found fire water hoses inside the entrance of the intensive care unit and in the administrative offices area of the 11th floor which had been decommissioned but did not have signage warning people that the equipment was not in use.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. We saw in records that risk assessments were completed and clear records were maintained. Records we reviewed included individual risk assessments such as mobility/falls, nutrition, skin integrity and mental capacity assessments. Where risk had been identified we also saw evidence that risk management plans were developed in line with national guidance.

All potential admissions to the unit were discussed with the consultant on duty and had consultant oversight. On admission to the intensive care unit, patients had a treatment plan and were reviewed by the consultant within 12 hours, in accordance with the Guidelines for the Provision of Intensive Care Services, 2015.

All patients were reviewed by a consultant twice daily and there was a 'consultant of the week' system on the acute respiratory unit which provided continuity of care over seven days. A consultant in intensive care medicine was available 24 hours a day and could attend to patients within 30 minutes. In daytime hours the critical care outreach and resuscitation team were also available. This meant that there was appropriate liaison with critical care available to other areas of the hospital in the event a patient required input from the critical care service.

We saw tracheostomy posters at bed spaces indicating to staff that a patient had a tracheostomy. The document was marked with the date, size of tracheostomy and who to contact in an emergency. Each bed space had an emergency tracheostomy box which could be kept with the patient at all times and contained essential equipment required in case of an accidental decannulation or for an emergency tube change.

All staff we spoke with could clearly articulate how to recognise sepsis. They also showed us the electronic patient record system which had prompts for identifying sepsis. We reviewed patient records and saw nurses completed a daily assessment and recorded hourly observations for each patient.

The critical care service included the critical care outreach and resuscitation team who supported all aspects of the acutely and critically ill patient pathway. The critical care outreach and resuscitation team comprised six specialist nurses and was led by a band 8a outreach and resuscitation lead nurse. The team were now available seven days a week from 8am to 8pm. The team followed up patients after their discharge from the intensive care unit, conducted daily reviews of patients, responded to the needs of the deteriorating patient and provided ongoing support to patients until their admission to the unit. The team also provided training to staff in the

management of critically unwell patients including courses in the deteriorating patient, management of tracheostomy, non-invasive ventilation and resuscitation training.

Out of hours provision was provided by the clinical site practitioner who received a formal written handover from the critical care outreach and resuscitation team. The clinical site practitioner was supported by an airway trained medical registrar. A handover was then written in the morning for when the critical care outreach and resuscitation team came on shift.

Patients were never ventilated in theatre recovery areas but on occasion, level two patients were cared for in recovery but would always be nursed on a one to one basis by a critical care nurse and monitored by a registrar.

We observed the nursing handover which took place twice a day and found it to be detailed and comprehensive with discussion of national early warning scores (NEWS) which is the tool used to improve detection and response to clinical deterioration in adult patients. Additional needs of the patient were also discussed at the handover. At the time of our inspection, the hospital was about to launch NEWS 2 which was an updated version of NEWS. Alongside NEWS 2, the trust was also about to launch a new adult deteriorating patient guideline and response action cards to standardise the escalation response to a deteriorating patient in the trust in line with NEWS 2 recommendations. This would be supported with mini teaching sessions and e-learning.

There was now a clear, formal pathway between level two and level three beds. Since the last inspection all level two beds were now co-located within the intensive care units on the 11th floor or were on the five-bedded acute respiratory unit where there were strict admission criteria. Teleconferences also took place at 5am and 5pm everyday cross site between the intensive care units to discuss staffing and acuity. We attended surgical bed meetings, site team bed meetings, and the 11am meeting between the acute respiratory unit and the intensive care unit. These meetings discussed escalation, patients of concern and potential step-down patients and we found the discussions to be comprehensive.

On the acute respiratory unit, risks to patients were assessed, monitored and managed on a day to day basis. Staff sought support from senior staff when patients deteriorated. The critical care outreach and resuscitation team could also access specialist support from critical care consultants at all times.

Staff in the intensive care units and acute respiratory care unit could access mental health support for patients if they were concerned about a patient's mental health. Staff reported there was generally good support available for those patients that required mental health support.

We also attended the safety briefing where staff read out the 'Big 4' which were the four cross site learning points for the month such as hand hygiene, safety alerts or changes in practice. The 'Big 4' was repeated every morning for a month to help instil learning among staff.

Training records showed that 93.4% of nursing staff had received training in fire safety awareness which was better than the trust target of 85%. However, 70% of medical staff and 74.1% of doctors in training had completed fire safety awareness training which was below the trust target. Band 7 staff and nurses in charge had fire warden training which meant that there would always be a fire warden allocated on a shift. Fire evacuation plans were available to staff in paper format at the reception desk. Staff trained as fire wardens could clearly articulate what action they would take in the event of a fire in line with local procedures. However, the training they received was classroom based and no fire drills had been undertaken since 2010.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust reported their staffing numbers below in critical care for Charing Cross Hospital, Hammersmith Hospital and St Mary's Hospital as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
Charing Cross Hospital	109.8	106.4	96.9%
Hammersmith Hospital	152.1	132.3	87.0%
St Mary's Hospital	140.1	143.6	Over-established by 2.5%
Total	402.0	382.3	95.1%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 1.7% in critical care at Charing Cross Hospital. This was lower than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 5.3% in critical care at Charing Cross Hospital. This was lower than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 5.2% in critical care services at Charing Cross Hospital. This was higher than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Charing Cross Hospital:

From October 2017 to September 2018, the trust reported 21,104 (11.9%) bank hours and 3,593 (2.0%) agency hours at the trust were filled by qualified nurses in critical care. There were 14,712 hours (8.3%) that were over-filled by bank/agency staff.

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Intensive care (ICU)	177,997	21,104	11.9%	3,593	2.0%	Over-filled by 14,712	Over-filled by 8.3%

During the same period, the trust reported 2,860 (34.8%) bank hours and 253 (3.1%) agency hours were filled by nursing assistants in critical care. There were 2,487 hours (30.3%) that were over-filled by bank/agency staff.

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Intensive care (ICU)	8,222	2,860	34.8%	253	3.1%	Over-filled by 2,487	Over-filled by 30.3%

The trust confirmed that the over-establishment reflects actual and planned for months where the actual was greater than the planned (i.e. over established due to specialising, enhanced care, etc.). The trust report that the bank staff usage is mainly attributed to vacancies.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Nursing leads managed staffing requirements according to patient acuity. Rotas aimed to provide a spread of skill mix. Staffing levels and skill mix were planned and reviewed using a staffing acuity tool so that patients received safe care at all times. The service was meeting the Guidelines for the Provision of Intensive Care Services, 2015 and level three patients were nursed at a ratio of one to one, level two patients were nursed at a ratio of one nurse to two patients. The duty rosters demonstrated this ratio was met. There was a conference call at 5am and 5pm every day which discussed staffing levels and acuity across all three intensive care units and staff rotated cross site if required.

There were two nurses in charge covering 11 North and 11 West of the intensive care units. The nurses in charge was supernumerary during the day and night which meant they could focus on managing and leading the ward instead of doing clinical tasks.

During our inspection, we found the intensive care units were fully staffed. Quality and safety boards on the unit displayed planned and actual staffing numbers accurately. Regular agency staff were being used to mitigate any shortages, however the intensive care unit did not utilise greater than 20% of registered nurses from bank or agency on any one shift which met the Guidelines for the Provision of Intensive Care Services, 2015.

The acute respiratory unit was fully staffed with two registered nurses who were non-invasive ventilation (NIV) and critical care trained. Four healthcare assistants also supported the unit. The ward manager was supernumerary from Monday to Friday.

The intensive care units and acute respiratory unit were also supported by clinical nurse educators.

Medical staffing

The service now had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust has reported their staffing numbers below for Charing Cross Hospital, Hammersmith Hospital and St Mary's Hospital as at February 2019.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at February 2019
Charing Cross Hospital	32.7	32.1	98.2%
Hammersmith Hospital	18.0	18.0	100.0%
St Mary's Hospital	37.7	38.0	Over-established by 1%
Total	88.4	88.1	99.7%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 0.48% in critical care at Charing Cross Hospital. This was lower than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 0.0% in critical care at Charing Cross Hospital, compared to a trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 0.3% in critical care services at Charing Cross Hospital. This was lower than the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From November 2017 to October 2018, the trust reported no locum or agency hours available. However, 205 agency hours were filled in critical care. The trust was unable to confirm the number of locum or agency hours that were unfilled.

A breakdown of agency usage by ward is shown below:

Ward	Total hours available	Agency Usage
		Hrs
COS ITU CX	0	14
SM ITU Medical staff	0	191
Total	0	205

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Medical staffing levels had improved since our last inspection. There were 7.1 whole time equivalent consultants, 12 senior house officers and 10 registrars covering the intensive care units. This meant that there was enough medical staff on duty in relation to the number of patients on the intensive care units. The medical staffing of the critical care service complied with the Guidelines for the Provision of Intensive Care Services, 2015. These standards state the consultant to patient ratio should not exceed a range between one consultant to eight patients and one consultant to 15 patients. During our inspection the consultant to patient ratio was one consultant to 12 patients.

At the last inspection, due to high vacancies there was not always a registrar available out of hours on the intensive care unit. At this inspection we found that there was adequate cover. A consultant in intensive care medicine was also available 24 hours a day, and could attend to patients within 30 minutes of being called. The intensive care units were each staffed with a minimum of one consultant, one registrar and one senior house officer. This would increase to three registrars and three senior house officers depending on leave taken. A consultant covered both units from 6pm until 10pm seven days a week and then was available within 30 minutes of being called. These minimum staffing levels were maintained at weekends although weekend nights were covered by one registrar. The intensive care unit also had at a minimum of one registrar who was airway trained.

The acute respiratory unit was led by a respiratory consultant and outside of hours, there was a medical registrar and on call resident intensive care middle grade doctor.

Doctors we spoke with felt there were adequate numbers of doctors during the day and night. We saw consultants undertaking daily ward rounds which happened twice a day. Staff told us rotas were planned and manageable.

We observed handover of one patient who was stepped down to the ward. This handover was concise and contained all necessary information.

Records

The intensive care unit was in the process of moving fully to the use of electronic records but at the time of the inspection was still in transition and used a mixture of paper and electronic notes. Staff kept appropriate records of patients' care and treatment and record keeping was comprehensive. However, it was sometimes difficult to ascertain whether patient information had been fully completed due to some information being recorded by hand and some information being recorded on the electronic system. There was also a risk of prescribing errors due to the different systems being in use for documentation. Staff also reported that patient records needed to be printed off when a patient was being transferred cross site due to the different electronic record systems used at the other intensive care units in the trust. However, we did not find evidence of impact on patient safety and the issue was logged as a risk on the risk register with a plan in place for full transition to an electronic system in three months' time. The acute respiratory unit had transitioned fully to electronic records and did not encounter this issue.

We reviewed nine sets of records in the intensive care unit and acute respiratory unit and found that they were comprehensive and detailed. Records also noted patients' additional needs such as if they had dementia or a learning disability. On the acute respiratory unit, the use of a learning disability hospital 'passport' was encouraged, however this was not routinely found to be used on the intensive care unit.

Care plans were in place and there was evidence that these were reviewed daily. We reviewed drug charts which were consistently completed and there were full details of any medicines prescribed, as well as any allergies the patient had.

The electronic patient record system displayed specific symbols to alert staff to safeguarding concerns. When a patient was discharged to the ward from the intensive care unit, doctors gave a verbal handover and a discharge summary was written up on the patient's electronic record. We saw that these had comprehensive information about the patient such as falls risk assessments and physiotherapy needs. On the acute respiratory unit, care summaries were sent to a patient's general practitioner (GP) electronically when the patient was discharged from hospital.

Staff ensured records were kept secure and patients details remained confidential. Any paper notes were kept secure in locked trolleys. We saw that staff logged computers off when they were not using them.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Suitable arrangements were in place for the ordering, dispensing, prescribing, recording and handling of medicines.

Nursing staff were aware of the policies on the administration of controlled drugs (CDs) (medicine that is controlled under the 'Misuse of Drugs Act' (2001)). CDs were stored in line with required legislation and recorded in a controlled drugs register. The register containing details of the contents of the CD cupboard was stored within the cupboard and identified the expected stock of medicine. Two members of staff checked the CD stock levels. We checked the CD stock levels and found them to be accurate and the medicine in date. The keys for the CD cupboard were held by the nurse in charge on the unit. Checks for expired medicines were completed as well as the daily fridge temperature used to store medicines. The fridge temperature logs that we checked were all within acceptable range.

Medication records showed that allergies were clearly documented in prescribing documents. Medicines to take out (TTO) were stored securely until the patient was discharged. Patients' medications were kept secure. On the intensive care unit, there was a keypad locked box containing patients' medications behind each bed space.

Trust protocols for the administration of antibiotics were available on the hospital intranet and staff knew how to access these. The trust had a specialist antimicrobial pharmacist and we viewed guidelines which were in date and available on the trust intranet. Microbiology ward rounds occurred every day on the intensive care unit.

The intensive care unit had two dedicated pharmacists who visited the unit every day from Monday to Friday and limited hours on Saturday and checked prescription charts and CD books. A pharmacy communications book was used by nurses to communicate to pharmacists when stock was low. Patients' medicines were reconciled and documented by the pharmacist in line with national guidance. Staff told us the pharmacy team were always available to provide advice and guidance from the on-call pharmacist who was available out of hours.

Pharmacists attended the acute respiratory unit from 8am to 7pm from Monday to Friday with an on-call pharmacist available on site out of hours. The pharmacist also took part in the two multidisciplinary ward rounds and took the lead on antibiotic prescribing stewardship.

The acute respiratory unit used an electronic prescribing system while the intensive care unit were still using paper medications charts together with an electronic patient records system which meant that there was a risk of errors due to different documentation systems being in use. We saw that patients were having venous thromboembolism (VTE) assessments completed and that these were being reviewed in line with the trust policy. However, the VTE assessment section of the paper medicines record was left blank and the assessment was completed on the electronic records system which meant that it could lead to required interventions being missed. The use of different documentation systems (paper and electronic) was logged as a risk on the risk register with a plan in place for full transition to the electronic system. To mitigate risks, the pharmacy team reviewed and reconciled all medicines when patients transferred internally between care settings with different prescribing modes

The trust undertook a bi-annual pharmacy antimicrobial point prevalence study (PPS) in February and August 2018. The study examined key antimicrobial prescribing and safety indicators in order to identify areas for improvement.

In the August 2018 PPS, within critical care, 93% of antimicrobials were reviewed in 72 hours and over 90% were of a duration in line with policy and guidance. The key actions from the study included changes in the antibiotics prescribed due to a resistance strain. The critical care pharmacy team and the microbiology team also raised awareness of these indicators and the importance of documentation during infection ward rounds which took place three times a week. On a quarterly basis, the trust antimicrobial review group and infection, prevention and control team, monitored overall antimicrobial consumption as part of the antimicrobial commissioning for quality and innovation (CQUIN) which is a framework which supports improvements in the quality of services and the creation of new, improved patterns of care.

Incidents

The service managed patient safety incidents well. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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. The trust used an electronic incident reporting system to report incidents. Staff were aware of their responsibilities for reporting incidents and were able to explain how this was done. Staff told us they were encouraged to report incidents and received feedback from incidents they had reported.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a

never event.

From November 2017 to October 2018, the trust reported no incidents classified as never events for critical care.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from January 2018 to December 2018.

Of these, the types of incident reported were:

- HCAI/Infection control incident meeting SI criteria with one (25.0% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (25.0% of total incidents).
- Pending review (a category must be selected before incident is closed) with one (25.0% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (25.0% of total incidents).

Site specific information can be found below:

- Charing Cross Hospital: two incidents (50.0% of total incidents).

(Source: Strategic Executive Information System (STEIS))

We reviewed the root cause analysis (RCA) reports for the SIs at Charing Cross Hospital and found that these were investigated appropriately in accordance with the Serious Incident Framework 2015. All RCA reports had corresponding action plans in place where action needed had been identified.

From February 2018 to January 2019, there were 420 incidents reported within critical care services at Charing Cross Hospital. Of these, 237 were categorised as 'no harm', 69 as 'near miss', 110 as 'low harm' and 4 as 'moderate harm'.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were able to explain the duty of candour fully. A sample of serious incidents were reviewed and we saw that the duty of candour was discharged appropriately.

At the last inspection, there was a backlog of incidents being signed off due to staff absence. This was no longer the case and all incidents were reviewed by the lead nurse and consultant in the specialism the incident was related to. Any learning and action points were shared with nursing and medical staff through the service's newsletter, at daily safety briefings and at monthly band 7 and 8 meetings where band 7 team leaders would then cascade learning down to their individual nursing teams. Incidents were presented at directorate quality and safety meetings which was open to all staff from critical care to attend.

Mortality and morbidity meetings were held bi-weekly and were open to all staff to attend. We viewed the logs of these meetings which included the outcome and lessons learned.

Consultants reviewed patient deaths in their service using a mortality screening tool (level 1 review) which identified patients requiring further review through speciality mortality and morbidity meetings (level 2 review) or an independent 'structured judgement review'. Consultants were also

responsible for sharing and escalating through the divisional structures, any deficiencies in care, systems or process identified through the review. Patient deaths that were identified in the level 1 review were reported to the weekly medical director incident review panel where the panel decided whether investigation under the serious incidents framework was required. Level 2 reviews were reported monthly to the MD panel. The trust mortality review group received divisional reports and was responsible for overseeing the mortality review process and reporting on themes for learning.

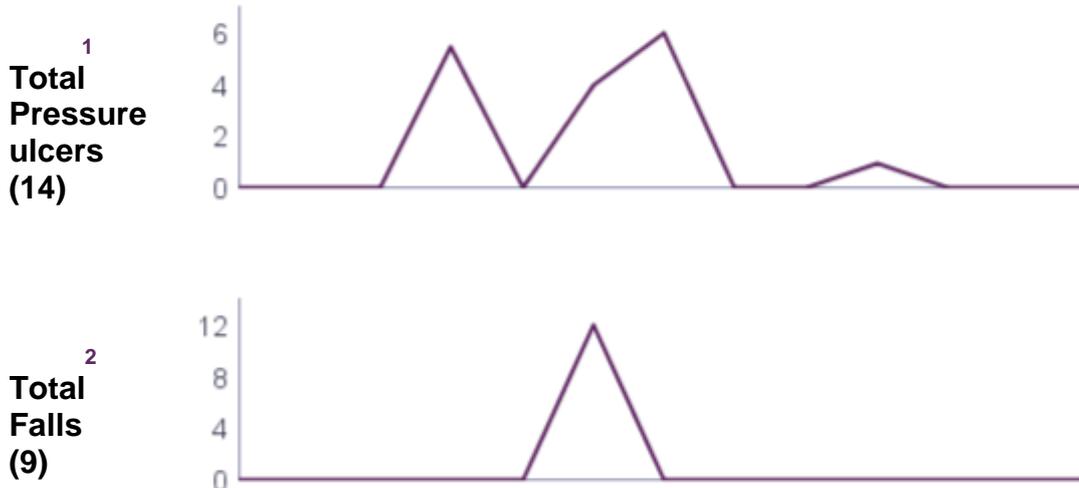
Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service. The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the patient safety thermometer showed that the trust reported 14 new pressure ulcers, nine falls with harm and no new catheter urinary tract infections from November 2017 to November 2018.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Imperial College Healthcare NHS Trust:



1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6

(Source: NHS Digital)

From April 2018 to January 2019, 100% of patients were screened for ventilator-associated pneumonia. In the same period, screening compliance for central vascular access for patients with central lines was also 100%. Screening compliance for peripheral vascular access for patients with central lines was 89.9%.

Between September 2018 to January 2019, 80% of patients on the intensive care unit had an assessment for venous thromboembolism (VTE). In the same period, 92.3% of patients on the acute respiratory unit had VTE assessments.

There was a quality and safety board on the intensive care unit which displayed information such as the last incidence of MRSA on the unit which was March 2013 and last incidence of Clostridium difficile which was October 2018. The board also displayed the last incidence of grade three pressure ulcers which was in June 2018 and last fall which was in December 2018. The cleaning audit for the week was captured as 98.7% compliant. The board also displayed the month's quality and safety priority topic which was to 'embed key messages and implement the invasive procedure checklist for unit procedures'.

Is the service effective?

Evidence-based care and treatment

The service delivered care in line with national clinical guidance. Staff had access to policies, protocols and care bundles that were based on national guidance on the trust intranet.

We reviewed nine patients' healthcare records. We found that patients had their needs assessed and their care planned and delivered in line with evidence based guidance, standards and best practice. For example, we saw that all patients were assessed and treated for venous thromboembolism (VTE) accordance with National Institute for Health and Care Excellence (NICE) guidance).

The Guidelines for the Provision of Intensive Care Services, 2015 states that patients discharged from an intensive care unit must have access to an intensive care follow-up clinic. It is recommended that a follow-up is needed for adults who were in critical care for more than four days or at were risk of morbidity. The critical care service at Charing Cross Hospital did not have routine follow-up clinics for patients to attend as outpatients to review their progress and receive further support from specialist staff such as a clinical psychologist and reassess health and social care needs. However, consultants held ad hoc follow-up appointments with patients where requested. Patients and relatives were also invited to attend patient experience groups which the trust held every three months. This gave patients and relatives a forum to feed back on their experiences and receive support from the critical care team where required. The meeting was attended by nurses, consultants, allied health professionals and reception staff. The leadership team told us there was a plan in place to have follow-up clinics with multidisciplinary input.

We reviewed a sample of trust policies and found that they were in date and made appropriate reference to national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE), intensive care society and other professional bodies.

There was an extensive range of critical care specific protocols and guidelines as well as corporate policies and guidance on various clinical interventions on the trust intranet. Policies contained appropriate guidance for screening referrals and specific interventions. We looked at a sample of guidelines such as renal replacement therapy, violence and aggression, bowel management, sedation for adult critical care patients, sepsis management in adults and found them all to be in date. We also viewed a bedside safety checklist which included flow charts and prompts on handover, monitors, alarms airway and breathing were also available on the critical care section of the intranet.

The service used evidence based 'care bundles'. A care bundle is a set of evidenced based interventions that, when used together, can improve patient outcomes. For example, we saw that staff used a skin care bundle to prevent and treat pressure ulcers.

Physiotherapists assessed the rehabilitation needs of all patients admitted to the intensive care unit. Records we reviewed showed a comprehensive physiotherapist-led mobility assessment and a plan for how each patient mobilised each day.

We observed handovers where staff considered the patients' physical, emotional and social care needs as part of a holistic assessment process. At the time of our inspection, the critical care service was about to launch the confusion assessment method (CAM) tool for intensive care units. This is a standardised evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognise delirium quickly and accurately in a clinical setting.

Adherence to and understanding of NICE guidelines was embedded and evidenced through the use of audit programmes to benchmark practice. The service was able to demonstrate that it participated in a number of national clinical audits including the intensive care national audit and research centre, the national cardiac arrest audit and organ donation. The acute respiratory unit undertook non-invasive ventilation (NIV) audits and were also about to submit data to the British Thoracic Society to further benchmark practice. Local audits were undertaken by junior doctors and presented locally.

The critical care service participated in a regular audit programme where audits were undertaken monthly or as required. The audit programme included audits on unanticipated surgical admissions, urinary catheter care bundle, oral and enteral medications audit, transfers, nasogastric tubes, hand hygiene and delirium prevention and management. The service also contributed to the north west London critical care network audits and national adult critical care dashboard. Key successes, key concerns and key actions following the audits were recorded. For example, results from the national adult critical care dashboard audits showed that out of hours discharges, readmission rates and blood infection rates were low but that delayed discharges were a concern. To focus on the discharge process and patient flow through the critical care units, the service joined the weekly hospital wide flow group meeting to discuss and to better understand how to efficiently step patients down from intensive care to the hospital's wards.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Patients' nutritional and hydration needs were discussed at handovers and the dietitian also attended ward rounds and the weekly multidisciplinary meeting. We saw evidence of dietetic reviews in patient records which was in line with Guidelines for the Provision of Intensive Care Services, 2015. We also saw that fluid balance charts had been completed.

The intensive care unit had 1.5 whole time equivalent dietitians dedicated to the unit from Monday to Friday. The dietitian supported patients who were unable to feed orally by giving them nutrition in an alternative way. Nutrition was provided either through a feeding tube (enteral nutrition) or through an intravenous tube (parenteral nutrition). Out of hours, a feeding regime with a risk assessment was arranged and supported by the out of hours pharmacist.

For patients who were able to eat, the catering hostess served meals throughout the day with a wide variety of choices to meet cultural and religious needs. Meals could also be accessed out of hours. For patients who stayed on the unit for a long period of time, there was also the option of meal vouchers for the hospital canteen.

Records we reviewed showed that nursing staff assessed patients' nutrition and hydration needs using the malnutrition universal screening tool (MUST). Nutrition was audited monthly cross site and data from the audit was reviewed on a monthly basis by the lead nurses for each site. The audit assessed whether the patient had a gastrointestinal nursing care plan completed on admission and daily by a registered nurse, whether the patient's weight and height had been documented within 24 hours, whether nutrition support had been started within 48 hours of

admission, whether the correct feeding plan was being followed, whether there was a record of food and fluid intake if the patient was eating and drinking and if a reason was documented if enteral or parenteral nutrition had been stopped. Overall compliance for the intensive care units trustwide between November 2018 to January 2019 was 91%.

The speech and language therapy (SaLT) service was a referral based service. The SaLT team undertook swallowing assessments and management. They also discussed patients' needs with the physiotherapist team on walk arounds of the intensive care unit.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. Staff assessed patients pain regularly using pain tools. Patients able to verbalise were asked to describe their pain with a score of zero (no pain) to ten. For patients who had difficulties communicating, such as ventilated patients, staff assessed their pain using a critical care pain observation tool which was designed to scale the pain of patients who were unable to report it themselves, through objective findings. This tool helped assess patients' pain by observations of facial expression, body movements and muscle tension.

We reviewed patient records and saw the observational pain tool was used regularly for all ventilated patients. We also observed staff on the intensive care unit and acute respiratory unit checking on patients' pain. Patients we spoke with told us they were able to obtain pain relief when they needed.

There was an up to date policy and guidelines for treating acute pain in adults and an up to date sedation guideline which was accessible on the hospital intranet.

The pain service led an epidural compliance audit in August and October 2018. The audit in August found critical care areas were not always consistent when labelling epidural infusions and were not compliant with the trust guideline which stated that both the line and giving set should be labelled. The audit also found that not all critical care areas were compliant with the guidance for the storage of epidural infusions containing opioid. However anaesthetic infusion bags were always stored away from other intravenous fluids and staff used ready-made bags to reduce the need for complex calculations and mistakes in preparations. An action plan was formed following the audit, which included points around ensuring pharmacists reinforced the storage of epidural infusions on daily rounds and the pain service team reinforcing labelling on daily rounds. A drive by the nurse educator to complete epidural competencies also formed part of the action plan. The service made improvements in the re-audit in October 2018. The re-audit found that 100% of patients were compliant with the labelling of epidural infusions which was an improvement from 60% in the August audit. The October audit also found that 100% of the sample was compliant with the trust guideline compared to the none in the August audit. The audit also found that 100% of critical care areas were compliant with the guidance for the storage of epidural infusions containing opioid and 83% of critical care areas were compliant with keeping local anaesthetic infusion bags away from other intravenous fluids.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. At this inspection the service was able to demonstrate that it contributed to relevant clinical audits such as the intensive care national audit and research centre, the national cardiac arrest audit and organ donation. The critical care outreach team were also now able to demonstrate outreach activity data and audit results. This was an improvement from our last inspection where the service was unable to demonstrate patient outcomes from audit participation.

The trust had three units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report.

(Source: Intensive Care National Audit Research Centre (ICNARC))

Charing Cross Hospital:

For the intensive care unit at Charing Cross Hospital, the risk adjusted hospital mortality ratio was 1.0 in 2016/17. This was within expected range. The figure in the 2015/16 annual report was 1.0.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
611 admissions	Risk-adjusted hospital mortality ratio (all patients)	1.0	1.0	1.0	none	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

We received updated ICNARC results from April 2018 to September 2018 which showed that the risk adjusted hospital mortality ratio was 1.08. This was within expected range.

Charing Cross Hospital:

For the intensive care unit at Charing Cross Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.8. This was within expected limits. The figure in the 2015/16 annual report was 1.0.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
453 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	1.0	0.8	1.0	none	Within expected limits

(Source: Intensive Care National Audit Research Centre (ICNARC))

We received updated ICNARC results from April 2018 to September 2018 which showed that the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.98. This was within expected limits.

The trust participated in organ donation and reported to the NHS Blood and Transplant national potential donor audit. The trust referred 104 potential organ donors during 2017/18. There were 12 occasions where potential organ donors were not referred. When compared with UK performance, the trust was average (bronze) for referral of potential organs. Audits showed a specialist nurse for

organ donation was present for 65 organ donation discussions with families during 2017/18. There were four occasions where the specialist nurse was not present. When compared with UK performance, the trust was average (bronze) for specialist nurse for organ donation presence when approaching families to discuss organ donation.

The service contributed to the cardiac arrest audit. Results showed that at Charing Cross Hospital there had been a reduction of cardiac arrests since August 2017. This may have been attributed to an embedded critical care outreach and resuscitation team on site in combination with end of life care and deteriorating patient workstreams. The critical care outreach and resuscitation team now collected data about the service. From April 2018 to September of 2018, the critical care outreach and resuscitation team received 898 referrals. 98.7% of the referrals received a visit from the team. 9% of the referrals were transferred to the intensive care unit.

The service participated in relevant quality improvement initiatives such as peer review and quality improvement projects on hand hygiene, medications safety and delirium. We requested outcomes of recent peer reviews but did not receive the information for the Charing Cross Hospital site.

Competent staff

The service made sure staff were competent for their roles. Staff had regular appraisals and performance was monitored through mentorship from band 7 nurses. Staff commented that the appraisal process was very meaningful and focused on an individual's development. Administrative staff also commented that they had regular appraisals and interim reviews which they found useful.

From November 2017 to November 2018, 99.2% of required staff within the critical care department at Charing Cross Hospital received an appraisal compared to the trust target of 95%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met? (Yes/No)
NHS Infrastructure support	4	4	100.0%	Yes
Support to doctors and nursing staff	5	5	100.0%	Yes
Qualified healthcare scientists	2	2	100.0%	Yes
Support to doctors and nursing staff	111	110	99.1%	Yes
Total	122	121	99.2%	Yes

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Data from the trust showed that 51.4% of the registered nurses on the intensive care unit at Charing Cross Hospital were critical care trained which met the requirements of the Guidelines for the Provision of Intensive Care Services, 2015. All band 6 staff were critical care trained on the unit. 85% of the nursing staff on acute respiratory unit were critical care trained and non-invasive ventilation trained.

Nursing staff told us they received a comprehensive induction and supernumerary support for six weeks when they started on the unit. There were dedicated clinical nurse educators responsible for coordinating the education, training and continuing professional development for the nursing staff and pre-registration nursing students. The nurse educator also conducted one to one clinical coaching with new nurses.

The service was meeting the national competency framework for critical care nursing and access to degree and master levels for critical care study (critical care course and national step

competencies.) We saw posters displayed of what students learned on the course and brought back as learning to the unit.

All band 5 nursing staff new to critical care attended the foundation to critical care programme which focused on topics including but not limited to, respiratory assessment, skin care and tissue viability, tracheostomy, intubation, extubating and emergency airway, arterial blood gas analysis and organ donation. Sepsis awareness was taught on the cardiovascular study day. 35.5 hours was allocated to staff to attend the seven sessions on the programme. All new members of staff attended pain and epidural training, manual handling, and immediate life support training.

The trust's standard for nurses working in epidural areas was for 75% of qualified nurses to have been trained and obtained their epidural competency. The standard for senior nurses in critical care was for 95% to have completed their competency. In October 2018, epidural training at Charing Cross intensive care unit was 83% for qualified nurses and 100% for band 7 and 8 nurses which was better than the trust's standards. However, due to high turnover of nursing staff in some areas or few patients receiving epidural therapy at some intensive care units, epidural competency levels were low. For the Charing Cross intensive care unit site, competency was 25% for nursing staff and 91% for band 7 and 8 staff. To improve competency rates, critical care areas across the trust were targeted to complete epidural competencies and the pain service team supported clinical educators to improve completeness of epidural competencies. All nurses attended an epidural study day, took a written test, had a period of supervised practice in their ward area and undertook an assessment.

New starter training and development was monitored to identify any development needs and progress made. New starters also had clinical coaching time with the nurse educator. There were sustainable arrangements for supporting staff to deliver effective care and treatment on an ongoing basis. All band five and six nurses were part of a team led by a band seven nurse who acted as their mentor. The mentor was responsible for overseeing their achievement and for completing or delegating the ongoing review of critical care competencies. Some shifts were arranged so team members worked with the mentor and it was encouraged that staff did not swap shifts on these days so they could spend time with their mentor. Nursing staff we spoke with also told us that rotations across sites gave them good experience of different case mixes on intensive care units. Nurses that were rotated to the Charing Cross Hospital intensive care unit were supported by the nurse in charge if they did not have much experience with the case mix at the site.

Secondment opportunities in to the outreach team and the critical care education team as well as trustwide secondments were supported by the service.

Junior doctors told us there were lots of good learning opportunities on the unit. They told us the induction was 'excellent' and that they received a basic course on their first two days which included an introduction to intensive care medicines and ventilators which they said was very useful. Junior doctors also attended case meetings and teaching sessions every other week. The clinical nurse educator taught doctors about the aseptic non-touch technique (ANTT) tool which was used to prevent infections. Junior medical staff we spoke with told us that they were supported by the critical care lead consultant and that there was a good teaching programme supervised by the consultant team.

All staff were invited to mortality and morbidity meetings. Learning and development was also encouraged on the acute respiratory unit.

The intensive care unit at Charing Cross Hospital had a bespoke simulation suite where simulation teaching sessions could be held. Nursing teams on their team days had sessions in the simulation suite focusing on learning from specific incidents, or having a session on a scenario that the unit did not see so often such as chest drains. All teams undertook airway simulation sessions every two years.

All staff we spoke with were appropriately trained and familiar with the use of the equipment on the intensive care unit. Training in the use of medical devices was informally taught during a new starter's six-week supernumerary period and also supported in competencies in the critical care step competency framework. The critical care technologist, supported by the nurse educator, also carried out equipment training and supported staff to become familiar with using the equipment. Training took place twice a year and was a face to face learning session. However, equipment training compliance rates were low for the intensive care unit at Charing Cross Hospital at 48.2%.

Staffing on the acute respiratory unit consisted of a lead band 8b nurse overseeing the unit, two band 7 nurse managers and a supernumerary band 6 nurse during peak hours from Monday to Sunday. Nursing cover for the level two beds was one nurse to two patients in open bays and one nurse to one patient in the side room. A respiratory consultant was the lead physician for the acute respiratory unit. Out of hours cover was by the medical registrar or night senior house officer and an on-call resident intensive care unit middle grade doctor. Medical, nursing and allied health professionals who covered the acute respiratory unit had non-invasive ventilation (NIV) and tracheostomy competencies signed off and reassessed yearly by the critical care outreach and resuscitation team.

NIV and tracheostomy training days were held at the trust by the critical care outreach and resuscitation team. Junior doctors also joined the rolling programme for NIV training. There was also a weekly educational meeting for the respiratory medical team which covered the key elements of respiratory medicine on a rolling programme. New members of the critical care outreach and resuscitation team undertook a 12-week competency based induction process and were supported by an experienced member of the team until the competency had been achieved.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked as a team to provide good care. We saw evidence of good multidisciplinary team (MDT) working within critical care services and on the acute respiratory unit. The critical care service held a weekly MDT meeting which was attended by a wide range of staff including consultants, nurses and allied health professionals such as physiotherapists and dietitians. We spoke with staff who told us these meetings involved inclusive discussions about the patients.

We saw evidence of good working relationships between nurses and medical staff. Nursing staff said that consultants and physiotherapists were always available for advice and support. Dietitians told us their advice is always listened to.

We observed multidisciplinary approaches to care planning for patients. Patient records demonstrated input from the full clinical team of doctors, nurses and allied health professionals such as physiotherapists.

Staff on the acute respiratory unit reported good working relationships and timely input from occupational therapists, physiotherapy staff and speech and language therapists.

There was evidence of effective multidisciplinary partnership working with external agencies and professionals. Letters were sent electronically to a patient's general practitioner (GP) following discharge. A complex discharge team supported patients with complex healthcare and nursing needs.

During our inspection we observed a comprehensive and structured ward round attended by a full multidisciplinary team including the neurology team. We saw that there was respect for each member of the multidisciplinary team and the contribution they made. There was a holistic discussion about the patient's needs and communication was clear and inclusive. The consultant also took the time to explain accurate dosing to two junior doctors who were also in attendance.

There was a critical care delivery group which was responsible for ensuring a trustwide multi-disciplinary approach to critical care. Meetings were held quarterly and included neurology, vascular, and trauma specialist services leads from different sites. Emergency department, outreach and pharmacy were also represented at the meetings.

Seven-day services

There was suitable provision of services at all times to ensure care and treatment delivery and supporting achievement of the best outcomes for patients. However, the critical care outreach team did not provide service at night.

The critical care outreach and resuscitation team reviewed patients daily and now provided a seven-day service from 8am to 8pm however did not provide a service out of hours. Outside of hours, patients would be cared for by the clinical site practitioner who received a formal written handover from the critical care outreach and resuscitation team. The trust also planned to extend the critical care outreach and resuscitation team service to be provided 24 hours a day.

While there was a full five-day physiotherapy service with on-call provision at the weekend, we were told physiotherapy staff could not always provide all patients with 45 minutes of active therapy per day five days a week as recommend in the Guidelines for the Provision of Intensive Care Services, 2015. We were told this was due to the lack of post creation within the physiotherapy team.

There was no dedicated occupational therapist for the unit but the 'neuro-outliers' team did provide an occupational therapist who attended to neurological patients on the unit. The acute respiratory unit had access to an occupational therapist but they were not allocated to the unit.

There was a full-time dietitian five days a week. Outside of these hours, a feeding regime with a risk assessment was arranged and supported by the out of hours pharmacist.

There was access to the speech and language therapy service Monday to Friday. The service was referral based and was used mainly to conduct swallowing assessments for patients on the unit.

The intensive care units had a dedicated critical care pharmacist who visited every day from 9am to 5pm, Monday to Friday and attended ward rounds. The pharmacist also provided a shorter service on Saturdays and Sundays and an on-call pharmacist on site covered the unit out of hours.

All patients were reviewed by a consultant twice daily and there was a 'consultant of the week' system on the acute respiratory unit which provided continuity of care over seven days. A consultant in intensive care medicine was available 24 hours a day, and could attend to patients within 30 minutes.

Health promotion

Health promotion information on the intensive care unit was limited. There were some examples of staff supporting patients and those close to them to manage their own health. For example, the unit had strong links with the substance misuse liaison officer to support patients. Patients were also signposted to other organisations that could assist with other physical and mental health problems.

There were posters on the walls of the intensive care unit informing visitors about flu vaccinations, however we did not see any other health promotion information on general topics such as healthy eating, smoking cessation, or the benefits of exercise.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. Staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff understood the relevant consent and decision-making requirements of current legislation and systems were in place to ensure compliance with deprivation of liberty safeguards. Deprivation of Liberty Safeguards training and Mental Capacity Act training were within the mandatory training module for consent. Compliance rates were 98.1% for nursing staff and 100% for medical staff.

We checked patient records and saw thorough records of mental capacity act assessments. We saw evidence of best interest decisions being made and documentation regarding conversations about a patient's care with the patient's family. Any decisions made were reviewed daily.

During the inspection we observed staff obtaining consent and procedures being explained to patients and carers by doctors and nurses. Staff we spoke with understood the importance of shared decision-making with patients. All patient records we reviewed demonstrated consent was sought and clearly recorded in the patients' notes.

Staff reported that they felt well supported by the psychiatric liaison team and mental health liaison team and could call them at any time for assistance. They reported that within work hours support would be provided in a timely manner. Staff on the acute respiratory unit commented that the older person's assessment team were very accessible and supportive in managing patients with mental health needs especially dementia and delirium.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. We observed all staff in the intensive care unit and the acute respiratory unit to be caring and compassionate with both patients and their relatives without exception during the inspection. Feedback from patients and relatives on both the acute respiratory and intensive care units confirmed that staff treated them well and with kindness.

Comments from relatives about staff on the intensive care unit included, "I cannot stress how good they are", "they are absolutely magnificent" and "they are very kind and they really care". Staff acted as advocates for their patients' wishes and showed sensitivity to relatives' feelings. We saw staff taking the time to have conversations with relatives about advance decisions when patients were not conscious or able to express their wishes.

We attended a ward round on the intensive care unit where staff were visibly pleased to see a patient showing improvement in their condition. We saw doctors and nurses introducing themselves to patients before reviewing or providing care.

We saw staff on the acute respiratory unit asking patients before delivering care. We observed a nurse on the intensive care unit crouching down to be eye level with a patient and explaining a procedure to them.

We saw many thank you cards displayed on the reception of the intensive care unit. Comments included, "thank you so much for your care, kindness and support during my stay on the ICU" and "bless you and your cheery disposition who put up with my emotional rollercoaster". A comments box with comment slips was available in the relatives' waiting room.

Staff on the acute respiratory and intensive care units were passionate about their work and focused on delivering patient centred care. We saw that staff had developed a good rapport with

patients who had been on the intensive care unit for a long time. A relative commented that a nurse had voluntarily come on the unit before their shift had started in order to take part in music therapy for the patient they were caring for.

Staff promoted privacy and patients were treated with dignity and respect. Curtains were always drawn closed when personal care was being provided and we saw staff asking permission before entering a bay if curtains were closed.

The service had a patient experience questionnaire which asked questions around privacy and dignity, visiting times, noise at night, pain management and whether patients had ample opportunity to speak to doctors and have procedures explained to them. Overall results trustwide between February 2018 and January 2019 were positive with 75.7% of patients reporting an 'excellent' experience and 21.6% reporting a 'good' experience of critical care. On the Charing Cross site, overall patient satisfaction in the same period showed 86% of patients were satisfied with their experience on the intensive care unit. 88.3% of patients were satisfied with their experience on the acute respiratory unit.

Emotional support

Staff provided emotional support to patients to minimise their distress. We found a high level of emotional support provided by staff on the intensive care unit and acute respiratory unit. Relatives spoke highly of the service and how supportive the staff were to them and their loved one. We observed staff talking sensitively to relatives and explaining what was happening. The receptionist played soothing music in the reception area of the intensive care unit to create a calming atmosphere and help minimise distress.

Staff had access to a psychiatric liaison team however there was no designated psychological service for critical care patients.

The intensive care unit had regular music therapy sessions where music would be played by musicians and sometimes staff to help reduce anxiety and agitation in patients.

Spiritual support was offered by multi-faith chaplains which staff could request for patients and relatives.

Staff understood the emotional impact of a patient's condition on the patient and their relatives. Relatives were treated with sensitivity and supported to manage their emotional wellbeing. Relatives we spoke with told us staff had signposted them to relevant support groups and counselling services and had done so in a sensitive way.

We observed many interactions between staff and patients that went beyond just supporting patients with their physical wellbeing. We heard of an occasion where the clinical team supported a patient to go outside of the intensive care unit for some fresh air to help alleviate the frustration of being on the unit for a long period of time.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Records we reviewed showed discussions which involved relatives and patients. We saw staff communicating with patients and their relatives in ways they could understand. Relatives confirmed that everything was explained to them in a way they could understand and that they felt confident to challenge staff if needed. They told us all of their questions were answered in a timely manner and felt involved in decision making. Relatives told us nurses were always happy to explain procedures and kept them updated about the condition of their loved one.

We saw that patients and relatives were routinely involved in planning and making decisions about care options. A parent of a patient was well informed about next steps and told us they were always able to speak to the consultant when they needed.

Staff empowered patients to take an active role in their care. We saw a nurse supporting a patient to brush their teeth and we observed physiotherapists using encouraging language when supporting a patient in their daily rehabilitation exercises. During a ward round doctors and nurses actively involved the patient in their conversation.

Staff understood patients' frustrations when they were unable to vocalise their needs because they had a tracheostomy tube. A nurse described always carrying a notebook and pen so patients could write down their needs. There were also picture boards with simple symbols or words which patients could point at that staff said they used.

Nurses spoke of being supported by the specialist nurse for organ donation when a conversation with relatives about potential organ donation was needed. The palliative care team were also called upon for sensitive conversations.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people and patients who came from other regions for specialist care. The intensive care unit at Charing Cross Hospital was set across the 11th floor of the hospital and split into two units: 11 North and 11 West. The service accommodated up to 14 level two and 10 level three patients. Level two care describes patients requiring more detailed observation or intervention. This includes support for a single failing organ system or post-operative care, and those 'stepping down' from level three care. Level three care refers to patients requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multiple organ failure. The service was commissioned to 24 beds (with 26 physical bed spaces) and offered both intensive and high dependency care for adults with immediate life-threatening medical and surgical conditions (planned and emergency).

At our last inspection, we found that some level two patients were being cared for in non-critical care areas. At this inspection, we found that level two patients were being cared for in critical care areas. Level two and level three beds were now co-located within the intensive care unit and accommodated up to 14 level two and 10 level three patients. There was also a five-bedded acute respiratory unit (ARU) on the ground floor within the trust's acute medical unit which provided non-invasive respiratory support for level two patients only. The ARU was managed by the medicine directorate with day to day oversight and input from the critical care directorate and team of doctors.

There was a relatives' waiting room located on the 11th floor just outside of the intensive care unit. The room was spacious with a television, water dispenser and a telephone with a direct line to the reception of the intensive care unit. There was a range of information leaflets in the relatives' waiting room such as 'information and advice for adult inpatients', 'bereavement information for relatives and carers' and leaflets on organ donation however they were not available in languages other than English. Some relatives commented that the relatives' waiting room was "bare" and "basic" but that it was "useful to have". Relatives could stay in the relatives' waiting room overnight if necessary and reception staff commented that if this happened, they brought blankets for relatives to use in the room. There was a separate room where staff could have sensitive conversations with relatives and carers. The trust had Wi-Fi for public use. Relatives and patients we spoke with said they were able to access the Wi-Fi service.

Drinks and snacks were available throughout the day for patients who were able to eat and drink and administrative staff told us they would bring relatives hot drinks in the waiting room. There was no accommodation for relatives at the Charing Cross Hospital site, however reception staff signposted relatives to accommodation which was available at the Hammersmith Hospital site.

There was multidisciplinary partnership working with external agencies and professionals. Letters were sent electronically to a patient's general practitioner (GP) following discharge. A complex discharge team supported patients with complex healthcare and nursing needs.

There was a specialist nurse for organ donation who worked cross site and could be called to support patients and relatives when having conversations about potential organ donation.

Shower and toilet facilities were available on the acute respiratory unit and the intensive care unit for patients who were well enough to use them.

There was a chapel and a quiet room for reflection located on the ground floor of the hospital which relatives could use. Staff told us they could call upon the multi-faith chaplaincy service at any time to support patients and relatives.

Visiting times for the acute respiratory unit was from 8am to 10pm and 10am to 10pm for the intensive care unit however the team showed flexibility on a case by case basis.

Meeting people's individual needs

The service took account of patients' individual needs. Dietitians, physiotherapists and pharmacists visited patients on the unit throughout the week, updated care records and provided guidance for ongoing care. On the acute respiratory unit, the palliative care team, the older person's assessment and liaison team often attended the joint meeting between the acute respiratory unit and intensive care unit to discuss escalation of patients and potential step down and the patients' needs.

Interpreter services were available for patients whose first language was not English and staff knew how to access them. Staff said they were easily able to arrange interpreting services for patients.

Patients on the intensive care unit were supported to orientate themselves to real time. Each bed space faced a dementia friendly clock which clearly displayed in analogue and words the time and date. We saw that there were chairs for those with a high body mass index (bariatric) and high-backed chairs for patients who could sit out of bed.

Staff had access to communication aids such as picture boards for patients with learning disabilities. Nurses on the unit told us that they had strong links with the learning disability advice and support, inclusion and vulnerability officer. Staff also had good links with the psychiatric liaison officer and substance misuse liaison officer.

In the acute respiratory unit, patients with learning disabilities were given hospital 'passports' which described a patient's likes and dislikes and important information the nursing team needed to know about the patient's care needs. The unit also used a carer's passport which allowed carers to visit outside of the usual visiting times. However, hospital passports were not routinely used on the intensive care unit.

Staff told us that the service did not use patient diaries. Patient diaries are a daily record of the patient's condition and is written by nursing staff or relatives. The diary is given to the patient after they are discharged from the unit to support their recovery process with an understanding of what has happened to them. However, staff described that they would sometimes show former patients

around the intensive care unit as people often remembered very little about their stay on the intensive care unit and the tour helped support their long-term recovery process.

The catering hostess on the unit brought food to patients who were able to eat. Nurses would indicate on a whiteboard in the kitchen on the unit informing the catering team which patients were able to eat that day. Menus had options for specific cultures such as halal and vegetarian. A patient commented that their religious needs were well supported during her time on the intensive care unit.

Patients who were identified to be at the end of their life had their needs assessed and were supported by the palliative care team who could be called upon at any time.

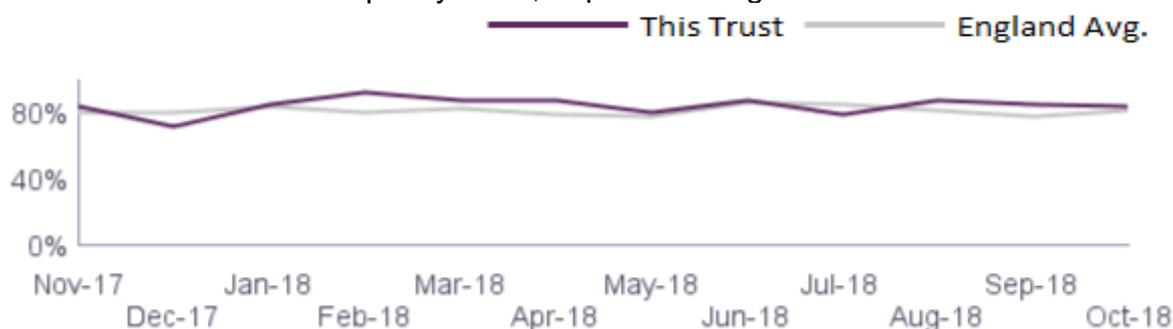
At the time of our inspection, the critical care service was about to launch the confusion assessment method (CAM) tool for intensive care units to better assess patients with delirium. This is a standardised evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognise delirium quickly and accurately in a clinical setting.

Dementia awareness was not part of the mandatory training curriculum, however staff received dementia awareness training during their induction. The acute respiratory unit had good links with older person's assessment and liaison team which supported patients living with dementia. However, we did not see dementia assessments being used on the intensive care units.

Access and flow

From November 2018 to October 2018, Imperial College Healthcare NHS Trust adult bed occupancy was about the same as or slightly higher than the England averages for 10 months out of the 12-month period. In the latest period, October 2018, performance for adult bed occupancy was 84.6%, compared to the England average of 80.8%.

Adult critical care bed occupancy rates, Imperial College Healthcare NHS Trust:



Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Charing Cross Hospital:

For the intensive care unit at Charing Cross Hospital, there were 4,125 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 2.6%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 1.2%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
4,125	Crude	1.2%	2.6%	4.9%	0%	Not in the worst 5%

available critical care bed days	delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)					of units
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(Source: Intensive Care National Audit Research Centre (ICNARC))

Charing Cross Hospital:

For the intensive care unit at Charing Cross Hospital, there were 670 admissions, of which 0.0% had a non-clinical transfer out of the unit. This was within expected range. The figure in the 2015/16 annual report was 0.2%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
670 admissions	Crude non-clinical transfers	0.2%	0.0%	0.4%	0%	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

Charing Cross Hospital:

For the intensive care unit at Charing Cross Hospital, 1.0% of admissions were non-delayed, out of hours discharges to the ward. These are discharges which took place between 10pm and 6.59am. This was within expected range. The figure in the 2015/16 annual report was 0.2%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
520 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	0.2%	1.0%	1.9%	0%	Within expected range

All potential admissions were discussed with the consultant on duty and had consultant oversight. All admissions to critical care were reviewed by a consultant within 12 hours. Between April 2018 and January 2019 which showed that 91.9% of patients were admitted to the intensive care unit within four hours. This was in line with the Guidelines for the Provision of Intensive Care Services 2015. ICNARC results also showed that readmission rates were reducing; unplanned readmissions rates were 1.7% which was similar to other units.

Bed occupancy rates remained high. Occupancy of beds on the intensive care unit at Charing Cross Hospital between April 2018 to January 2019 averaged 93.5%. The leadership team were aware of the high occupancy rates and told us this was due to a high number of patients awaiting discharge to ward beds. As a result, delayed discharges were on the risk register for critical care.

Due to delayed discharges, there were mixed sex breaches on the unit for patients awaiting discharge to a ward bed. The unit was monitoring these breaches, and this was captured on the risk register.

During our inspection we found a large two bedded bay which was shared by two patients of mixed sex due to delays discharging patients out of the intensive care unit. Curtains or screens were not used to separate the space which meant that the privacy and dignity of the patients was not maintained. However, no patients we spoke with raised any concerns in this regard and there had been no complaints about the issue.

The service was aware of the pressures on beds in the hospital and did what they could to reduce the waiting time for patients to be discharged to a ward. This included continued monitoring through submission to ICNARC, attending site bed meetings and teleconferences twice a day with the other sites' intensive care units to discuss acuity and staffing challenges. The leadership team also attended a trustwide flow group meeting on a weekly basis which was a hospital wide group looking at how to efficiently get patients ready for stepping down from the intensive care unit by for example having lead nurse attendance at surgical bed meetings and improved communication to the site team such as early requests for beds. Delayed discharge data was reported monthly to the divisional quality and safety meeting and trust performance report.

Learning from complaints and concerns

From November 2017 to October 2018, there were 10 complaints about critical care trustwide, with nine of these closed. The trust took an average of 33 working days to investigate and close complaints. This was in line with their complaints policy, which stated complaints should be completed in an average of 40 working days.

- Charing Cross Hospital: There was one complaint, relating to communications.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From November 2017 to October 2018 there were 15 compliments within critical care at Charing Cross Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. We saw evidence that formal complaints were now discussed at the directorate quality and safety meeting as well as band 7 and 8 meetings with any learning disseminated to staff through team meetings. Complaints were handled by the lead nurse for critical care at the Charing Cross Hospital site and the lead nurse spoke directly with patients and relatives to reach a resolution at a local level. If patients or relatives were not satisfied with the response, they were directed to take the Patient Advice and Liaison Service (PALS). Leaflets about the PALS office were available in the relatives' room and reception.

One of the key themes from complaints was frequency of communication with consultants. However, during our inspection, relatives we spoke with said they felt they were able to speak with consultants when they needed and would receive frequent updates from the nurses as well.

While the critical care service at Charing Cross received very few complaints, staff used patient and relative feedback to improve the service. For example, in response to feedback regarding stepping down to the ward environment, staff prepared patients for the change in environment by reducing the frequency of observations, removing beeping machines that were no longer needed and introducing a call bell that patients could use.

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. Critical care services at Charing Cross Hospital was managed by the critical care directorate which was part of the surgery, cancer and cardiovascular sciences division. As part of trust reconfiguration, critical care services became a standalone directorate in 2016. The critical care directorate leadership team consisted of a clinical director, general manager and senior nurse who managed the trust's critical care services across the three sites: Charing Cross Hospital, St Mary's Hospital and Hammersmith Hospital. Site leadership at Charing Cross Hospital was managed by a lead consultant, lead nurse and outreach and resuscitation lead.

As part of the creation of the critical care directorate, high dependency services at Charing Cross Hospital were reconfigured to sit within the critical care directorate and a critical care outreach and resuscitation team was developed across all sites. High dependency level two beds were co-located on the intensive care units with the exception of five level two beds which formed the acute respiratory unit. The acute respiratory unit cared for level two acute respiratory failure patients and while managed under the medicine directorate, the critical care directorate also had oversight of this unit. The critical care team met daily with the acute respiratory unit staff to discuss patients for escalation and potential step down on a daily basis.

Staff were able to identify the directorate leadership team as well as the site leadership team and told us they were very visible and approachable on the unit. We were told by staff how the move to a new structure in 2016, in which critical care was its own directorate, showed real benefits to critical care in that it had raised the profile of critical care within the trust. The site leadership team also commented that critical care now had good representation at trust board level.

Both nursing and medical staff of all grades across critical care and the acute respiratory unit spoke of good teamwork.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The service was in a process of developing their strategy and the documented strategy was awaiting ratification at the time of our inspection.

Leaders were able to explain the service's strategy to us. The strategy emphasised the two main priorities of the directorate which was to develop services to be fully comprehensive, such as expanding outreach service to include an out of hours service and to reconfigure the trust's high dependency units and intensive care units to be under the same directorate. The vision of the service included providing high quality care, maintaining a high research profile, and delivering high quality general and specialist services. The service had a workforce steering group which focused on the service's aims to develop new roles such nurse practitioners and advanced critical care practitioners.

The directorate leadership team also planned to focus on ensuring compliance with the Guidelines for the Provision of Intensive Care Services standards across all of the trust's critical care units. sites' units. In order to achieve this, there was a critical care delivery group which was responsible for ensuring a trustwide multi-disciplinary approach to critical care.

The vision for the acute respiratory unit was to provide 'excellent high quality and patient centred care for acute respiratory failure patients'. Quality improvement projects were ongoing to develop a training programme and collaboration with other units in the region.

The trust was in the process of exploring themes and concepts around their vision, values, and behaviours and had involved staff in its development. Staff awareness of the vision of the service had improved since the last inspection.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff were passionate about their work and spoke of good teamwork in a patient-centred environment on the intensive care unit and acute respiratory unit. We found an inclusive and constructive working culture within critical care services and on the acute respiratory unit.

We found an open and honest culture and staff were knowledgeable about the duty of candour. Staff knew about the trust's processes and procedures and could give examples of how they applied the duty of candour and the learning that was shared from an incident.

All staff we spoke with, including nurses, allied health professionals, catering staff and administrative staff consistently told us they felt supported by their managers and spoke of an open-door policy.

Consultants told us there was a supportive culture among clinicians and an approach to challenge. Junior doctors told us they felt well supported by consultants and that their supervisors were approachable.

We attended safety briefings, handovers, ward rounds and bed meetings during our inspection and found that there was respect for each member of the multidisciplinary team and the contribution they made.

Governance

Governance structures were in place. The service used a systematic approach to continually improve the quality of its services and safeguard high standards of care. The site-based leadership team demonstrated good cross site working. The critical care site leadership teams cross site attended a critical care directorate board meeting every month which was chaired by the clinical director. The meeting discussed clinical performance, quality and safety issues such as delayed discharges, staffing including outreach, research and education as well as finance.

Critical care directorate quality and safety meetings took place bimonthly and were attended by the site leadership teams. It was chaired by the senior nurse for the critical care directorate. Topics that were discussed included items on the risk register, serious incidents, performance data, updates on mortality and morbidity meetings, complaints, patient feedback, audits such as hand hygiene and medicines management, quality improvement presentations and guidelines. We saw that audit results had been embedded in the minutes of these meetings.

The directorate leadership team also attended divisional directorate meetings where incidents were fed back up to divisional level. Clinical governance half days were held bimonthly where feedback from learning from incidents were discussed as well as new quality improvement projects. There were also monthly senior management meetings where issues such as staffing and capacity were discussed.

A critical care clinical guidelines group was held monthly and was attended by the clinical director, senior nurse and cross site clinical education teams. The group looked at clinical guidelines that had reached their review dates and discussed topics for audit post implementation.

Respiratory governance meetings for the acute respiratory unit were provided through the medicine directorate and took place every three months. These meetings were open to all staff involved with the unit including critical care services and included clinical updates, presentations of audits and quality improvement projects, discussion of incidents and a morbidity and mortality session.

At the last inspection, level two beds outside of the intensive care unit were not under the same governance structure as the intensive care unit. At this inspection level two beds were now co-located with level three beds on the intensive care unit and were under the same critical care governance structure. There were five level two beds on the acute respiratory unit which were managed by the medicines directorate with daily input from the critical care service who had oversight of the unit and were invited to respiratory governance meetings.

At our last inspection we found that the critical care outreach teams were not part of the critical care department's governance arrangements and there were issues of parity between the teams across the three sites. At this inspection we found that the critical care outreach teams were now part of the critical care department's governance arrangements and there was now parity between outreach teams across the three sites which was an improvement from the last inspection.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The service kept a risk register which was discussed at directorate quality and safety meetings. The risk register was regularly reviewed and was now being updated in a timely manner with action plans in place. This was an improvement from the last inspection where we found that some risks had been on the risk register for a long time without a completion date.

The issues and risks which managers identified were in line with what we found on inspection and there was alignment between these and the risks outlined on the risk register. The leadership team told us their top risks included: staffing – sickness, turnover, consultant numbers, recruitment and retention, lack of availability of the same electronic patient record system on all sites, fully meeting the Guidelines for the Provision of Intensive Care Services, maintaining good patient flow and delays in discharging patients to wards once they are medically fit.

Risks to the service had been considered in planning and delivery. For example, the leadership team on the Charing Cross Hospital site were aware of the risks of not having fully transitioned to an electronic patient records system and had built in mitigations such as pharmacy support to audit paper prescribing charts and a project led by the general manager to implement a fully electronic system.

There were regular meetings where risk, issues and performance reports were monitored and managed. This included directorate quality and safety meetings bimonthly and senior nurse (band 7 and 8) meetings which took place monthly. We reviewed the minutes of the quality and safety meetings and band 7 and 8 meetings and saw evidence of monitoring and management of risk. Mortality and morbidity meetings were held bi-weekly and were open to all staff to attend. We viewed the logs of these meetings which included the outcome and lessons learned.

The leadership team attended a trustwide flow group meeting on a weekly basis which was a hospital wide group looking at how to prevent delayed discharges from the unit to the ward. Delayed discharge data was reported monthly to the divisional quality and safety meeting. Weekly multidisciplinary team meetings were well attended by a wide range of staff including consultants, nurses, physiotherapists and dietitians.

The service held safety briefings which took place every morning to identify potential risks, allocate resources effectively and disseminate information such as safety alerts. Lead nurses also attended daily bed meetings where intensive care unit discharges, capacity and booked elective admissions were discussed.

However, we found that while policies were easily accessible on the trust intranet, some trustwide policies that the critical care service used, lacked detail in signposting staff to practical guidance which staff used. For example, at the Charing Cross Hospital site, the critical care service used trustwide restraint guidance but also used a paper document on restraint which had more detailed checklists indicating how often a patient should be checked. However, it was not clear how staff working on the intensive care unit, particularly new or agency staff, would know to use both the paper checklist and trust wide guidance as the trust wide guidance alone did not indicate the use of the paper checklist for critical care staff.

Information management

The service collected, analysed, managed and used information well to support all its activities. At our last inspection, senior management did not submit audit results to demonstrate the service's effectiveness. At this inspection we received audit data which demonstrated that the service collected, analysed, managed and used information well to support all its activities. The service kept a monthly performance scorecard which contained information about the service's performance such as staffing, infection prevention and control compliance and audit data.

Staff had access to patients' health records and the results of investigations and tests in a timely manner. However, the intensive care unit was in the process of moving fully to the use of electronic records but at the time of the inspection was still in transition and used a mixture of paper and electronic notes. At the time of our inspection, the electronic system did not meet the service's needs and did not communicate with the systems at the other intensive care units. The issue had been captured on the service's risk register and there was a project led by the general manager of the directorate to ensure a fully electronic system was implemented by May of this year. The acute respiratory unit had transitioned fully to electronic records and did not encounter this issue.

There were effective arrangements to ensure the confidentiality of identifiable data. Paper based patient records were stored securely and electronic information was only accessible by authorised staff members. There were computer stations throughout critical care services and the acute respiratory unit. Staff told us there were sufficient numbers of computers to access when they needed. We observed staff logging off after using computers. There were clearly labelled drawers at the nurse's station where staff could access forms and assessment tools.

Information governance formed part of mandatory training for nursing and medical staff. Compliance levels for nursing staff was 88.7% which was better than the trust target of 85%. Compliance levels for medical staff was 80% which was below the trust target of 85%.

The trust had Wi-Fi for public use. Relatives and patients we spoke with said they were able to access the Wi-Fi service.

Engagement

Patients' views and experiences were gathered and acted upon to shape and improve the service. Patients and relatives on the unit were encouraged to share their views on the quality of the service through comment cards, comments from the patient experience group and by filling in a questionnaire on an electronic tablet. Compliance was monitored through the submission of this data to the north west London critical care network. A patient experience lead told us that they had

taken a patient story to the trust board around noise at night and had begun work on a sleep project led by the patient experience and frailty teams.

The service did not undertake structured follow-up clinics for patients which meant that they were unable to gain a better insight into patients' experiences when they had been discharged from critical care.

The service also encouraged staff to report on the incident reporting system whenever they observed excellence in patient care or great practice. Learning from excellence was promoted and shared at team meetings. Staff we spoke with were positive about this feature.

The trust had created a 'make a difference' staff recognition award scheme where patients, relatives and staff members were encouraged to fill in a form to nominate a staff member who had gone the extra mile in their work. Staff members who were nominated received a thank you card and a badge. There was a board on the acute respiratory unit and intensive care unit (11 North and 11 West) with photographs of previous winners of the award.

The intensive care unit had a monthly newsletter which informed staff about new starters, safety information and infection prevention control as well as learning from incidents. The acute medical unit which housed the acute respiratory unit also produced a similar newsletter with topics that were relevant to the unit at the time. The acute respiratory unit devised a 'you said, we did' action plan following the results from the staff survey. Actions included improvements made to staff changing room facilities and more portable computers.

The trust had ensured there was learning from the major incidents which had occurred in London in the previous year. Staff recalled their involvement in the transfer of existing patients at St Mary's intensive care unit to the Charing Cross intensive care unit in order to create capacity at St Mary's to accommodate casualties. The trust had arranged a cross site debrief which staff said was helpful and that a lot of staff had attended. The critical care service had since focused on staff wellbeing and had implemented weekly wellbeing meetings where staff could attend for a debrief after a particularly difficult shift or event. Staff were also directed to the trust's confidential staffing counselling, mediation and stress management service. Weekly wellbeing meetings were now established within the service however staff told us attendance was variable.

Learning, continuous improvement and innovation

The service was committed to improving services and promoted training, research and innovation. There were systems to support innovation and improvement work. Nursing teams took ownership of various quality improvement projects such as hand hygiene, medications safety and assessments for delirium.

The trust was involved in national and international research projects including research looking at antibiotics, barriers to mobilisation, a study into the reversal of septic shock with a beta blockade, early vasopressin use in septic shock (VANISH), and levosimendan for the prevention of organ failure (LeoPARDS).

The intensive care unit was accredited for teaching for undergraduate students, postgraduate trainees and nursing students. Teaching took place regularly at Charing Cross Hospital and consultants at the trust also held academic positions.

There was a trustwide ward accreditation scheme to monitor quality and safety performance in each inpatient ward. As part of this scheme, each clinical area was reviewed by a team of senior staff who undertook an unannounced inspection, where they rated the area against a set of criteria. Results were then used to identify areas of good practice and areas for improvement. The intensive care unit was awarded gold ward accreditation which was the highest rating.

Hammersmith Hospital

Imperial College Healthcare NHS Trust was formed on October 1, 2007 by merging St Mary's NHS Trust and Hammersmith Hospitals NHS Trust and integrating with the faculty of medicine at Imperial College London.

The trust has 12 registered locations and employs almost, 11,000 staff. The registered locations are:

- Queen Charlottes and Chelsea Hospital
- Western Eye Hospital
- Hammersmith Hospitals
- Northwick Park Renal Centre
- Ealing Renal Satellite Unit
- St Charles and Hammersmith Renal Centres
- West Middlesex Renal Centre
- Brent Renal Centre
- Charing Cross Hospital
- St Mary's Hospital
- Hayes Renal Centre
- Watford Renal Centre

The trust has an estimated range of population served is between 1,500,000 and 2,000,000 people.

- The trust has a total of 1004 inpatient beds spread across various locations
- 534 outpatient clinics per week.
- 297 day case beds.
- 38 Children's beds.
- No dedicated End of Life Care beds.
- 52 inpatient wards.

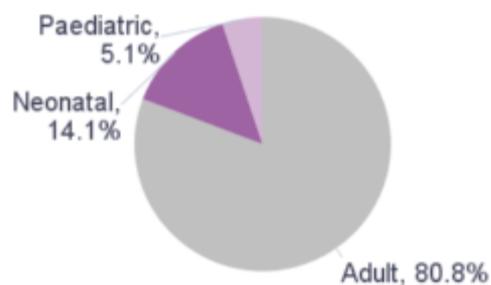
Critical care

Facts and data about this service

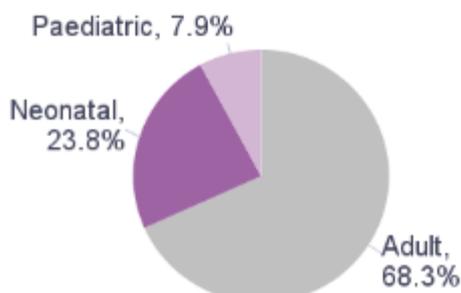
The trust has 177 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Imperial College Healthcare NHS Trust and England.

This trust



England



(Source: NHS England)

Critical care services are provided at the St Mary's, Charing Cross, and Hammersmith hospitals sites. There are speciality differences within each of the units, reflective of the configuration of services provided at each site.

There is an intensive care unit at each of the sites delivering level 2 and level 3 care. Level 2 care is for high dependency patients needing single organ support (excluding mechanical ventilation) such as renal haemofiltration or ionotropes and invasive BP monitoring. They are staffed with one nurse to two patients. Level 3 is intensive care for patients requiring two or more organ support (or needing mechanical ventilation alone). Staffed with one nurse per patient and usually with a doctor present in the unit 24 hours per day.

St Mary's has a major trauma centre, covering North-West London. Charing Cross is a tertiary referral centre for Neurosciences. At Hammersmith Hospital there are two separate ICUs: cardiothoracic ICU and the general ICU.

In addition, the Charing Cross site and St Mary's hospital sites have acute respiratory units (ARUs), which provide non-invasive respiratory support for a defined patient population. There is also a renal unit at the Hammersmith Hospital site which provides level 2 care for this speciality group.

There is Critical Care Outreach service provision at St Mary's, Charing Cross, and Hammersmith hospital, which is a combined service with resuscitation.

(Source: Routine Provider Information Request (RPIR) – Context acute)

The trust treats approximately 1,640 critically ill patients each year. Critical care teams include medical staff, nurses, physiotherapists, pharmacists, and dietitians, who provide care for patients affected by a range of serious health conditions.

Critical care services at Hammersmith Hospital were located in two principal units. One was the general intensive care unit and the other was the cardiac intensive care unit. The general intensive care unit consisted of 16 beds where there was an average of four to five level 2 patients with the

rest level 3 care. The cardiac intensive care unit had 16 beds where on average there were four to five level 2 patients with the rest level 3 care.

There were also four beds funded for level 2 care located within the De Wardener; a renal ward. It was reported there were up to eight level 2 patients a month and up to two level 3 patients a month. However, there were no high dependency patients present for the duration of our visit.

The critical care service also included a critical care outreach team who supported patients in other areas of the hospital. The team was led by specialist nurses who were available seven days a week between 8am and 8pm.

The three units were all managed within different directorates. The general intensive care unit sat within the critical care directorate while the cardiac intensive care unit sat within the cardiothoracic directorate. Both belonged to the trust wide division of surgery, cancer, and cardiovascular sciences. De Wardener ward sat within a different trust division as well as different directorate. As a result, all three were led by different general managers and nurse leads. Both general and cardiac intensive care units were led by consultant intensivists. Medical care for both was provided by the critical care directorate. The renal ward was not intensivist led and came under the medical care division.

At our last inspection in 2014 we rated the service as requires improvement. This inspection took place between 25 and 27 February 2019. We spoke with 32 members of staff including senior managers, support staff, band 5, 6, 7 and 8 nurses, cleaners, a dietician, junior doctors, consultant intensivists, pharmacist, and physiotherapists. We reviewed the healthcare records of nine patients and spoke with six patients and relatives.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to most staff. The trust set a target of 85% for completion of mandatory training. A breakdown of compliance for mandatory training courses as at November 2018 for qualified nursing staff in the critical care department at Hammersmith Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Medicines management	64	64	100.0%	85%	Yes
Moving and handling level 1	64	64	100.0%	85%	Yes
Resuscitation level 2	1	1	100.0%	85%	Yes
ANTT	63	64	98.4%	85%	Yes
Conflict resolution	63	64	98.4%	85%	Yes
Equality and diversity	63	64	98.4%	85%	Yes
Fire safety awareness	63	64	98.4%	85%	Yes
Invasive procedures policy	63	64	98.4%	85%	Yes
Nutrition	63	64	98.4%	85%	Yes
Venous thromboembolism	63	64	98.4%	85%	Yes
Consent	62	64	96.9%	85%	Yes
Health and safety	61	64	95.3%	85%	Yes
Blood transfusion	60	64	93.8%	85%	Yes
Infection prevention and control level 2	59	64	92.2%	85%	Yes
Resuscitation level 3	56	63	88.9%	85%	Yes
Information governance	54	64	84.4%	85%	No

Moving and handling level 2	54	64	84.4%	85%	No
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At Hammersmith Hospital critical care department, the 85% target was met for 15 of the 17 mandatory training modules for which qualified nursing staff were eligible. Information governance and moving and handling level two training modules both failed to meet the trust target with 84.4% completion rate each.

A breakdown of compliance for mandatory training courses as at November 2018 for medical staff in the critical care department at Hammersmith Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
ANTT	3	3	100.0%	85%	Yes
Blood transfusion	3	3	100.0%	85%	Yes
Conflict resolution	3	3	100.0%	85%	Yes
Consent	3	3	100.0%	85%	Yes
Equality and diversity	3	3	100.0%	85%	Yes
Fire Safety awareness	3	3	100.0%	85%	Yes
Health and safety	3	3	100.0%	85%	Yes
Infection prevention and control level 2	3	3	100.0%	85%	Yes
Information governance	3	3	100.0%	85%	Yes
Invasive procedures policy	3	3	100.0%	85%	Yes
Medicines management	3	3	100.0%	85%	Yes
Moving and handling level 1	3	3	100.0%	85%	Yes
Resuscitation level 2	3	3	100.0%	85%	Yes
Venous thromboembolism	3	3	100.0%	85%	Yes

At Hammersmith Hospital critical care department, the 85% target was met for all of the 14 mandatory training modules for which medical staff were eligible, with all modules achieving 100.0% completion rates.

A breakdown of compliance for mandatory training courses as at November 2018 for doctors in training staff in the critical care department at Hammersmith Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Blood Transfusion	8	8	100.0%	85%	Yes
Conflict Resolution	8	8	100.0%	85%	Yes
Equality and Diversity	8	8	100.0%	85%	Yes
Fire Safety Awareness	8	8	100.0%	85%	Yes
Health and Safety	8	8	100.0%	85%	Yes
Infection Prevention and Control Level 2	8	8	100.0%	85%	Yes
Information Governance	8	8	100.0%	85%	Yes
Invasive Procedures Policy	8	8	100.0%	85%	Yes
Medicines Management	8	8	100.0%	85%	Yes
Moving and Handling Level 1	8	8	100.0%	85%	Yes
Nasogastric Tube Placement	8	8	100.0%	85%	Yes
Resuscitation Level 2	8	8	100.0%	85%	Yes
Venous Thromboembolism	8	8	100.0%	85%	Yes
Consent	7	8	87.5%	85%	Yes
ANTT	5	8	62.5%	85%	No

At Hammersmith Hospital critical care department, the 85% target was met for 14 of the 15 mandatory training modules for which doctors in training staff were eligible. The aseptic non-touch technique (ANTT) training module did not meet the trust target with 62.5% completion rate. Performance should be taken in context when dealing with small numbers of eligible staff.

The intranet provided access to 'WIRED' which provided details on compliance with mandatory training. In house training was done through 'WIRED'. There were modules for learning disability, mental health, and safeguarding.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. The trust set a target of 85% for completion of safeguarding training. A breakdown of compliance for safeguarding training courses as at November 2018 at trust level for qualified nursing staff in critical care is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding adults level 2	379	388	97.7%	85%	Yes
Safeguarding children level 2	374	388	96.4%	85%	Yes

In critical care the 85% target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as at November 2018 at trust level for medical staff in critical care is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding children level 2	24	24	100.0%	85%	Yes
Safeguarding adults level 2	23	24	95.8%	85%	Yes

In critical care the 85% target was met for both of the safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as at November 2018 at trust level for doctors in training in critical care is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding adults	56	65	86.2%	85%	Yes
Safeguarding children level 2	55	65	84.6%	85%	No

In critical care the 85% target was met for one of the two safeguarding training modules for which doctors in training staff were eligible.

A breakdown of compliance for safeguarding training courses as at November 2018 for qualified nursing staff in the critical care department at Hammersmith Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding adults level 2	62	64	96.9%	85%	Yes

Safeguarding children level 2	62	64	96.9%	85%	Yes
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At Hammersmith Hospital critical care department, the 85% target was met for both safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as at November 2018 for medical staff in the critical care department at Hammersmith Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding adults level 2	3	3	100.0%	85%	Yes
Safeguarding children level 2	3	3	100.0%	85%	Yes

At Hammersmith Hospital critical care department, both of the safeguarding training modules for which medical staff were eligible had a completion rate of 100%. Performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for mandatory training courses as at November 2018 for doctors in training staff in the critical care department at Hammersmith Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding adults	8	8	100.0%	85%	Yes
Safeguarding children level 2	8	8	100.0%	85%	Yes

At Hammersmith Hospital critical care department, both of the safeguarding training modules for which doctors in training staff were eligible had a completion rate of 100%. Performance should be taken in context when dealing with small numbers of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Discussion with staff nurses regarding their knowledge of safeguarding demonstrated a good understanding of what constituted different forms of safeguarding risks and of the reporting processes.

We reviewed the trust's adult safeguarding policy which was available on the trust intranet. The policy detailed individual responsibilities and processes for reporting and escalation of concerns. There was a poster on the wall in the acute respiratory unit next to the nurse's station with relevant telephone numbers and contact details of safeguarding leads. The safety brief folder on the general intensive care unit (ICU) showed what was discussed at each handover. This included unit risks and included safeguarding issues and hospital alert status. On cardiac ICU there we observed information at the nursing station on how to access trust resources including the safeguarding team.

When patients aged 16 or 17 were admitted to the intensive care unit, trust guidance on the admission of adolescents to inpatient wards was used. The guidance advised staff about ensuring that the young person is admitted to the department which best met their needs and to ensure that environmental and young person-centred needs are met such as educational resources.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Information on the average MRSA screening compliance (Aug 2018 to Jan 2019) for areas in the critical care core service were provided by the trust. The trust target was 90%.

Ward	Overall compliance
GICU	100%
Cardiac ICU	100%
De Wardener	98%

On the cardiac ICU the cleaning routine appeared to be thorough, with particular focus on equipment around patient's beds, where all of the piped gases and connections for pumps and intravenous infusion were located. All available equipment we saw was clean, with stickers that recorded the date and time they had been cleaned.

Bare below the elbows and handwashing routines were observed, together with aprons worn as appropriate. However, we did observe medical staff entering the unit without observing hand hygiene. This was challenged by the nurse in charge. Display boards showed weekly cleaning audits at 98.6% (25 Feb) and monthly hand hygiene audit at 91%. This was accompanied by a 'back to basics' note stating a need to improve documentation around first moment of hand hygiene.

Aseptic non-touch technique (ANTT) is a set of principles to increase patient safety by reducing the risk of introducing infection into a susceptible body site during procedures such as intravenous therapy, wound care, and urinary catheterisation. We observed good ANTT on cardiac ICU, with appropriate aprons in use when attending to patients.

On general ICU we observed signs stating the need to wash hands and wear personal protective equipment (PPE). We observed good infection prevention and control (IPC) from staff with PPE and bare below elbows. Green stickers were found on all equipment such as IV fluid and drug infusion pumps, with dates to indicate they were clean. There was a sink and hand gel at every bed space. The space was clean and dust free. The sluice was clean and tidy with green stickers on commodes. A cleaning audit took place every Friday with the domestic supervisor and senior nurse. There was an infection prevention and control (IPC) information board with audit results. In Jan 2019, ANTT compliance was stated as 98%, hand hygiene 73%, CPE/MRSA screen 100%. There had been three cases of clostridium difficile (C Diff) between April 2018 and June 2018.

Environment and equipment

The service had suitable premises and equipment and looked after them well. Cardiac ICU had 16 beds providing care at level 2 and 3. On general ICU there were 16 beds and an average of four to five level 2 patients with the remaining patients requiring level 3 care. There were also four beds on De Wardener ward, a renal ward which were funded for level 2 care, where there were no high dependency patients present for the duration of our visit. All units had secure access and staff ensured that people coming on to the units were checked when buzzed through. Some under 18 patients were accepted on the units. We were told they would be cared for in side rooms, and staff were made aware they are under 18.

On cardiac ICU, there was an equipment technician who worked 0.5 of a whole time equivalent on the unit. They were responsible for maintaining all equipment in working order. This included repair and set up, testing, and cleaning. They reported to a senior technician and managed from

general ICU. Clinical waste bins were stored behind locked door just outside the unit. All bags were tagged with the ward code and collected twice a day. There was a point of care machine to analyse blood gases. The machine kept an accurate record of when staff were due to have refresher training and staff could not access the machine if they were not trained.

On general ICU, nurses were responsible for checking if equipment was faulty. If equipment was damaged it went in to the technologist's room for repair. If equipment could not be repaired this way it was sent for the trust's equipment team to repair or for the manufacturers to repair. We found that equipment had been stored safely behind key code door. All equipment such as hemodiafiltration machines, internal transfer trolley, syringe drivers and fluid pumps were stored appropriately with green stickers on all items. There was an e-notes computer and wipeable keyboard available at every bedside. There was a hoist track in the ceiling covering all bed spaces. There was enough room for there to be adequate space around each bed. All electrical equipment had been checked in February 2019. Each bed space had a suitable amount of equipment to support a patient admitted in to that space.

On general ICU we found that the resuscitation trolley had been checked daily. Its key tag was intact and all items were in date, present and checked such as defibrillator, suction, and sharps bin. On cardiac ICU, checks of resuscitation trolleys were taken daily and records went back to November 2018 and were also sealed. Difficult airway and chest opening trolley were both open due to immediate access required.

On both cardiac and general ICU all gas cylinders were properly secured behind a key coded door, attached to the wall in appropriate cradles and appropriately stored. Fridges were stored securely behind a key coded door. Temperatures were recorded daily in a folder at the nurses' station and were found to be within acceptable range. Nurses told us they had completed both online and face to face equipment training at St Mary's Hospital.

Fire escape plans were in place. Fire doors separated segments of the units and the circular layout of the units meant that isolation would be possible with escape from one of the two entrance/exits. Emergency evacuation chairs were available at the front and back of the unit as were two evacuation routes via a door or lift.

The hospital was made up of an amalgamation of different buildings built at various times. Routes to wards and units involved walking through these different buildings and there were many corridors. Wards were not well signposted, and we observed many confused visitors asking staff for directions as did we. On several occasions visitors also asked us for directions. We found all staff were helpful in this respect. However, poor signage did not help navigation. For instance, the cardiac ICU was also known as ward A6 and the cardiac recovery unit. It changed its name on signage between the front door and the unit making navigation even harder. We also observed that signage stopped mentioning the general ICU while on route.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. On general ICU, ward rounds took place for around an hour each morning and discussed every patient. There was good handover from the night doctor and a plan was always made at the end of each patient discussion. Staff would then disperse to see patients and action any outcomes from the ward round before regrouping at around 11.30am to review work undertaken. We attended the ward round and found it was well led. There was a systemic approach to each patient on the ward round. The nurse caring for each patient was present at each bedside. There was good representation from the

multidisciplinary team including the physiotherapist and pharmacist, who both contributed to the discussion regarding rehabilitation and contraindications with drugs. Junior doctors were confident to speak up and suggest a plan to the consultant. A safety huddle took place at 9.30am which included the critical care outreach team.

The ward round on cardiac ICU began at 8.30am and included the lead consultant, junior medical staff, and the nurse in charge. There was excellent interaction between the consultant and patients and good interaction between nursing and medical staff. The consultant was clear with the plan of care and treatment with supporting junior doctors, one of whom documented the review straight onto the computer. The consultant appeared to have good rapport with the team. They explained what they were looking at and doing. All extubated patients were seen first, as part of their discharge planning in preparation for transfer to the wards. Special notes were included for the transfer. Patients were reassured that they were fit for transfer and always asked if they were happy about this. There were good explanations of the importance of mobilisation and analgesia to prevent pain.

The staff nurse allocated to each patient that day was also present at the ward round and to ensure patient safety, staff breaks could only be taken once the patient had been reviewed. This policy was made in response to an incident involving a patient fall.

Nursing handover covered unit risks including airway, anticoagulant, do not attempt cardio pulmonary resuscitation, epidural, infection, similar names, stock issues, visitors/safeguarding and hospital alert status.

The safety brief folder on general ICU contained critical care related information and top three incident themes. The top three themes were all in relation to skin care (these were grade 2 pressure sores and moisture lesions). It also included the plan for if the clinical information system went down. We were told the system had gone down twice and the plan had worked well.

On the cardiac ICU the safety brief took place at 7.30 each morning. We were told that in the safety brief a number of items were discussed such as new procedures and staffing. We also attended the cardiac ICU unit handover, which included anything of note including general information regarding any audit results and any messages from the organisation.

We reviewed several patient records and found all risk assessments were present and assessed. This included Waterlow assessments, wound assessments, catheter assessments, intra venous cannula care plans and risk assessments, ventilator assessments, manual handling risk assessment, delirium scoring and pain assessments. We found on the general ICU that photos of skin lesions were added to patient records electronically making daily assessment easier. All pictures were deleted at end of shift for safety.

All staff interviewed were aware of escalation processes and stated they would inform the nurse in charge if they had any concerns or go directly to the medical staff. We found effective communication between different groups of staff who were comfortable raising concerns with one another. Nurses felt happy to raise any issues regarding patient care if they felt unsure or unsafe and felt comfortable talking to doctors and physiotherapists to be more informed about patient care.

On general ICU the sepsis policy was available at every bed space via the intranet and staff were aware they should escalate to the medical staff and commence appropriate treatment immediately. Staff carried out septic screening. Bloods were taken every day and patients were constantly monitored.

We were informed that National Early Warning Score version 2 (NEWS 2) was to be introduced the week following our inspection. NEWS 2 was the latest version of the (NEWS), which advocates a system to standardise the assessment and response to acute illness. Staff had been carrying out the NEWS 2 tests in preparation. De Wardener ward, where there were four level 2 beds, used NEWS 2. We were told that the critical care outreach team came to review patients who had stepped down from ICU. There were no high dependency patients present on the ward for the entirety of our inspection.

The critical care outreach team (CCOT) worked from 8am to 8pm. Out of those hours they handed over to the site team. They completed a written handover and did a telephone handover with them. If there were concerns about a patient they asked the site team to see them with a member of the CCOT before handover. They could also ask for the general ICU team to look over patients on other wards if the site practitioners did not have specific ICU training. There was only one site practitioner at the hospital, that meant they could sometimes not manage to complete a handover straight away, as site practitioners were busy. The team stayed with patients until they were available. We were told there had not been any specific incidents related to this, and where there were concerns with delays in seeing the site practitioner, the ICU registrar and the medical registrar were also available.

When wards had a concern about a patient that met the critical care outreach team's criteria for referral of a NEWS score of 7, they completed a situation, background, assessment, recommendation (SBAR) handover. CCOT staff told us they carried out a peer review of the outreach service and had feedback that they were supportive and dependable, with doctors stating they were grateful for a second pair of eyes. However, we were also told that wards did not always act on the plans they were given, and sometimes they saw that nothing had changed for the patient in 12-24 hours. The CCOT were not aware of any incidents that had arisen from this and told us they would report it as an incident if there was patient harm. However, there had been some cases where the NEWS proforma had not been completed and the team had seen patients who should have been escalated sooner. In December 2018, CCOT delivered some training to encourage staff to bring issues to them quicker, which we were told had not completely solved the issue. It was stated that the roll out of NEWS 2 would help to address this.

Patients that had stepped down from ICU with tracheostomy care needs were reviewed by CCOT. There was not a tracheostomy ward round as numbers were small as Charing Cross Hospital had a specialist ENT service for the trust.

Nurse staffing

The service had faced some challenges to provide enough staff to keep people safe from avoidable harm and to provide the right care and treatment. The trust reported their staffing numbers below in critical care for Charing Cross Hospital, Hammersmith Hospital, and St Mary's Hospital as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
Charing Cross Hospital	109.8	106.4	96.9%
Hammersmith Hospital	152.1	132.3	87.0%
St Mary's Hospital	140.1	143.6	Over-established by 2.5%
Total	402.0	382.3	95.1%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 11.9% in critical care at Hammersmith Hospital. This was higher than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 6.9% in critical care at Hammersmith Hospital. This was lower than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From October 2017 to September 2018, the trust reported 81,709 (12.5%) bank hours and 14,827 (2.3%) agency hours at the trust were filled by qualified nurses in critical care. There were 31,636 hours (4.8%) that were over-filled by bank/agency staff.

During the same period, the trust reported 16,486 (75.0%) bank hours and 407 (1.9%) agency hours were filled by nursing assistants in critical care. There were 12,391 hours (56.4%) that were over-filled by bank/agency staff.

Staff type	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Qualified nurses	653,132	81,709	12.5%	14,827	2.3%	Over-filled by 31,636	Over-filled by 4.8%
Non-qualified nurses	21,989	16,486	75.0%	407	1.9%	Over-filled by 12,391	Over-filled by 56.4%

The trust confirmed that the over-establishment reflects actual versus planned for months where the actual was greater than the planned (such as over established due to enhanced care). The trust reported that the bank staff usage was mainly attributed to vacancies.

From October 2017 to September 2018, the trust reported 35,976 (15.7%) bank hours and 4,889 (2.1%) agency hours at the trust were filled by qualified nurses in critical care. There were 13,753 hours (6.0%) that were over-filled by bank/agency staff.

A ward breakdown is shown below:

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
A6 CICU	73,429	6,432	8.8%	253	0.4%	Over-filled by 418	Over-filled by 0.6%
De Wardener ward	36,037	5,345	14.8%	3,999	11.1%	Over-filled by 1,793	Over-filled by 5.0%
Intensive care (ICU)	119,473	24,199	20.3%	637	0.5%	Over-filled by 11,542	Over-filled by 9.7%
Total	228,939	35,976	15.7%	4,889	2.1%	Over-filled by 13,753	Over-filled by 6.0%

During the same period, the trust reported 6,647 (118%) bank hours and 57 (1%) agency hours were filled by nursing assistants in critical care. There were 4,403 hours (78%) that were over-filled by bank/agency staff.

A ward breakdown is shown below:

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
De Wardener ward	2,032	5,679	279.5%	57	2.8%	Over-filled by 3,739	Over-filled by 184.0%
Intensive care (ICU)	3,605	968	26.9%	0	0.0%	Over-filled by 664	Over-filled by 18.4%
Total	5,637	6,647	117.9%	57	1.0%	Over-filled by 4,403	Over-filled by 78.1%

The trust confirmed that the over-establishment reflects actual v planned for months where the actual was greater than the planned (i.e. over established due to specialising, enhanced care, etc.). The trust report that the bank staff usage was mainly attributed to vacancies.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The general ICU was led by a matron. There were six band 7s, 24.6 band 6s and 46 band 5s. There were also three healthcare assistants (HCAs), one technologist and one ward clerk. There were 16 critical care trained nurses on duty per shift. There were some staffing challenges. Very recently four band 6 nurses, and a band 7 nurse had left. In addition, upper gastrointestinal (GI) oesophagostomy surgery was moving to the hospital in May 2019. To be ready for this, an extra 5.6 WTE posts had been created, which had pushed the vacancy rate up to 12.6 over a period of two months. The unit followed a 'grow your own' philosophy by promoting band 5 and 6 nurses, which had meant that all band 6 and 7 vacancies had been filled. There was a rolling advert for band 5 nurses and three had been recently recruited, with a further four names attached to posts but yet to receive clearance to start. Vacancies were also managed by flexing up and down according to bed numbers. The unit can run up to 16 beds and dependency was kept an eye on at all times.

The general ICU staff rotas were published more than a month in advance and followed a self-rostering system. All staff completed their roster requirements two to three months in advance and the band 7 leads inputted this information in to an auto-rostering system. Study days and annual leave were also incorporated in to this which was then reviewed by the nurse lead to ensure it was balanced in terms of weekends worked and balance of teams before being verified and published.

A 'safer staffing' model was used to e-roster and checked on staffing numbers but this would also be used on an ad hoc basis to keep a check on dependency and numbers. There was a twice daily conference call across the trust's critical care directorate's units at 5am and 5pm. The lead from each ICU reviewed staffing need for cross site working. We were told that cross site movement occurred regularly. The nurse in charge was supernumerary to lead and a junior nurse was supernumerary to support. If there was a staffing need at short notice, shifts could be moved and bank, usually their own staff, could also be called upon. The last resort was to use agency staff of which there was a pool who they knew worked well.

At the time of our inspection there was a 17% vacancy rate for nursing staff on cardiac ICU which was on the risk register. Last year the unit dropped its nursing establishment from 60.12 whole time equivalent (WTE) nurses down to 51.27. This was due to resources being prioritised elsewhere within the directorate of cardiac sciences. When staff numbers were reduced there was

a reduction to eight level 3 and eight level 2 beds. Since this time there had been a higher demand for level 3 beds and the number of beds was put back up to 10 level 3 beds and 6 level 2.

A review had identified non-compliance with the Guidelines for the Provision of Intensive Care Services (GPICS) standards. Published by the Faculty for Intensive Care Medicine, GPICS standards are seen as the definitive reference source for planning and delivery of UK Intensive Care Services. Another factor contributing to non compliance with staffing standards was because cardiac ICU were taking on a higher number of level 3 patients.

Staffing levels on cardiac ICU were managed by identifying levels of patient need as they arose, which could be one or two days in advance of a shift. Staff were asked to change or fill shifts at short notice. We were told this arrangement worked well for some staff because staff would also ask to change at short notice due to personal commitments. Bank and agency staff were used to make up shortfalls but we were told that sometimes they were without two floating members of staff, which was non compliant with GPICS standards and potentially meant less breaks for nurses and less of a timely response to meet patient needs. Agency staff had been used since January 2019. The cost of this was weighed up against the cancellation of operations due to a lack of unit staffing, of which the cost was greater. Four agency nurses had been doing regular shift work and were familiar with the unit's processes and practices. Staffing need was flexed up and down depending on the number and patient's care needs, calculated by the number of level 2 and 3 beds being utilised.

Cardiac ICU were rarely over the 20% of nurses being agency (as per GPICS standard). There were 61% of nursing staff who were critical care trained and three more were in training. When the rota was completed it was ensured that the band 7 nurse in charge was critical care trained, plus two more, so three on each shift; one in charge and one on each side of the unit as a minimum. All agency staff were critical care trained, which meant they always had more than over 50% critical care trained nurses on duty as per GPICS standard.

There was not a matron on cardiac ICU at present. They had been placed on secondment the week before our inspection. We were told that a new matron was due to start next week on an interim basis. In the meantime, the lead nurse for the directorate of cardiac sciences was taking charge of the unit, and had been overseeing its management since January 2019.

We observed that the team on cardiac ICU supported each other and worked well together. Nurses told us they sometimes had an issue with lack of staff and that a supernumerary nurse was not always available and staff sometimes needed more support. However, we were also told that the situation was getting better with a change of ward leadership.

Non-invasive ventilated (NIV) patients were being cared for in haematology, often in side rooms and without a nurse or doctor present all the time. A patient placed on NIV is a level 2 patient and if in a side room alone, they were at risk: for example, if they involuntarily vomited or if the machine failed. This was an unidentified ICU staffing risk and an inconsistency in the care of patients around the hospital.

De Wardener ward was a 12-bedded renal ward caring for post kidney and pancreas transplant patients. There were four nurses on duty in the day and four at night for the 12 general care beds, plus one HCA and a ward sister. Two band 6 nurses were always on duty. There were currently five vacancies.

Four of the beds on De Wardener ward were funded for level 2 patients and we were told that on average the ward had up to eight level 2 patients per month and up to two level 3 patients a month. For the period of our inspection, there were no level 2 or level 3 patients present on the ward. We were told that if the critical care beds were all filled then staffing could be increased. The

ward used agency nurses when this occurred. There was a supernumerary nurse. This was currently a renal student nurse. A safety briefing took place every morning and we were told that staffing could be escalated and nurses pulled from other wards. There were three nurses who had a critical care course and one with a high dependency unit course. The ward was not compliant with the critical care staffing standards for having 50% of staff with a critical care course; they were five nurses short of this. It was recognised that staff required further training. The ward was not measuring its level 2 (or level 3) beds by GPICS standards and was unaware of compliance. The critical care steering group had been set up within Hammersmith Hospital to look at GPICS compliance. However, the renal unit was not part of this group.

The critical care outreach team (CCOT) worked seven days a week from 8am to 8pm. This was on a trial basis which began in 2018. They were led by a band 8b nurse who was trust wide and supernumerary. There were five team members; three band 7 nurses and one band 6 nurse, who was not currently in post but we were told was soon due to join the team on secondment. The service had discussed provision of staff to deliver a 24 hours service but at present were not currently meeting GPICS staffing standards for an outreach service.

Medical staffing

The service had enough medical staff to keep patients safe. The trust reported their staffing numbers below for Charing Cross Hospital, Hammersmith Hospital, and St Mary's Hospital as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
Charing Cross Hospital	32.7	32.1	98.2%
Hammersmith Hospital	18.0	18.0	100.0%
St Mary's Hospital	33.5	39.4	Over-established by 17.6%
Total	84.2	89.5	Over-established by 6.3%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 8.5% in critical care at Hammersmith Hospital. This was lower than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 0.0% in critical care at Hammersmith Hospital, compared to a trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate for medical staff at in critical care at Hammersmith Hospital was 0.09%. This was within the trust target of 3%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From November 2017 to October 2018, the trust reported no locum or agency hours available. However, 205 agency hours were filled in critical care. The trust was unable to confirm the number of locum or agency hours that were unfilled.

General ICU was led by consultant intensivists and operated a consultant of the week model. For instance, there were five intensivists who led the unit in turns. One took Monday to Friday and the

next worked Friday to Monday and so on. On General ICU all five intensivists were together on Wednesdays and joint working days took place on the handover days of Monday and Friday. Upper GI oesophagostomy surgery was moving to the hospital in May 2019 and the unit needed two further consultants for the number of beds. The unit was currently recruiting.

Cardiac ICU also followed a consultant of the week model. There were eight intensivists treating post-operative cardiac patients and patients with cardiac arrests and was staffed to establishment. Both general and cardiac ICUs were supported by a team of junior doctors.

De Wardener ward, was not led by an intensivist. It treated post kidney and pancreas and dialysis patients and acute kidney injury. The renal registrar and consultant reviewed patients who were high dependency and support was provided by the critical care outreach team (CCOT) for patients who had stepped down from the ICUs.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. A digital healthcare information system was used on cardiac ICU. On general ICU, an intensive care information system was used. On general ICU all assessments were made and recorded using the electronic system. All ward rounds, medication, interventions, and nursing care documentation were recorded on the information systems. Flags on the system were observed regarding medication reviews which were picked up by junior doctors. The ward rounds were documented directly on to the computer. Care plans were reviewed daily. Records also noted patients' additional needs such as if they had dementia or a learning disability.

In all patient records we checked plans and assessments were up to date. On cardiac ICU nursing and medical documentation was electronic but summaries of any plans of care were made on the paper chart such as any special instructions. All patient observations were documented on paper at intervals according to patient condition. We found all records to be complete and up to date. Care plans were reviewed daily. Records also noted patients' additional needs such as if they had dementia or a learning disability.

Nurse educators did some spot checks on the quality of record completion. However, there were no notes audits in place. Trust told us that since they moved primarily to an electronic patient record in April 2016, audits for the availability of records were not routinely undertaken. Audits regarding the quality of the notes included in the electronic patient records may be undertaken as part of a local audit plan. In addition, internal reviews such as ward accreditation, core service reviews and peer reviews look at a sample of patient records as part of those reviews.

Medicines

The service followed best practice when prescribing, giving and recording medicines. On cardiac ICU there was pharmacy support from Monday to Friday for four hours a day. They did not attend ward rounds and were unable to provide sufficient pharmacy time on the cardiac ICU meet the Guidelines for the Provision of Intensive Care Services (GPICS) standards. The unit was looking at getting more funding to support this.

On general ICU, a pharmacist was on the unit Monday to Friday for ward rounds, advice and daily monitoring. They covered stock problems and ordered medications following ward rounds. We were told they were available on the unit up to around 11 to midday and always contactable when

not on the unit. A band 7 nurse worked closely with the pharmacist. Another band 7 was the link lead for medicines safety workstream, which was a trust wide initiative.

On general ICU we found the controlled drugs (CD) cupboard was appropriately stocked. Daily checks were recorded in the CD book. There were no discrepancies. There was a good system in place for IV drug administration where two nurses were recording; one who checked and one who administered. Medicines policies were available on the trust's intranet and staff knew how to access these. This included policies on the administration of controlled drugs. Microbiology protocols for the administration of antibiotics were also available on the intranet.

Incidents

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From November 2017 to October 2018, the trust reported no incidents classified as never events for critical care.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from January 2018 to December 2018.

Of these, the types of incident reported were:

- HCAI/Infection control incident meeting SI criteria with one (25.0% of total incidents).
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (25.0% of total incidents).
- Pending review (a category must be selected before incident is closed) with one (25.0% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with one (25.0% of total incidents).

Site specific information can be found below:

- Charing Cross Hospital: two incidents (50.0% of total incidents).
- Hammersmith Hospital: one incidents (25.0% of total incidents).
- St Mary's Hospital: one incidents (25.0% of total incidents).

(Source: Strategic Executive Information System (STEIS))

Information provided from data requests stated that the last serious incident regarding critical care at Hammersmith Hospital occurred in May 2016. In the last 12 months, (February 2018 to February 2019) it was reported that at Hammersmith Hospital there had been a total of 322 incidents of which one resulted in moderate harm and none in extreme harm.

Quality and safety meetings for the cardiac directorate took place on the first Monday of each month and each area within the directorate reported on their numbers of incidents including serious incidents (SIs) and near misses with no harm or with low harm. If there were outstanding SIs, each area reported on this and why this was the case. Ward meetings for cardiac ICU took

place on the first Friday of every month. The detail from incidents and concerns, was reported back to staff. Trends were identified such as equipment failure or falls. If any such trends were identified it was added to the following month's 'big 4'. These were four pertinent issues to tackle each month on each unit, which changed depending on what was happening month to month. This could also include trust or directorate wide issues where shared.

On general ICU, incidents were reported to the nurse in charge of the unit and an incident report completed was shared with the governance team. Investigation was allocated to the band 7 nurse on duty or it was reported to the nurse lead where this was not possible. If a serious medical incident had occurred then one of the intensivists took the lead.

A safety performance, quality research meeting took place monthly (SPQR). This was a multidisciplinary meeting that looked at practice and quality issues such as audits and incidents. Incident learning was looked at through themes and talking to staff. Feedback to staff of individual incidents was through band 7 nurses, through email, team days, unit meetings and handover.

Consultants reviewed patient deaths in their service using a mortality screening tool (level 1 review) which identified patients requiring further review through speciality mortality and morbidity meetings (level 2 review) or an independent 'structured judgement review'. Consultants were also responsible for sharing and escalating through the divisional structures, any deficiencies in care, systems or process identified through the review. Patient deaths that were identified in the level 1 review were reported to the weekly medical director incident review panel where the panel decided whether investigation under the serious incidents framework was required. Level 2 reviews were reported monthly to the MD panel. The trust mortality review group received divisional reports and was responsible for overseeing the mortality review process and reporting on themes for learning.

On general ICU we were told an incident reporting system was in use with an icon on all desktops. One nurse gave an example of how to report using the incident reporting system. The band 7 on shift investigated and fed back on incidents; how it happened and what could be done to prevent it happening in future. Emails regarding learning were sent to all staff by the lead.

On cardiac ICU nurses told us that incident debriefs took place and there was a no blame culture. The band 7 investigated then disseminated incident learning via ward meetings. Nurses were able to explain the Duty of Candour.

There was a serious incident on cardiac ICU in March 2018 that involved a patient falling out of bed. Action had been taken that included updating assessment processes and introduction of a new policy, which meant that staff breaks could only be taken once the patient had been reviewed, assessments undertaken, and the patient handed over. Senior staff told us that they could get an additional staff to work one to one with patients at risk.

We were also told of another example of learning from incidents, where there was an incident that related to critical care and the Mental Capacity Act (MCA) at another trust hospital. There was an updated mental health module included on the Foundation to Critical Care course.

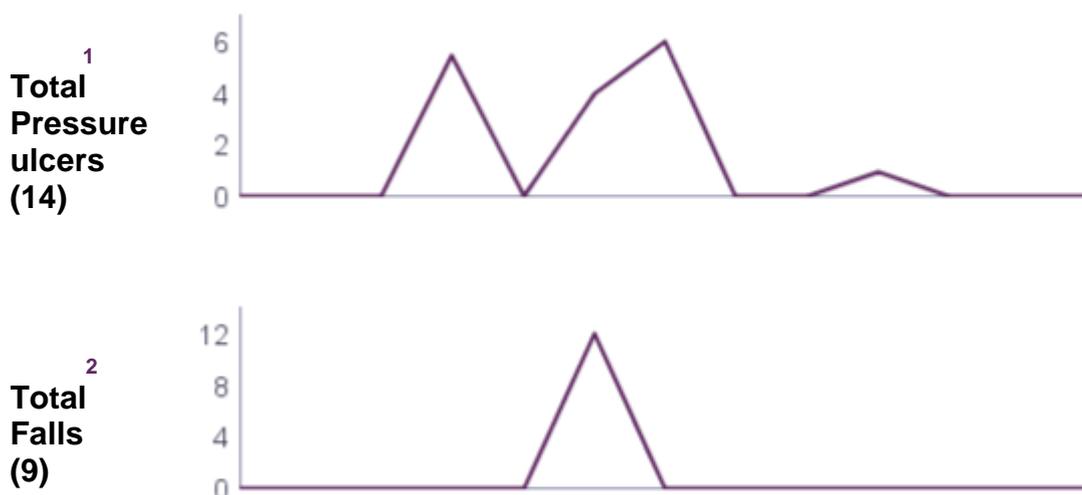
Safety thermometer

The service collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service. The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 14 new pressure ulcers, nine falls with harm and no new catheter urinary tract infections from November 2017 to November 2018.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Imperial College Healthcare NHS Trust



1 Pressure ulcers levels 2, 3 and 4

2 Falls with harm levels 3 to 6

(Source: NHS Digital)

Safety thermometer information was collected as part of an online data collection system which we were shown on the computer. There were four parts to it; hand hygiene, care bundles, saving lives and medicines matter. Hand hygiene and medicines matter were submitted every week. Care bundles and saving lives were collected every month. They were reported on monthly in the harm free care report. December 2018's report showed hand hygiene, VTE assessments, falls including those with harm.

There were quality and safety boards displaying information in each ward. On general ICU we were told the harm free care report looked at several data items including falls and pressure care. A monthly report was provided to all units with figures which were addressed in different ways such as senior nurses' meetings. Areas for attention could also be highlighted as a 'big 4' item. These were four pertinent issues to tackle each month on each unit, which changed depending on what was happening month to month. This could also include trust or directorate wide issues where shared.

Is the service effective?

Evidence based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. The critical care clinical guidelines group looked at new guidance, updating policy, guidelines, and standard operating procedures (SOP). It was led by a senior educator who worked across the trust's three acute sites and meetings were bi-monthly. For example, the group were looking at a standard operating procedure for pacemakers for which Hammersmith Hospital's general ICU were taking a lead. Cardiac ICU were part of a different directorate and so were not part of the critical care clinical guidelines group. However, we were told they 'could' be involved as the links were there, however, this had not occurred so far.

On cardiac ICU the quality and safety agenda worked towards setting out an agenda that covered compliance with new guidance and practice which came through from different workstreams such as medical practice and practice education. For instance, NEWS 2 was being introduced throughout critical care by the practice educators and training. The quality and safety agenda applied for directorates and the division.

The cardiac directorate were currently reviewing their service to look at how it fitted with standards of care published by the Faculty for Intensive Care Medicine. The Guidelines for the Provision of Intensive Care Services (GPICS) standards were an authoritative reference source for planning and delivery of UK Intensive Care Services. They were aware that the general ICU was compliant with the guidance but not the other renal and cardiac critical care areas. The cardiac division were aware they were not meeting these standards and a working group had been formed in January 2019 to look at compliance with the GPICS standards. Within critical care services on the Hammersmith Hospital site, a steering group had been set up to facilitate this and enable 'future proofing' of the overall service. There were working groups looking individually at: finance, patient flow, IT and workforce and we were told the group were working to get a paper to the board by the end of May/June 2019. However, the renal level 2 beds were not part of this conversation and were not currently benchmarking themselves against these standards.

The Guidelines for the Provision of Intensive Care Services, 2015 states that patients discharged from an intensive care unit must have access to an intensive care follow-up clinic. It is recommended that a follow-up is needed for adults who were in critical care for more than four days or at were risk of morbidity. On general ICU, patients who had been on the unit for a period of five days or more, were sent an invite to come in and attend the follow up clinic. Patients were identified by the ward clerk looking at the electronic records to identify length of stay and then sent them invitation letters. The clinics were run once a month but sometimes twice a month if there was demand. On cardiac ICU, a follow up clinic had only just been started; in February 2019 in the weeks preceding our inspection as a Quality Improvement project. The plan was for follow up clinics to occur monthly but depended on the number of patients, as they gave them the choice of being involved. The project had been started by a nurse with one of the consultants. The reason for commencing the follow up project was concerned with giving additional support in line with guidance as they were aware that they were not working to current guidance in this respect.

General ICU contributed to the north west London critical care network audits and national adult critical care dashboard. Key successes, key concerns and key actions following the audits were recorded. To focus on the discharge process and patient flow through the critical care units, the service joined the weekly hospital wide flow group meeting to discuss and to better understand how to efficiently step patients down from intensive care to the hospital's wards. However, this did

not include the cardiac ICU or renal level 2 beds. There was no formal cardiac network in this area which meant there was no conversation about cardiac and critical care.

There was an extensive range of critical care specific protocols and guidelines as well as corporate policies and guidance on various clinical interventions on the trust intranet. Policies contained appropriate guidance for screening referrals and specific interventions. We looked at a sample of guidelines such as renal replacement therapy, violence and aggression, bowel management, sedation for adult critical care patients, sepsis management in adults and found them all to be in date. We also viewed a bedside safety checklist which included flow charts and prompts on handover, monitors, alarms airway and breathing were also available on the critical care section of the intranet.

The service used evidence based 'care bundles'. A care bundle is a set of evidenced based interventions that, when used together, can improve patient outcomes. For example, we saw that staff used a skin care bundle to prevent and treat pressure ulcers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

They used special feeding and hydration techniques when necessary. Patient assessments demonstrated that nutrition and hydration needs were being regularly assessed and met through the use of the malnutrition universal screening tool (MUST). Patients who were unable to take food and fluid orally had nutrition support to ensure adequate nutrition. There was also regular input from the unit dietitians. On general ICU there was a dietitian on the unit five days a week and on call at weekends, contributing to multidisciplinary input with patients. The dietitian attendant multidisciplinary team meetings on the cardiac ICU to discuss and complex tracheostomy patients.

Nutrition was audited monthly cross site and data from the audit was reviewed on a monthly basis by the lead nurses for each site. The audit assessed whether the patient had a gastrointestinal nursing care plan completed on admission and daily by a registered nurse, whether the patient's weight and height had been documented within 24 hours, whether nutrition support had been started within 48 hours of admission, whether the correct feeding plan was being followed, whether there was a record of food and fluid intake if the patient was eating and drinking and if a reason was documented if enteral or parenteral nutrition had been stopped. Overall compliance for the intensive care units trustwide between November 2018 to January 2019 was 91%.

There were regular meals, drinks and snacks provided for patients who could eat and drink. One patient told us that staff made sure they had access to food and drinks and that food was good.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. Patient records we reviewed showed that pain was being assessed and managed. Ward rounds we attended on both cardiac and general ICU demonstrated that teams were assessing and managing pain. There were good explanations to patients of the importance of mobilisation and analgesia to prevent pain. Staff checked during follow up clinics how patients were including their pain assessment.

On the cardiac ICU we attended a multidisciplinary meeting where a patient's activities such as sitting out of bed and pain relief were discussed. Display boards explained pain observation as

information for relatives. There was a delirium champion and a team of five nurses who started the delirium project at the start of 2018 as a QI project. As part of this ongoing work the critical care pain observation tool and the Richmond Agitation Sedation Scale were currently being introduced following teaching sessions. The Richmond Agitation-Sedation Scale is used to measure the agitation or sedation level of a person. It was developed with efforts of different practitioners, represented by physicians, nurses and pharmacists.

One patient we spoke with told us staff had been quick to recognise when they needed pain relief.

The trust told us that following a National Patient Safety Agency (NPSA) alert for safer practice with epidural injections and infusions in acute care in 2006, data was now being collected in compliance with this alert. In August 2018, the pain service collected data using a modified version of the NPSA data collection forms and critical care areas and found that 60% of patients were compliant with the NPSA guidance for labelling epidural infusions trust wide. This was a small sample of five patients over a five-day period. The audit in August found critical care areas were not always consistent when labelling epidural infusions and compliant with the trust guideline. The department prepared an action plan in response to the findings and re-audited in October 2018 where they noted improvements in adherence to guidance on storage and labelling.

Patient outcomes

The trust monitored the effectiveness of care and treatment and used the findings to improve them. However, this was not extensive across all ICU services. The trust had three units which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2016/17 Annual Report. Any available quarterly data should be considered alongside this annual data.

(Source: Intensive Care National Audit Research Centre (ICNARC))

For Hammersmith Hospital, General Adult Critical Care Unit at Hammersmith Hospitals, the risk adjusted hospital mortality ratio was 1.0 in 2016/17. This was within expected range. The figure in the 2015/16 annual report was 1.0.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
362 admissions	Risk-adjusted hospital mortality ratio (all patients)	1.0	1.0	1.0	none	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

For Hammersmith Hospital, General Adult Critical Care Unit at Hammersmith Hospitals, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.0. This was within expected limits. The figure in the 2015/16 annual report was 1.5.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
210 admissions	Risk-adjusted hospital mortality ratio	1.5	1.0	1.0	none	Within expected limits

	for patients with predicted risk of death <20% (lower risk)					
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(Source: Intensive Care National Audit Research Centre (ICNARC))

There was a researcher role responsible for collection of data including ICNARC data. ICNARC data was only collected from the general ICU. Both the level 2 renal beds and cardiac ICU were excluded. Data collection was from a mix of paper records and electronic, as well as data from the trust's other acute sites of Saint Mary's and Charing Cross hospitals, and then entered manually into an electronic system for collecting data. There was a clinical research audit manager who oversaw the data collection. The researcher had a counterpart at Saint Mary's Hospital, and there was also an audit assistant. Data was presented at team meetings and at training days where it was used as part of discussions.

We were told that a project on pressure ulcers was carried out in 2018, looking at admission and grading on admission and in care in records in ICU. Recommendations were made on improvements. Renal HDU beds were not included.

Competent staff

The service made sure staff were competent for their roles in most cases. From November 2017 to November 2018, 92.8% of staff within critical care at the trust received an appraisal compared to a trust target of 95%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met? (Yes/No)
Support to doctors and nursing staff	13	13	100.0%	Yes
Qualified allied health professionals	1	1	100.0%	Yes
Qualified nursing and health visiting staff	417	394	94.5%	No
Qualified healthcare scientists	8	7	87.5%	No
NHS Infrastructure support	20	11	55.0%	No
Total	459	426	92.8%	No

From November 2017 to November 2018, 95.3% of required staff within the critical care department at Hammersmith Hospital received an appraisal compared to the trust target of 95%. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met? (Yes/No)
Support to doctors and nursing staff	4	4	100.0%	Yes
Qualified nursing and health visiting staff	138	133	96.4%	Yes
NHS Infrastructure support	5	4	80.0%	No
Qualified healthcare scientists	2	1	50.0%	No
Total	149	142	95.3%	Yes

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

There were two nurse educators at the critical care units; one for cardiology and one for general ICU. Educators role involved supporting new starters and the development of existing staff. New staff remained supernumerary for a minimum of five weeks even if transferring from another critical care environment. This time was used to complete mandatory training and shadow staff, ideally their mentors. They shadowed in theatres, so they could follow the patient pathway from theatres into critical care; pre and post-operative pathways. Mentors and team leaders signed off the new starters' competencies. Bank staff on cardiac ICU were inducted locally on to the unit by the nurse educator with an induction checklist. They were also given a booklet with information. Both agency and bank staff were paired with experienced staff. After staff had completed the five weeks of training, they worked with level 2 patients and were buddied up with experienced staff to work with level 3 patients. Staff also completed a local competency test for non-invasive ventilation, working with inotropes, for syringe drivers, and chest drains.

On cardiac ICU we learned that band 6 nurses were encouraged to do a 'springboard' course; lasting six to nine months for skilling nurses up to band 7. There was also a deputy shift leader role which a band 5 nurse could take up, where they were deputy to the band 7 to prepare them for leadership roles. We were told that nurses were encouraged to settle into their role for 18 to 24 months before they start the 'step 4 competencies' for the core skills required to take charge of a critical care unit.

On general ICU, the nurse educators provided training to new and existing staff which were signed off by mentors. Established staff were also given progression training on 'springboard' and the critical care competencies. Band 5 and 6 nurses were given the opportunity to complete the critical care course. General ICU was nominated for learning environment of the year in 2018 at the trust awards. The clinical nurse educator ran the local Foundation to Critical Care Programme, for critical care staff, which had been in place for the last few years. The programme included specific focus in critical care depending on the speciality offered at the specific trust hospital. The clinical nurse educator also managed the step competencies training for staff which were developed by the critical care society.

On cardiac ICU, band 7 nurses led their own nursing teams and each team had three team days a year. As part of team day there was training, speakers, different development topics and people responsible for individual things such as information collection that fed in to harm free care which was discussed in ward meetings.

Nurses told us that those on the critical care programme were allocated a mentor and well supported by staff. Mentors were allocated to new staff and the clinical nurse educator for the unit also helped with new staff. One student nurse told us they had an induction with the nurse in charge who demonstrated the resuscitation trolley, fire exits and general orientation around the ward. They were allocated a mentor and a learning package. The mentor was allocated to work with them three times a week. They were allocated to someone else to continue learning when the mentor was unavailable. There was an induction by the nurse in charge for all agency nurses and the band 7 ensured that all mandatory training was up to date including equipment. A student nurse had attended the ward round and was supported by nursing staff. There was good interaction by the student who felt able to check the plan before reiterating it to the patient. They appeared confident and happy in their work. On cardiac ICU we were told that some staff had to pay towards the cost of post graduate qualification.

There were no national competencies for critical care outreach as of yet, so training was developed in house. The critical care outreach team (CCOT) completed a twelve-week competency period, during which time specific competencies were completed in a number of areas such as tracheostomy care and non-invasive ventilation. The 12-week course was built

around improving assessment skills, response to emergency scenarios and use equipment. They were also sent to the other trust sites to learn about them; one day at each site. They were part of the London North West Critical Care Network.

The critical care outreach team (CCOT) told us they would like to create link roles on each ward. The critical care outreach team were all trained in advanced life support. They carried out training with staff for basic life support sessions, which included an assessment module, to enable staff to better stabilise the patient.

De Wardener ward were not compliant with GPICS standards by having 50% of staff on duty with a critical care course. Three nurses had a critical care course and one had a high dependency unit course. Senior leads understood more training was required to meet the needs of level 2 and 3 patients admitted to De Wardener ward, and the ward had invested in courses including non-invasive ventilation; bilevel positive airway pressure (BPAP) and continuous positive airway pressure (CPAP) and nasal high flow therapy.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. There was a clear multidisciplinary team approach to the care and treatment of patients. For instance, in the ward round on general ICU, all members of the multidisciplinary team (MDT) were given opportunities to participate and add information. There was good representation including the physiotherapist and pharmacist, who both contributed to the discussion regarding rehabilitation and contraindications with drugs. The nurse caring for each patient was present at each bedside. Junior doctors were confident to speak up and suggest a plan to the consultant. We were told that all visiting professions such as physiotherapists, medical staff and dietitians commented on it being an easy unit to work on. We were told that medics were approachable. We observed a nurse interacting with a physiotherapist. The conversation was very respectful and they demonstrated they worked as a team. A dietitian was on the unit five days a week and on call at weekends. Three physiotherapists worked Monday to Friday but also had other duties elsewhere in the hospital.

The ward round on cardiac ICU included the lead consultant, junior medical staff, and the nurse in charge. There was excellent interaction between the consultant and patients and good interaction between nursing and medical staff. The consultant was clear with the plan of care and treatment with supporting junior doctors and asked for feedback from them. The consultant appeared to have good rapport with the team. To ensure patient safety, staff breaks could only be taken once the patient had been reviewed, assessments undertaken and the patient handed over. However, we were told that the unit kept long term patients now rather than transferring them to general ICU, therefore an increase in staffing and physiotherapy input was required. The pharmacist was not present at the cardiac ICU ward round. We were told they did not attend ward rounds and that physiotherapists only attended sometimes. There was a band 5 and 6 physiotherapist who worked on the cardiac ICU as required. We were told there was not an exact amount of time allocated but we were told they attended the unit at least 3 times per week depending on the needs of the patients. They always saw the complex patients and felt they could manage the demand. They attended the ward rounds occasionally but saw complex patients and anyone the nursing team suggested needed a review. They followed up patients after transfer from the unit to the wards. They told us they felt integrated well within the team and that the cardiac team worked well

together. One of the physios was included in the weekly MDT meeting where certain patients were discussed.

The ICU's MDT meeting was attended by speech and language therapy, dietitian, physiotherapy, junior doctor, and nurse educator.

There was a clear multidisciplinary approach to the management of sepsis. The CCOT told us that there were sepsis trolleys on all wards, including the emergency department and CCU, that sepsis training had been delivered to all clinical staff in these areas and a sepsis screening tool was embedded in the hospital-wide NEWS chart. The hospital followed the 'sepsis six bundle', which is a term used for the management of sepsis after admission to hospital involving three treatments and three tests.

Seven-day services

There was suitable provision of services for patients. However, the critical care outreach team did not provide service at night. The critical care outreach team worked seven days a week from 8am to 8pm. This was on a trial basis which began in 2018. They were led by a band 8b nurse. There were five team members; one band 8 nurse, three band 7 and one band 6, who was not currently in post but we were told was soon due to join the team on secondment. The service was not meeting the Guidelines for the Provision of Intensive Care Services (GPICS) standards, published by the Faculty for Intensive Care Medicine for the 24 hours seven days a week critical care outreach team service provision.

Out of those hours the outreach team handed over to the site team. They completed a written handover and did a telephone handover with them. They could also ask for the general ICU team to look over patients on other wards if the site practitioners did not have specific ICU training. There was only one site practitioner at the hospital, that meant they could sometimes not manage to complete a handover straight away, as site practitioners were busy.

Consultant cover was provided 24 hours seven day a week, this was not always on-site cover; on-call support was provided from 10pm to 8am. Consultant intensivists were reported as routinely present out of normal working hours. For instance, being present for intake from 4am. On general ICU we were told that consultants could attend the unit quickly at short notice. All lived close by and were easily contactable. We were told that all got in to the unit quickly when required.

On general ICU there were five intensivists who led the unit in turns. One took Monday to Friday and the next worked Friday to Monday and so on. All five intensivists were together on Wednesdays and joint working days took place on the handover days of Monday and Friday.

Pharmacists were available on call at weekends and overnight. A dietitian was on the unit five days a week and on call at weekends. Three physiotherapists worked Monday to Friday but also had other duties elsewhere in the hospital.

Health promotion

Health promotion information was available although limited. On ward rounds the multidisciplinary team interacted with patients to inform them of daily activities to promote health such as importance of being active and the benefits of pain relief. Follow up clinics took place on both units and were an opportunity for ongoing assessment and providing advice on rehabilitation and health promotion.

Relatives were kept informed of treatment, included in rehabilitation planning welcomed with extended visiting hours on both units. Assisted eating by relatives could be encouraged, however, most patients on cardiac ICU were elective patients so wanted to get up and get moving, so this was done on an individual basis.

Trust leaflets were available outside of the units, giving information on a number of health-related subjects such as delirium, deep vein thrombosis, non-invasive ventilation, complaints, infections such as C. Diff and MRSA, and learning disability services. Display boards explained issues related to tissue viability or pain control.

Consent, Mental Capacity Act, and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. The trust told us that the mandatory consent training module included the mental capacity act and deprivation of liberty safeguarding. Current training rates for the consent module for medical staff were 78% and for all critical care nursing staff it was 99%.

Ward rounds and multidisciplinary meetings demonstrated that staff worked with relatives and patients for shared decision making and best interests. We observed staff discussing consent with patients on ward rounds. Staff ensured this was communicated clearly and understood the importance of shared decision making with patients.

Staff we spoke with were knowledgeable about consent and capacity. Doctors told us that they completed assessments for patients who lacked capacity and described what action was taken when a patient lacked mental capacity. Consent was recorded in the patients' notes. On cardiac ICU one staff nurse talked through the delirium assessment process. E-learning modules were completed for Mental Capacity Act and Deprivation of Liberty Safeguards. They demonstrated a good understanding of consent and capacity.

We were told about an example of learning from incidents, where there was an incident that related to the Mental Capacity Act (MCA) at another trust hospital. There was an updated mental health module included on the Foundation to Critical Care Programme training that included MCA and the Deprivation of Liberty Safeguards.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. We observed that nurse interaction with patients was kind and caring. Nurses were confident and caring for their patients. On general ICU we spoke to the relative of a patient who told us the staff were caring towards their relative and in interactions with them.

On cardiac ICU, clinical areas appeared calm with staff interacting with patients and respecting privacy as appropriate. On the ward round on cardiac ICU, we observed that medical staff always introduced themselves and gave a good explanation of what had happened and of the plan of care going forward. Privacy and dignity was maintained at all times. Patients were constantly reassured and treatment plans were explained to them by doctors and then reiterated by nursing staff. The ward round was controlled and calm.

On the cardiac ICU, cleaning was in progress during the ward round but avoided areas where doctors were talking to patients thus being respectful of patient privacy and dignity.

On general ICU we spoke to the relative of a patient who very were complimentary about staff and happy about the care and treatment they had received.

Emotional support

Staff provided emotional support to patients to minimise their distress. On ward rounds and in multidisciplinary meetings we found that psychological and emotional wellbeing were considered when discussing patients. For instance, on cardiac ICU we attended the multidisciplinary meeting. A long stay patient was discussed. Environment was considered to help change the patient mood and reduce anxieties and psychological need.

A 'what matters' board had been introduced on to cardiac ICU. This was placed on the headboard where relatives' patients and nurses could write patient's likes, dislikes, hobbies, what mattered to them such as pets, football team, sport, pastimes and improve their emotional wellbeing during admission.

Nursing staff told us that emotional support was important part of caring for patients. There were many thank you cards on wards' noticeboards, they documented that patient's emotional and psychological wellbeing had been considered in the way they had been treated and cared for. A nurse told us the cards were rotated as there were more than the noticeboards could hold. We were also told it made the teams feel proud of their work.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We observed that staff were knowledgeable regarding patient treatment and care in their interactions with patients and relatives. Patients and relatives told us they felt involved in their care. On general ICU a relative of a long-term patient told us they were happy with the treatment and care provided and felt involved. Staff had kept them well informed of the treatment and care. Another family told us they sometimes felt unaware of what was going on with care probably because the family rotated visits on different days. However, they felt able to ask and were always updated when they did.

During cardiac ICU's multidisciplinary team meeting, when a long stay patient was discussed, family views were considered and suggestions made regarding how to involve them more. Patients were involved in their weaning plan. Staff were adapting patient's care to their needs and personality.

One patient told us their family had been able to visit the unit easily. We were also told the unit could be a little noisy due to the patient in the next bed. Staff had listened and been helpful, but that there was not much more the staff could do.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. Senior staff told us that accommodation for relatives was available on site for those who were in need. The cardiac ICU had two keys that they paid for, meaning they had two rooms at their disposal. Accommodation was in small en-suite bedsit type rooms.

On general ICU, facilities for relatives included a quiet room. We spoke to the relative of a patient who had stayed a few nights in the quiet room located just off the waiting room and were now staying in the nearby hospital accommodation with the cost being subsidised by the medical directorate who were originally treating them. They were happy with the visiting times of 10am to 10pm and happy to step out when care was required.

There were seats outside of the general ICU and a vending machine for relatives' use was also located in the area just outside the unit. This had been installed following consultation with relatives. On cardiac ICU visiting hours were 11am to 12.30pm and 3pm to 8pm. The ward wanted to respect protected mealtimes. However, we were told this was flexible and could be free visiting if a patient was at the end of life or seriously unwell. Patients could get a 'carer card' which meant they could come and go as they please. Relatives were offered tea and coffee where needed. Relatives could also get a sandwich from the ward.

On general ICU a bereavement box was available that contained condolence cards, small envelopes for locks of hair and equipment for taking hand prints of loved ones following death.

One relative we spoke with told us that car parking was too expensive and that often, there was nowhere to park. Their family visited regularly and wished there was some concessions available for critically ill patients. We were told by senior staff that regarding car parking, concessions were available for relatives of patients at the end of life and those who were very sick. We were told this was a finite resource. We were given an example where relatives of one current patient could park in the car park free of charge. This involved letting security know and there was a card to display, so as to avoid penalty.

On cardiac ICU there were photos of staff on noticeboards for better identification, including of medical staff. Visitor information could be found just inside the main doors including contact numbers, nursing information and chaplaincy information. Visiting times were stated. There were also trust leaflets in the main area providing information on a range of topics such as complaints, MRSA, delirium, and learning disability.

Meeting people's individual needs

The service took account of patients' individual needs. We attended ward rounds and multidisciplinary meetings on both cardiac and general ICUs. Patients' individual needs were identified and plans were formulated to meet those needs. Family views were also considered. Staff were adapting plans to meet individual needs such as with airway, disability, religion, speech and language, diet, and physiotherapy.

On cardiac ICU there was information at the nursing station on how to access the tissue viability nurse, safeguarding and mental health team. We were told that the psychiatric liaison team were based at Charing Cross Hospital and a psychiatric liaison nurse was based at Hammersmith Hospital. If there was a patient with a mental health history or showed signs of mental health

issues, they were called over. We were told they came within a couple of hours and will follow up if they had any concerns. We were also told that funding was available for an healthcare assistant to sit with a patient if needed, and a mental health nurse if needed.

Delirium is a condition often seen in ICU where patients can become confused and agitated. On cardiac ICU there was a 'delirium champion' and a team of five nurses who started a delirium Quality Improvement project at the start of 2018. An awareness day was held in March 2018, with a display in the renal building which contained three units, including the renal unit as well as cardiac ICU. This included showing a delirium awareness video to team members and a teaching session for all staff on the unit over four sessions. Policy and practice on sedation and delirium were updated over the same period. Assessment and education methods were also updated. A three-month data collection process looked at the demographic of dementia, social history such as alcohol consumption and whether surgery had taken place prior to diagnosis. On discharge, the psychiatric liaison nurse who was based at HH and carried out clinics for patients on explanation upon discharge. There was a poster on display on the unit that focussed on the aims of the project but did not give a review of results or of what had been achieved. There was no publicising of the results and no stated baseline for further improvement.

On general ICU, as part of working with a patient experience group, a 'what matters' board was created. This was placed on the headboard where relatives, patients and nurses could write on it what the patient's likes and dislikes were. Also, what were their hobbies, what mattered to them such as pets, football teams, sports, and pastimes. This had benefits such as when the patient might be confused, including delirium, so staff know how to be compassionate such as when engaging with the patient about subjects they could relate to such as gardening. Music for patients was also introduced on the unit. Colouring books with colouring pencils were introduced too. The books contained pictures of beds and ward settings for improved familiarity.

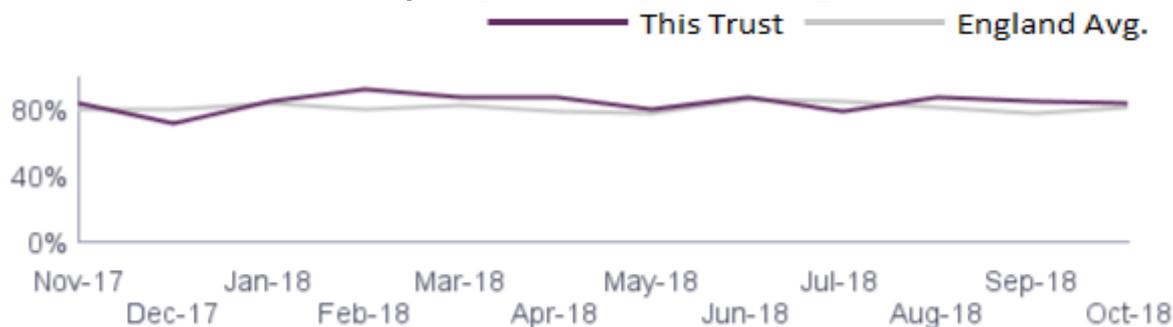
Staff had access to expert advice and assistance within the trust for patients with learning disabilities. Communication aids such as picture boards were also available for patients with learning disabilities.

On cardiac ICU, there was a telephone follow up by a staff nurse. Patients were asked about different experiences of the unit such as with communication, visibility, privacy and dignity. They were also asked about any symptoms including the pain assessment and mobility, any respiratory and cardiac issues.

Access and flow

People could access the service when they needed it. Arrangements to admit, treat and discharge patients were in line with good practice. From November 2018 to October 2018, Imperial College Healthcare NHS Trust has seen adult bed occupancy about the same as or slightly higher than the England averages for 10 months out of the 12-month period. In the latest period, October 2018, performance for adult bed occupancy was 84.6%, compared to the England average of 80.8%.

Adult critical care Bed occupancy rates, Imperial College Healthcare NHS Trust.



Note: data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

For Hammersmith Hospital, General Adult Critical Care Unit at Hammersmith Hospitals, there were 4,400 available bed days. The percentage of bed days occupied by patients with discharge delayed more than 8 hours was 0.5%. This compares to the national aggregate of 4.9%. This meant that the unit was not in the worst 5% of units. The figure in the 2015/16 annual report was 1.3%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
4,400 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	1.3%	0.5%	4.9%	0%	Not in the worst 5% of units

(Source: Intensive Care National Audit Research Centre (ICNARC))

For Hammersmith Hospital, General Adult Critical Care Unit at Hammersmith Hospitals, there were 382 admissions, of which 0.0% had a non-clinical transfer out of the unit. This was within expected range. The figure in the 2015/16 annual report was 0.0%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison
382 admissions	Crude non-clinical transfers	0.0%	0.0%	0.4%	0%	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

For Hammersmith Hospital, General Adult Critical Care Unit at Hammersmith Hospitals, 0.0% of admissions were non-delayed, out-of-hours discharges to the ward. These are discharges which took place between 10:00pm and 6:59am. This was within expected range. The figure in the 2015/16 annual report was 1.1%.

Number of cases	Metric	2015/16	2016/17	National aggregate	Aspirational Standard	Comparison

198 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	1.1%	0.0%	1.9%	0%	Within expected range
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(Source: Intensive Care National Audit Research Centre (ICNARC))

The bed manager for the cardiac directorate coordinated all access and flow issues for the directorate. We were told that apart from extreme circumstances, out of hours transfers were non-existent. Transfers were done on a need basis only. All transfers ideally took place before 5pm. One bed within cardiac ICU was kept empty when on call for aortic dissection to avoid any non-clinical out of hours transfer. Senior staff told us that flow in and out was dependent upon the whole flow and step down in cardio thoracic unit. Non-clinical transfers did not take place. However, this was not audited.

On cardiac ICU the length of stay was up to and more than 4 days. Extubation was within 4 to 5 hours following surgery so a fast recovery system in line with guidance from the National Institute for Health and Care Excellence (NICE). We were told they did not really get delayed discharges and there were no outlier patients on cardiac ICU, who kept post-operative patients until they were stabilised and able to go to the cardiology wards. On average there were four to five level 2 patients with the rest level 3 (out of 16). Some were post-operative, some cardiac arrests, some multiple organ failure but principally patients were heart patients. General ICU was the only unit set up to look after tracheostomy patients, with staff having the appropriate training.

Multidisciplinary meetings took place on general ICU every Tuesday where two or three patients were discussed who may have complex needs or complicated discharge. The team could utilise the 'complex discharge team' who were trust wide and assisted with aspects of complicated discharges such as complex post discharge support needs, placements, and funding issues. On general ICU we were told that they occasionally had to cancel operations due to there being no beds available and level 2 patients were sometimes transferred to wards. Cardiac ICU would sometimes be able to take patients, theatre recovery was used and the anaesthetic rooms were also used occasionally. The critical care outreach team worked with outliers to support this and also brought patients to their attention through attendance at ward rounds and safety huddles.

The researcher responsible for the collection of data told us they started the clock on discharge when they received an email from the lead nurse informing them of the discharge from critical care. As part of the critical care network they followed up patients until they were discharged. The follow ups were included in their data. However, this did not include the cardiac ICU.

The critical care outreach team (CCOT) monitored the number of patients were seen by them after discharge from ICU, the number of patients referred and how many were seen by them within 24 hours.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. From November 2017 to October 2018, there were 10 complaints about critical care, with nine of these closed. The trust took an average of 33 working days to investigate and close complaints. This is in line with their

complaints policy, which states complaints should be completed in an average of 40 working days. There were seven complaints, with a main them of clinical treatment at Hammersmith Hospital. One complaint at Hammersmith Hospital relating to care needs not being met had been open for 35 working days at the time of reporting.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From November 2017 to October 2018 there were four compliments within critical care at Hammersmith Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Nurses and unit leads tried to resolve issues in real time to the satisfaction of patients and relatives. They were also able to escalate to the nurse in charge if this was not possible. PALS were available to all and people were made aware of the official complaint route too. The lead nurse could recall one complaint in the last year due to the loss of private property which they took as an unfortunate system failure that they learnt from. Formal complaints were discussed at the directorate's quality and safety meeting as well as at band 7 and 8 meetings. Learning was shared through team meetings and emails.

The trust told us that the only complaint referred to the PHSO within critical care areas last year was for De Wardener ward (renal HDU).

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities. However, there appeared to be a lack of collaborative working across the three units providing critical care. There were three units within the hospital that had level 2 or 3 funded beds. All were managed from different directorates. The general ICU sat within the critical care directorate while the cardiac ICU sat within the cardiothoracic directorate. Both belonged to the trust wide division of surgery, cancer, and cardiovascular sciences. De Wardener, the renal ward where there were four level 2 beds, sat within a different trust division as well as different directorate. As a result, all three were led by different general managers and nurse leads.

Both general and cardiac ICUs were intensivist led. Both units operated a consultant of the week model which meant the team's intensivists rotated leadership of the unit with appropriate handovers in between. Medical care for both was led by the critical care directorate. The renal ward was not intensivist led and came under the medical care division.

The general ICU was led by a matron. The lead nurse reported to the trust wide senior nurse for critical care. Both the critical care and cardiovascular directorates reported to the trust wide division of surgery, cancer and cardiovascular sciences which was led by a director of nursing and divisional director.

There was not a band 8a in place on cardiac ICU at the time of inspection. We were told that a new matron was due to start the week following our inspection on an interim basis. In the meantime, the lead nurse for the directorate of cardiac sciences was taking charge of the unit and had been overseeing its management since January 2019.

Considering the three different directorates and leadership structures, we found little assurance that all level 2 and level 3 patients (particularly the ones on De Wardener ward) had sufficient oversight on an on-going basis. There appeared to be a lack of close collaborative working or oversight between the different teams across the three units.

Vision and strategy

The trust was in the process of developing a vision and strategy for what it wanted to achieve with its critical care service. Critical care was now two years old as a directorate. Prior to this they came under the directorate of surgery and anaesthetics. The current position was described as better because there was a better focus on what a critical care service needed and a better understanding of how it fitted in to the trust. It also had a voice at more senior level as there was a trust wide critical care senior nurse, general manager and lead clinician so were represented at board level. Trust leads were looking at a review of strategy. Currently the directorate did not have its own. We were told the service was in a process of developing their strategy and the documented strategy was awaiting ratification at the time of our inspection.

Leaders were able to explain the service's strategy to us. The strategy emphasised the two main priorities of the directorate which was to develop services to be fully comprehensive, such as expanding outreach service to include an out of hours service and to reconfigure the trust's high dependency units and intensive care units to be under the same directorate. The vision of the service included providing high quality care, maintaining a high research profile, and delivering high quality general and specialist services. The service had a workforce steering group which focused on the service's aims to develop new roles such nurse practitioners and advanced critical care practitioners.

The directorate leadership team also planned to focus on ensuring compliance with the Guidelines for the Provision of Intensive Care Services standards across all of the trust's critical care units. In order to achieve this, there was a critical care delivery group which was responsible for ensuring a trust wide multi-disciplinary approach to critical care.

A critical care steering group was established in Hammersmith Hospital four weeks before our inspection. This was to identify a strategy and an appropriate governance structure for critical care services on the hospital site. Currently this conversation did not include De Wardener ward.

We were told the trust values were care, achievement, kindness, and expert. These values were interwoven in to appraisals.

Culture

Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. It was reported that the culture and the performance of the cardiac ICU had improved since the nurse lead for the cardiothoracic directorate had been based in cardiac ICU and overseeing the unit since the beginning of January 2019. This was a role familiar to them from a previous role within the hospital. They described their approach as having an understanding towards staff and making patient care a priority. We were given examples where kindness and understanding had been given to staff to promote a more compassionate culture on the unit. Staff also told us this was the case. They told us they felt they worked well as a team and were happier than they had been for a while. Nurses told us that the best thing about the unit was teamwork and support. Nurse managers and leads were visible. Nurses were proud of their team work and that was what made nurses stay. The nurse lead was described as approachable and they instilled a culture where priority was to patients and staff.

On general ICU, staff told us that there was a good working culture. We were told that when nurses were rotated to the Hammersmith Hospital general ICU, regular comments were that it was a supportive and friendly unit where people were accessible. There was a 'lead nurse clinic' staff drop in every two weeks for staff to have clear time to talk about any issues they wanted to bring.

As a result, we were told, it created more positivity. All visiting professions such as physiotherapy, medical and dietetic staff commented on it being an easy unit to work on. Consultants were approachable and the lead clinician considered the welfare of staff by checking in with people if they were busy or stretched. The transport links were described as down side to working at the hospital.

The critical care outreach team (CCOT) told us they felt their management was supportive and they had developed a relationship with the site since their inception 18 months ago. We were told their attitude was that they were there to support ward teams and had developed relationships based on this. As a result, they felt they saw a lot more support for us from ward teams.

Governance

The trust used a systematic approach to governance and continually improving the quality of its services. The trust had a critical care delivery group established in accordance with national guidance and chaired by divisional director or divisional director of nursing. The group oversaw the trust wide development and performance of critical care services within the directorate. Quarterly reports from group's meeting were submitted to divisional committee meeting, then to the executive quality meeting.

The critical care site leadership teams from across the trust attended a critical care directorate board meeting every month which was chaired by the clinical director. The meeting discussed clinical performance, quality, and safety issues such as delayed discharges, staffing including outreach, research, and education as well as finance.

Critical care directorate quality and safety meetings were attended by the site leadership teams. It was chaired by the senior nurse for the critical care directorate. Topics that were discussed included items on the risk register, serious incidents, performance data, updates on mortality and morbidity meetings, complaints, patient feedback, audits such hand hygiene and medicines management, quality improvement presentations and guidelines. We saw that audit results had been embedded in the minutes of these meetings.

The directorate leadership team also attended divisional directorate meetings where incidents were fed back up to divisional level. Clinical governance half days which were held bimonthly. Feedback from learning from incidents were discussed as well as new quality improvement projects. Monthly reports were written for all directorates and fed up to divisional boards. The general ICU and the cardiac ICU both belonged to the trust wide division of surgery, cancer, and cardiovascular sciences where there were monthly divisional board meetings that included all directorates within the division; cardiothoracic, critical care, theatres, and anaesthetics. Renal sat within the medical division.

On general ICU unit meetings took place every two months. The unit received a monthly report with performance and risk data which were addressed in different ways such as band 7 meetings. Items could be addressed as part of their 'big 4' – four issues to tackle each month on each unit. This changed depending on what was happening month to month. This could also include trust or directorate wide issues where shared. Learning could also be included. For instance, in December 2018, a medicines management review took place. Looked at storage, medicines fridges, management of controlled drugs and consistent practice. There was a free agenda. There was also feedback from monthly band 7 meetings and identify new risks and tasks.

The critical care outreach team (CCOT) matrons across the trust met monthly. The critical care outreach team (CCOT) had recently began a monthly team meeting. ICU covered their bleeps during the meeting.

Management of risk, issues, and performance

The trust had effective systems for identifying risks and planning to eliminate or reduce them. There were directorate risk registers that were reviewed as part of the cross-site directorate quality and safety meeting. The senior nurse maintained the risk register. There were several risks that we came across while on site that were on the risk register. The provision of airway cover out of hours was a risk on the register for the hospital. An airway trained registrar had now been appointed to mitigate this risk. However, the whole hospital was not assured as they were not working as part of the critical care outreach team. Provision of on call, out of hours anaesthetists was also on risk register. Currently, there was only one for whole hospital. At the time of our inspection, there was a 17% vacancy rate for nursing staff on cardiac ICU which was on also the risk register as part of their non-compliance with the Guidelines for the Provision of Intensive Care Services (GPICS) standards. Another risk register item for cardiac ICU was that their audit cycle was not covering as many items as general ICU. This became known as they were compiling information for their CQC inspection and talking to general ICU. General ICU were short of two intensivists, which combined with an increase in workload when upper GI oesophagostomy surgery moved to the hospital in May 2019 represented a risk.

Senior trust managers identified their top risks regarding critical care at Hammersmith Hospital: Staffing, including the provision of nursing and consultant numbers, non-compliance with GPICS standards and tracheostomy services outside of ICU.

A critical care steering group was established in Hammersmith Hospital five weeks before our inspection. This was to identify a strategy and an appropriate governance structure for critical care on the hospital site. There were working groups within this structure, looking at compliance with the Guidelines for the Provision of Intensive Care Services (GPICS) standards, published by the Faculty for Intensive Care Medicine. GPICS standards were seen as the definitive reference source for planning and delivery of UK Intensive Care Services. It had been identified that staffing numbers on cardiac ICU were below the level of compliance, particularly because they were also taking on a higher number of level 3 patients. We were told they were trying to work to the GPICS staffing standards but were aware of their shortfalls in relation to this. The critical care steering group began in January 2019 and were looking at different workstreams on GPICS compliance: finance, patient flow, IT, and workforce. We were told they were working to get a paper to the board by June 2019. The main aims of the steering group were to look at how to deliver GPICS and the future of the service. However, De Wardener ward, where four level 2 beds were located, were not included in this work.

The work of the steering group also encompassed whether it was best for cardiac ICU to remain sitting within the cardiothoracic directorate or transfer to the critical care directorate. Both were within the same trust division of surgery, cancer, and cardiovascular sciences. Again, De Wardener ward, where the renal level 2 beds were located, were not included in this conversation.

The directorate scorecards looked at beds, training, staffing and all aspects of work. This covered directorates trust wide but was not broken down by unit.

On general ICU, a safety performance, quality research (SPQR) meeting took place monthly. This was the meeting that looked at practice and quality issues such as audits and incidents. The SPQR meeting had an open invitation for all as part of multidisciplinary working and for creating good whole unit discussion. An audit register was maintained trust wide within critical care to oversee what was being audited and all nurses and doctors can add to it. Following audits, action plans were worked through. For instance, the noise at night was a trust wide project on minimising

noise at night time. One of the band 6 nurses was working on it for general ICU. Actions included minimising lighting, alarms, fluid bags being opened by patient beds and other noise sources.

The 'big 4' was created in March 2018 to improve the unit and help patients. They identified four priorities for units from nurse comments. Cardiac ICU's current four were teamwork, respect and help each other, think delirium, and 6 C's (caring, compassionate). Audits were completed monthly on harm free care, hand hygiene, saving lives, food nutrition, venepuncture, and falls. Other audits were also completed.

All staff completed team days twice a year for each team. This covered team brief, operational and team business. Standing agenda items included statutory and mandatory training checking, some training as a group, new equipment training and team building. There was also training in the online system that collected quality and safety data in four parts; hand hygiene, care bundles, saving lives and medicines matter. Hand hygiene and medicines matter were submitted every week. Care bundles and saving lives were collected every month. They were reported on monthly in the harm free care report.

ICNARC data was only collected from the general ICU. Both the level 2 renal beds and cardiac ICU were excluded from this data collection. Data was presented at team meetings and at training days where it was used as part of discussions.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. A digital healthcare information system was used on cardiac ICU. On general ICU, an intensive care information system was used. We were told there were conversations regarding the two units using compatible software. The rest of the trust were using the digital healthcare information system. Patients came from wards and went back to wards, who were all using the healthcare system therefore continuity of documentation. There was also currently some debate about where cardiac ICU sat within directorates which may decide which system was to be used.

On general ICU all assessments were made and recorded using the electronic system. On cardiac ICU nursing and medical documentation was electronic but summaries of any plans of care were made on the paper chart such as any special instructions.

All staff including student nurses were able to access the information systems by smartcard, where general information could be accessed such as guidance and resources. Staff log in was dated and timed electronically via smart cards.

All ward rounds, medication, investigations, and nursing care documentation were recorded on the information systems. We attended ward rounds and handovers. This included handover from night teams at ward rounds where information regarding patients was shared appropriately.

Engagement

The service engaged well with patients, relatives and staff. Patient feedback was taken on tablets which were given to patients and relatives prior to discharge to ask questions such as; was it clean and tidy, was it respectful, did we introduce ourselves, did you get information, were you informed of discharge, noise at night, visiting hours okay. All results and any issues identified were shared with staff. Outcomes were reviewed at cross site matron meetings.

There was a patient experience user group on general ICU led by a band 7 nurse. Patients were invited back three months after discharge and given the opportunity to sit down with the group and review their experience. We were given examples where feedback from this group had resulted in several initiatives being introduced such as a change such as visiting hours had been extended to 10am to 10pm (with exclusions made for ward rounds and care). Another was installing glass in the unit door so that people buzzing to get in could see that staff were busy and that no one was on reception, thus easing frustration of not being responded to. A vending machine was also installed (located just outside the unit entrance) for closer availability of drinks and snacks. The patient experience group convened every three months if possible. Sometimes there was not sufficient uptake for this. Also as part of this work a 'what matters' board was created. This is placed on the headboard where relatives, patients and nurses can write on it what matters to them such as pets, football team, sport or pastimes, which had benefit as when a patient was confused, including delirium, staff know how to be compassionate such as talking to the patient about gardening.

On cardiac ICU there was a telephone follow up by a staff nurse, checking how patients were including their pain assessment and mobility, any respiratory issues and cardiac (palpitation). The follow up clinic was a QI project started in February 2019 and planned to take place monthly but depended on the number of patients as they gave them the option to be involved.

Learning, continuous improvement and innovation

The hospital was committed to improving services. On general ICU we learnt about the 'sleep helps healing in hospitals'; "shhh project". This was a trust initiative picked up by a band 5 and 6 nurse aimed at minimising noise at night time. Actions included minimising lighting, alarms, fluid bags being opened by patient beds and other noise sources.

On general ICU a bereavement box was available that contained condolence cards, small envelopes for locks of hair and equipment for taking hand prints of loved ones following death. Also on general ICU we learnt about the wellbeing meeting every Friday for staff which was expanded wider to all related services that critical care had contact with. It was reported to have improved communication across sites with the nurse educator getting trust recognition for this.

There was a patient experience user group on general ICU led by a band 7 nurse. Patients were invited back three months after discharge and given the opportunity to sit down with the group and review their experience. We were given examples where feedback from this group had resulted in several initiatives being introduced such as a change such as visiting hours had been extended to 10am to 10pm (with exclusions made for ward rounds and care). Another was installing glass in the unit door so that people buzzing to get in could see that staff were busy and that no one was on reception, thus easing frustration of not being responded to. A vending machine was also installed (located just outside the unit entrance) for closer availability of drinks and snacks. Also as part of this work a 'what matters' board was created. This was placed on the headboard where relatives, patients and nurses can write on it the patient's likes, dislikes, hobbies, what matters to them such as pets, football team, sport, pastimes etc. this has benefit as when the patient is confused including delirium staff know how to be compassionate such as talking to the patient about gardening.

The trust was involved in national and international research projects including research looking at antibiotics, barriers to mobilisation, a study into the reversal of septic shock with a beta blockade, early vasopressin use in septic shock (VANISH), and levosimendan for the prevention of organ failure (LeoPARDS).

Senior leaders and staff told us they were pleased to have resolved leadership challenge on cardiac ICU and that it was good to be developing a positive working culture for the benefit of patients and staff. On cardiac ICU there was a delirium champion and a team of five nurses who started the delirium project at the start of 2018 as a QI project. An awareness day was held in March 2018, with a display in the renal building which contained three units, including the renal unit as well as cardiac ICU. This included showing a delirium awareness video to team members and a teaching session for all staff on the unit over four sessions. Policy and practice on sedation and delirium were updated over the same period. Assessment and education methods were also updated. The critical care pain observation tool and the Richmond Agitation Sedation Scale were currently being introduced following teaching sessions. A three-month data collection process looked at the demographic of dementia, social history such as alcohol consumption and whether surgery had taken place prior to diagnosis. There was a poster on display on the unit that focussed on the aims of the project but did not give a review of results or of what had been achieved. There was no publicising of the results and no stated baseline for further improvement.

Services for children and young people

Facts and data about this service

The main base for children's services is at St Mary's Hospital (SMH), with some activity also at Queen Charlotte & Chelsea Hospital (QCCH) and Hammersmith Hospital (HH).

The trust continues to provide emergency, non-elective and elective inpatient services for infants, children and young people.

The trust provides end-to-end paediatric care from birth through to transition into adult services, combining integrated community services with secondary hospital care and 29 specialist commissioned services that include a paediatric intensive care unit (PICU), acute general paediatrics, a paediatric emergency department, diabetes, infectious diseases, clinical haematology and bone marrow transplant (BMT), neurology, allergy, rheumatology, nephrology and dermatology.

The surgical specialties include: ENT (ear, nose and throat), urology and ophthalmology. In addition, the trust collaboratively works with adult divisions in major trauma, plastics and vascular services. It also provides level 2 and level 3 neonatal critical care at SMH and QCCH.

Ambulatory services (outpatient and day-case) are also provided at SMH and QCCH. At HH this is the David Harvey unit; at SMH there is paediatric outpatients, a paediatric short stay unit and a paediatric haematology day unit. SMH also provides paediatric inpatient beds on PICU, Great Western ward and Grand Union ward.

(Source: Routine Trust Provider Information Request (RPIR) – Context acute)

The trust has 115 inpatient paediatric beds across the two main sites:

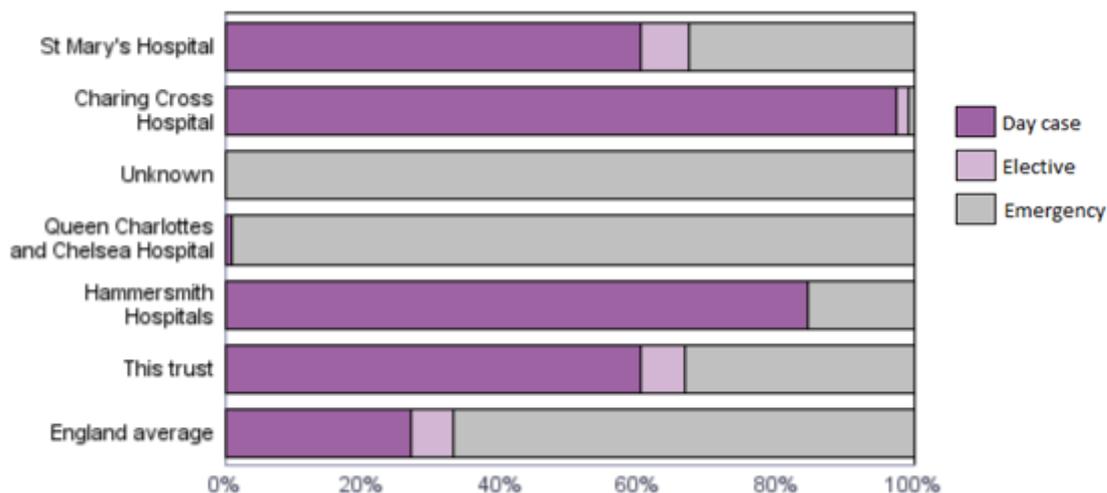
- St Mary's Hospital: 91 beds are located within nine wards/units, with an additional five sofas and one isolation cubicle at the paediatric haematology day unit.
- Queen Charlotte's and Chelsea Hospital: 24 beds are located within the neonatal intensive care unit (NICU)
- Hammersmith Hospital: There are no inpatient paediatric beds at Hammersmith.

(Source: Routine Trust Provider Information Request (RPIR) – Sites tab)

The trust had 12,454 activity spells within children's services from August 2017 to July 2018.

Emergency spells accounted for 33% (4,137 spells), 60% (7,498 spells) were day case spells, and the remaining 7% (819 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from August 2017 to July 2018, Imperial College Healthcare NHS Trust.



Total number of children’s spells by Site, Imperial College Healthcare NHS Trust.

Site name	Total spells
St Mary's Hospital	11,853
Charing Cross Hospital	343
Unknown	139
Queen Charlottes and Chelsea Hospital	106
Hammersmith Hospitals	13
This trust	12,454
England Total	1,125,448

(Source: Hospital Episode statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.

Staff received mandatory training on a rolling annual programme which was provided through a mix of practical sessions and e-learning. Topics included: venous thromboembolism, medicines management, health and safety, infection prevention and control and blood transfusion. Due to long term staff sickness and maternity leave, not all staff had completed all mandatory training sessions at the time of inspection.

There was a sepsis protocol in place and staff received additional education days on sepsis awareness. We spoke with staff on how to spot signs of sepsis and all were confident with how to use the ‘Sepsis 6’ protocol.

We were concerned on inspection that not all staff seemed to have received formal face-to-face resuscitation training. Following inspection, the trust provided data to us to indicate that all administrative staff had completed the appropriate level of basic life support (BLS) training.

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at Hammersmith Hospital for qualified nursing and midwifery staff in children and young people's services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
ANTT	5	5	100.0%	85%	Yes
Blood Transfusion	5	5	100.0%	85%	Yes
Conflict Resolution	5	5	100.0%	85%	Yes
Consent	5	5	100.0%	85%	Yes
Fire Safety Awareness	5	5	100.0%	85%	Yes
Health and Safety	5	5	100.0%	85%	Yes
Invasive Procedures Policy	5	5	100.0%	85%	Yes
Medicines Management	5	5	100.0%	85%	Yes
Moving and Handling Level 1	5	5	100.0%	85%	Yes
Resuscitation Level 2	5	5	100.0%	85%	Yes
Venous Thromboembolism	5	5	100.0%	85%	Yes
Equality and Diversity	4	5	80.0%	85%	No
Infection Prevention and Control Level 2	4	5	80.0%	85%	No
Moving and Handling Level 2	4	5	80.0%	85%	No
Information Governance	3	5	60.0%	85%	No

In children and young people's services the 85% target was met for 11 of the 15 mandatory and statutory training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at Hammersmith Hospital for medical staff in children and young people's services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Equality and Diversity	17	19	89.5%	85%	Yes
Moving and Handling Level 1	17	19	89.5%	85%	Yes
Conflict Resolution	16	19	84.2%	85%	No
Resuscitation Level 2	16	19	84.2%	85%	No
Fire Safety Awareness	15	19	78.9%	85%	No
Health and Safety	15	19	78.9%	85%	No
Medicines Management	15	19	78.9%	85%	No
Blood Transfusion	14	19	73.7%	85%	No
Consent	14	19	73.7%	85%	No
Duty of Candour	14	19	73.7%	85%	No
Information Governance	14	19	73.7%	85%	No
Invasive Procedures Policy	14	19	73.7%	85%	No
Venous Thromboembolism	14	19	73.7%	85%	No
ANTT	13	19	68.4%	85%	No
Infection Prevention and Control Level 2	13	19	68.4%	85%	No

In children and young people's services the 85% target was met for two of the 15 mandatory and statutory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at Hammersmith Hospital for doctors in training in children and young people's services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Infection Prevention and Control Level 2	42	48	87.5%	85%	Yes
Blood Transfusion	41	48	85.4%	85%	Yes
Conflict Resolution	41	48	85.4%	85%	Yes
Equality and Diversity	41	48	85.4%	85%	Yes
Resuscitation Level 2	41	48	85.4%	85%	Yes
ANTT	40	48	83.3%	85%	No
Consent	40	48	83.3%	85%	No
Health and Safety	40	48	83.3%	85%	No
Moving and Handling Level 1	40	48	83.3%	85%	No
Information Governance	38	48	79.2%	85%	No
Nasogastric Tube Placement	38	48	79.2%	85%	No
Invasive Procedures Policy	37	48	77.1%	85%	No
Medicines Management	37	48	77.1%	85%	No
Fire Safety Awareness	36	48	75.0%	85%	No
Venous Thromboembolism	36	48	75.0%	85%	No

In children and young people's services the 85% target was met for five of the 15 mandatory and statutory training modules for which doctors in training were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

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.

Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk of or had been exposed to abuse. All staff we spoke with showed an in depth understanding of safeguarding children and what was required of them regarding reporting

concerns.

The trust had a dedicated safeguarding team that were based at St Mary's Hospital (SMH). The team could offer support and guidance to staff throughout the trust and would attend Hammersmith Hospital as required. Whilst on inspection, we saw posters for the safeguarding team advertised throughout children's services. These posters contained names and a central email address for the safeguarding team. Both junior and senior staff were aware of how to contact the safeguarding team should they have any queries. Staff demonstrated a clear awareness of the referral process if they had any concerns about a child and could provide examples of times when they had to refer a patient to the safeguarding team.

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as at February 2019 for qualified nursing and midwifery staff in the children and young people's services at Hammersmith Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults Level 2	5	5	100.0%	85%	Yes
Safeguarding Children Level 3	5	5	100.0%	85%	Yes

In children and young people's services at Hammersmith Hospital, the 85% target was met for both safeguarding training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for safeguarding training courses as at February 2019 for medical staff in the children and young people's services at Hammersmith Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Children Level 3	19	19	100.0%	85%	Yes
Safeguarding Adults Level 2	16	19	84.2%	85%	No

In children and young people's services at Hammersmith Hospital, the 85% target was met for one of the two safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as at February 2019 for doctors in training in the children and young people's services at Hammersmith Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Children Level 3	44	48	91.7%	85%	Yes
Safeguarding Adults	39	48	81.3%	85%	No

In children and young people's services at Hammersmith Hospital, the 85% target was met for one of the two safeguarding training modules for which doctors in training were eligible.

The service met the trust target for safeguarding children level 3 for all staff. Where staff were not compliant, this was due to staff sickness, maternity leave or long term leave. This meant that the service was compliant with the national guidance Child Safeguarding: Roles and responsibilities for Healthcare Staff.

The trust had a named consultant nurse lead for the safeguarding of adults and children and a named doctor for safeguarding children. The safeguarding children team were available seven days a week for advice. Information on how to reach them was available on the unit via posters on the wall. Staff could make referrals to the safeguarding team and told us they always received feedback on referrals. The safeguarding team had three band 7 staff who would screen and triage all referrals received before deciding regarding how to proceed. The safeguarding team offered two weekly drop-in sessions and staff were offered supervision at least once a year.

Female genital mutilation (FGM) was part of the level 2 and level 3 safeguarding training. Staff were provided with guidance on identifying FGM or children at risk of FGM. Reports could be made directly to the safeguarding children team followed by a comprehensive referral to the police and children's social care. In the year prior to our inspection there were no cases of FGM identified within children and young people's services.

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional. Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to children's social services, adult social services or the police should take place. In the year prior to our inspection the children and young people's service made 2,273 safeguarding referrals¹.

If there were any children in the outpatient department who did not attend (DNA) their appointment, this would be followed up by staff. Administrative staff would call the patient or their carer to find out why the reason behind the DNA. In the case of this not being attributable to an administrative error, the consultant in charge of the clinic would review their case notes, and if necessary, the safeguarding team would become involved.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The hospital had an infection prevention and control (IPC) policy and all staff knew how to access it. The ambulatory care unit had an IPC link nurse who acted as the link between the unit and the wider infection control team. Their role was to increase awareness of infection control issues and motivate staff to improve practice. Staff received mandatory training relating to IPC as part of their rolling training requirements. At the time of the inspection, 83.3% of nurses had received IPC training.

All clinical areas were visibly clean and tidy. The main entrances were clean and free from clutter.

¹ Please note, the safeguarding referrals could not be broken down by site. This figure is from the children's and young people's service across Imperial Hospital.

There was antibacterial hand gel available at the entrance to the unit and throughout the unit itself. Green 'I am clean' stickers were in use throughout the unit to let colleagues know at a glance which pieces of equipment and surfaces were ready to use. All staff adhered to Bare Below Elbow (BBE) dress code.

Hand-washing facilities and personal protective equipment (PPE) were available for staff to use. We inspected the linen storage areas and noted that there was sufficient clean linen available.

The play leaders we spoke with informed us of the toy cleaning system and we regularly saw members of the play team cleaning toys. Whilst we saw a tick list for toys being cleaned, the unit did not have a protocol for how and when the toys should be cleaned. Members of the play team did however show a good understanding of how to clean the toys and all toys were visibly clean.

We saw that weighing scales were cleaned in between uses and members of the outpatient department demonstrated how to clean equipment based there. All outpatient rooms contained adequate amounts of PPE and each had a stock of gloves and wipes.

In the ambulatory unit, cleaning was performed by an external company. This company would clean every day. We saw a standard operating procedure (SOP) that was dated for 2015 regarding how often the unit should be cleaned. When we questioned staff about this they informed us that they had a more up-to-date SOP, but that it wasn't currently displayed because they were already aware of it.

In the ambulatory unit, most patients were cared for within bays separated by curtains. If a patient had a suspected infection, they would be placed in the one single room on the unit. Whilst on inspection, this room was not in use but staff of all levels knew of measures they should take to reduce the risk of healthcare-associated infections. In the 12 months prior to our inspection there were no incidences of MRSA, *meticillin sensitive staphylococcus aureus* (MSSA), E.coli or (*Clostridium Difficile*) C.Diff in the unit.

We saw safe systems for managing waste and clinical specimens during inspection. There were an adequate number of sharps bins throughout the ambulatory unit. Staff used sharps appropriately; the containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use. Waste was segregated as per national guidance.

In the CQC Children and Young People's Survey 2016 the trust scored 8.5 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

All clinical environments that we saw were safe for the age of the children who used them. The paediatric department comprised of the nine-bedded ambulatory care unit and the children's outpatient clinic across the corridor. Both clinical areas contained waiting areas with toys, books and games consoles. All play and waiting areas were fit for purpose for children of all ages, from babies to older teenagers. All paediatric beds complied with national guidance on safe cots and beds.

The environment was generally safe for the age of the children who visited the service (75% of the patient base was under five years old). The antibacterial hand gel at the entrance to the ambulatory care unit was quite low and within the reach of small children. Both clinical areas were only accessible by reception staff buzzing in patients and visitors.

All portable equipment that we checked in the clinical areas had been recently serviced and labelled to indicate the next review date. We checked two resuscitation trolleys and found them to be fully stocked with both adult and paediatric equipment. Resuscitation equipment was available on both units and tamper seals were in place. Emergency drugs were available and within the use by date. Nursing staff carried out daily and weekly checks to demonstrate that equipment was safe and fit for use, with appropriate actions recorded to report any missing or expired items. However, the checklist did not make it clear how often each section of the trolley was due to be checked as per guidelines. Whilst the trolleys contained defibrillator paddles, there was only one defibrillator shared between both clinical areas.

Disposable equipment was easily available, in date and appropriately stored.

The service made efforts to provide suitable environments for children with autism and learning disabilities. The play specialists informed us that children who required quiet spaces were usually known to them and would be asked to wait in the quieter of the two waiting areas. Children who required sensory toys were provided with texture balls and sensory boxes. The service received funding to purchase a piece of portable sensory equipment that could be used for any child with need of it. This machine would provide lights and sounds for children undergoing lengthy tests such as echocardiograms. All toys and sensory devices were cleaned by the play team every day, or after each use.

Scales were regularly used and we saw that they had been calibrated and were within date.

The outpatient department had their main entrance blocked by building works during our inspection. We found that the service dealt with this well and had put up a mural to cover up the building works directly outside. The building work was due to be completed by the end of 2019, as far as senior staff were aware. In the meantime, the department was clearly signposted from the main hospital building.

All sluice rooms were kept locked when not in use and we saw posters for Control of Substances Hazardous to Health (COSHH) on the walls of the sluice, to act as a reminder to staff.

Breast feeding rooms were available for mothers on both ambulatory care and the outpatient department. The play specialist was also trained in assisting mothers with breast feeding queries.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

The trust used a paediatric early warning score system (PEWS) to ensure the safety and well-being of children. The system enabled staff to monitor several indicators that identified if a child's clinical condition was deteriorating and when a higher level of care was required. This was evidenced in the notes we saw. We saw 10 PEWS charts during our inspection and found that scoring was accurate with the correct age charts being used.

Patients that attended the ambulatory care unit were seen by either a GP or a consultant paediatrician, after being triaged by a nurse. During inspection, we saw this process and were concerned by the lack of checking of the patients waiting to be triaged in the reception area. Nursing staff told us that they would informally check on waiting patients as they moved about the department to ensure that none were deteriorating rapidly. When we raised this issue with senior staff, they discussed the issue with the clinical team. On the final day of inspection, we saw that

the role of the 'safe to wait' nurse had been introduced, meaning an allocated member of the team would check on waiting patients every 15 minutes, as well as reviewing the booking log. This role was in the process of being formalised.

If a patient presented who was critically unwell or had a suspected time sensitive condition, such as a haematoma, they would be stabilised and sent to St Mary's Hospital for further investigation. Staff from the neonatal unit (NNU) could be asked to attend the unit in the case of a critically unwell new born. Senior staff informed us that critically unwell children were taken directly to St Mary's Hospital as they had the facilities to care for those patients.

The service had escalation processes in place in the event of a seriously unwell child presenting as a walk-in. In the event of suspected sepsis, the service would utilise NICE guideline, 'Sepsis: recognition, diagnosis and early management and the Sepsis 6.' Senior staff provided examples of what actions they would take in cases of presumed sepsis. All senior staff were aware of the 'sepsis 6' guidelines and treating patients within the 'golden hour'. The service attracted a lot of junior doctors and GP trainees. The senior staff informed us that they would direct junior clinicians to NICE guidelines in the event of suspected sepsis. The junior doctors we spoke with corroborated this and informed us that they had constant support from senior doctors in the event of suspected sepsis.

The hospital performed case scenarios for various clinical risks. We saw the minutes for the recognition and initial treatment of sepsis case scenario. The scenario would outline the immediate equipment and medications needed for the condition, as well as the necessary clinical observations.

The Royal College of Nursing recommends that at least one member of qualified staff on the children's unit has an advanced paediatric life support (APLS) qualification. There was at least one member of staff trained in APLS when the unit was open. As well as there always being a consultant on shift, there was also a middle grade doctor on each shift. All paediatricians and registrars were trained in APLS. The paediatric site practitioner team provided 24-hour cover and were 100% compliant with APLS training.

The service had a bed management escalation policy in place which stated that staff at the Hammersmith site would take part in a bed escalation call-in four times a day. Whilst on inspection, we saw that this call took place at least twice daily. This ensured that all sites were aware of any patients that required immediate escalation. The bed management escalation policy contained an escalation flowchart that staff could refer to if need be. The Nurse in Charge (NIC) had oversight of the escalation process for the unit at Hammersmith. The NIC would review the situation on an ongoing basis with the lead on-site consultant. In most cases, if a child presented at the service and required escalation, they would be sent to St Mary's Hospital.

There were no inpatient beds at Hammersmith Hospital for children and young people. If a child presented with mental health issues, they would be admitted to St Mary's Hospital for observation. The mental health policy directed staff to escalate concerns to the safeguarding team in the first instance. Cases of self-harm were supposed to be discussed with a senior clinician, before a referral to children's social care. Senior staff told us that children tended to present at the unit with physical injuries rather than mental health concerns, so they did not often need to follow this protocol.

Out of hours, paediatric patients could make use of the urgent care centre at Hammersmith hospital. The urgent care centre informed us that it saw children for minor ailments, such as cuts and grazes. All staff at the urgent care centre had an urgent care background with a lot of paediatric exposure. There was a member of staff who was Paediatric Immediate Life Support (PILS) trained on each shift.

Both units had access to paediatric resuscitation trolleys.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The ambulatory care unit was staffed by three to four paediatric trained nurses every day.

Planned staffing levels were appropriate for the acuity and dependency of patients. The service used a tool recommended by NICE to plan daily staffing levels. In addition, there was one healthcare assistant (HCA) per shift. Staffing was monitored and reviewed on a day-to-day basis and agency and bank staff were used as required.

The trust reported their nursing staffing numbers below as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
Cross site	3.0	2.0	66.7%
Hammersmith Hospital	5.0	4.5	90.2%
St Mary's Hospital	218.0	190.6	87.4%
Total	226.0	197.1	87.2%

From November 2017 to October 2018, the trust reported a vacancy rate of 13.2% in children's services at Hammersmith Hospital. This was higher than the trust target of 10%.²

The band 7 ward manager post had been vacant since September 2018. Previously, this role had been cross site, but a new post had been created after consultation with staff and now each site had their own band 7. Although the post at St Mary's Hospital had been filled, the service was on the third round of recruitment for the Hammersmith Hospital post. Although senior staff told us that other service leads supported the unit as required, this left the unit with no senior nursing leader with oversight of aspects of the unit that were not directly clinical.

From November 2017 to October 2018, the trust reported a turnover rate of 0% in children's services at Hammersmith Hospital. This was lower than the trust target of 12%.³

From November 2017 to October 2018, the trust reported a sickness rate of 4.9% in children and young people's services at Hammersmith Hospital. This was higher than the trust target of 3%.

From October 2017 to September 2018, the trust reported 1,089 (7.0%) bank hours and 707 (4.5%) agency hours at the trust were filled by qualified nurses in services for children and young people. There were 6,621 hours (42.5%) that were not filled by bank/agency staff.

² Source: Routine Provider Information Request (RPIR) - Vacancy tab

³ Source: Routine Provider Information Request (RPIR) – Turnover tab

A ward breakdown is shown below:

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
David Harvey ward	15,574	1,089	7.0%	707	4.5%	6,621	42.5%

During the same period, the trust reported no bank or agency hours were filled by nursing assistants in services for children and young people.

The outpatient department was staffed by nurses from the ambulatory care. During our inspection, we found that there was no single nurse that took the lead for the outpatient department.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The ambulatory care unit was staffed by a paediatric consultant, two middle grade paediatricians, a GP trainee and a foundation year trainee daily. Although the unit was not inpatient, it did comply with the Royal College of Paediatrics and Children 2015 guidance: Facing the Future. The service ensured that at least one consultant was present for at least 12 hours a day and that all patients were seen by a consultant paediatrician.

The trust reported their medical staffing numbers below for St Mary's Hospital as of October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
Cross site	6.3	1.4	21.4%
St Mary's Hospital	108.6	106.5	98.0%
Total	114.9	107.9	93.9%

From November 2017 to October 2018, the trust reported a vacancy rate of 9.5% in children's services. This was lower than the trust target of 10%. There was no site-specific data provided for Hammersmith Hospital.⁴

From November 2017 to October 2018, the trust reported a turnover rate of 3.1% in children's services. This was lower than the trust target of 12%. There was no site-specific data provided for Hammersmith Hospital.⁵

From November 2017 to October 2018, the trust reported a sickness rate of 0.3% in children and young people's services at Hammersmith Hospital. This was lower than the trust target of 3%.

From November 2017 to October 2018, the trust reported no locum hours and 16,845 (4.8%) agency hours were filled in children's services. There were no hours that were not filled by locum/agency staff.

⁴ Source: Routine Provider Information Request (RPIR) – Vacancy tab

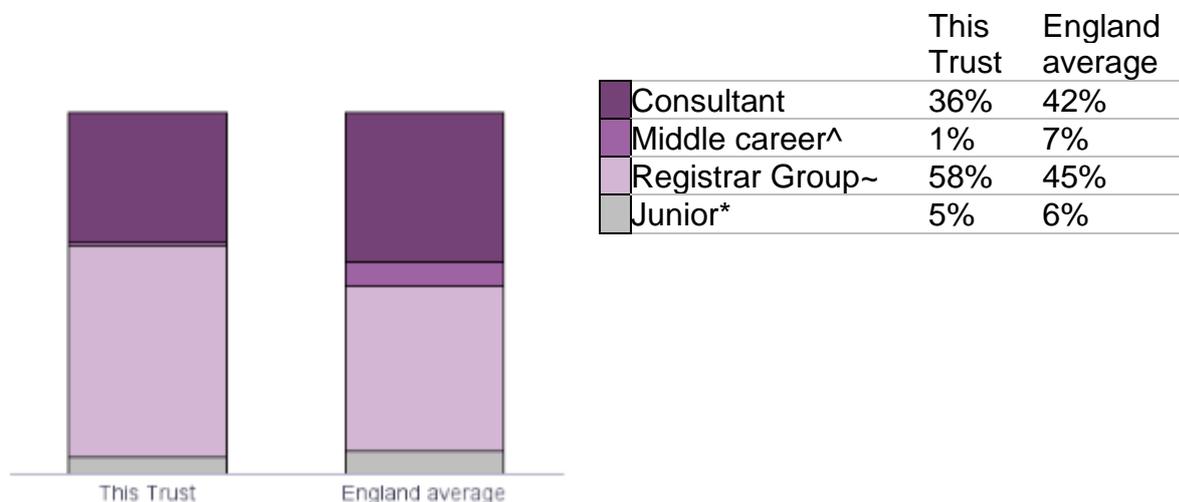
⁵ Source: Routine Provider Information Request (RPIR) – Turnover tab

Site/Ward	Total hours available	Agency Usage	
		Hrs	%
PICU - consultants	19,718	451	2.3%
PICU - Juniors	52,416	987	1.9%
NICU - consultants	40,976	2,232	5.5%
NICU - juniors	89,856	3,312	3.7%
Haematology - consultants	12,480	132	1.1%
Haematology - juniors	9,984	1,457	14.6%
Allergy - consultant	14,352	598	4.2%
General - consultants	33,571	3,636	10.8%
General - juniors	69,114	3,556	5.2%
General Surgery - consultants	9,984	375	3.8%
Total	352,452	16,845	4.8%

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

In September 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was about the same.

Staffing skill mix for the 148-whole time equivalent staff working in children's services at Imperial College Healthcare NHS Trust



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

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

The unit used electronic patient records to record patients' needs and care plans, medical decision-making and reviews, and risk assessments. Most records were electronic but there were

cases in which paper records were kept in the outpatient department. If a child did not attend, this would be noted and followed up by the administration staff initially, with further involvement from the consultant and the safeguarding team where required.

We reviewed 15 sets of electronic patient records and found that they all complied with the General Medical Council (GMC) and Nursing & Midwifery Council (NMC) standards for documentation. In all records we found that both allergies and weight were clearly documented.

At the time of our last inspection, we found issues with the availability of patient records for outpatient clinics. Since our last inspection this had improved. The service now had a fully integrated electronic record keeping system. Patients that were known to the service had their details stored on this electronic system. New patients had a new record created by the administrative team. We reviewed ten records in the outpatient department and found that they were all thorough and up to date.

The electronic records clearly indicated patients with enhanced needs, such as learning disabilities. This was also the case if a patient had an allergy. The electronic system would flag up if a healthcare professional attempted to exit the patient records without first inputting the weight and allergy status of a patient.

Discharge letters were generated for families and GPs, with copies forwarded to relevant additional health professionals. The administrative staff informed us that this information would be shared within 24 hours of discharge.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

Medicines were stored securely in locked cabinets within locked treatment rooms. Only authorised staff could access them. Fridge and room temperatures were monitored daily and staff could explain what action they would take when temperatures were not in range as per trust policy. IV fluids were stored appropriately in rooms with well-maintained temperatures.

Medicines were managed and stored appropriately on the unit. All drugs we checked were within date, with stickers used to indicate those nearing expiry.

The service stored, monitored and administered controlled drugs (CDs) in line with the Nursing and Midwifery Council (NMC) standards for medicines management. We saw that the CD cupboard contained a log book that showed that the drugs were checked both in the morning and the evening. No drugs were out of date.

The electronic patient records ensured that a staff member could not log out of a record without a child's weight and height being clearly documented. In the event of a child's height and weight not being recorded, a red flag would appear on the electronic record, prompting staff to input this data.

During our inspection we noted that the main medicines administered within the unit were pain relief medications. Due to the patient base that the unit saw, there was no need for a paediatric pharmacist.

Staff had access to copies of the British National Formulary (BNF) for children. This was available both online and in hard copies and we saw copies throughout the unit. Staff also had access to policies and training relating to medicines management (including the antimicrobial formulary), through the trust intranet.

In all records we checked, we found that all medicines administration records were completed accurately and contained allergies if necessary. Due to the nature of the unit and the patients seen, alternative routes of administration e.g. syringe pumps were not in use.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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 across the trust were aware of how to report and record safety incidents and near misses. All staff we spoke with were familiar with the electronic reporting system and how to navigate it. Staff we spoke with said they were encouraged to report incidents. They could give examples of when they had used the system to report appropriate incidents and changes resulting from learning from incidents. Learning from incidents was shared regularly in team meetings. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From January 2018 to December 2018, the trust reported no incidents classified as never events for children's services.⁶

Between November 2017 and February 2019, the service reported 71 incidents. Of these, the service reported 62 (87%) of all incidents as 'no harm' and six as 'low harm'. Most of the incidents (21) related to staff shortages, with the second largest incident theme relating to transport issues (9).

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in children's services which met the reporting criteria set by NHS England from January 2018 to December 2018. There was no site-specific data provided for Hammersmith Hospital and these appear to have occurred at St Mary's Hospital.⁷

Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. They were aware of their responsibilities with regards to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. In the year prior to our inspection there were no incidents that met the duty of candour criteria.

Safety thermometer

The service used safety monitoring well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harms and

⁶ (Source: Strategic Executive Information System (STEIS))

⁷ (Source: Strategic Executive Information System (STEIS))

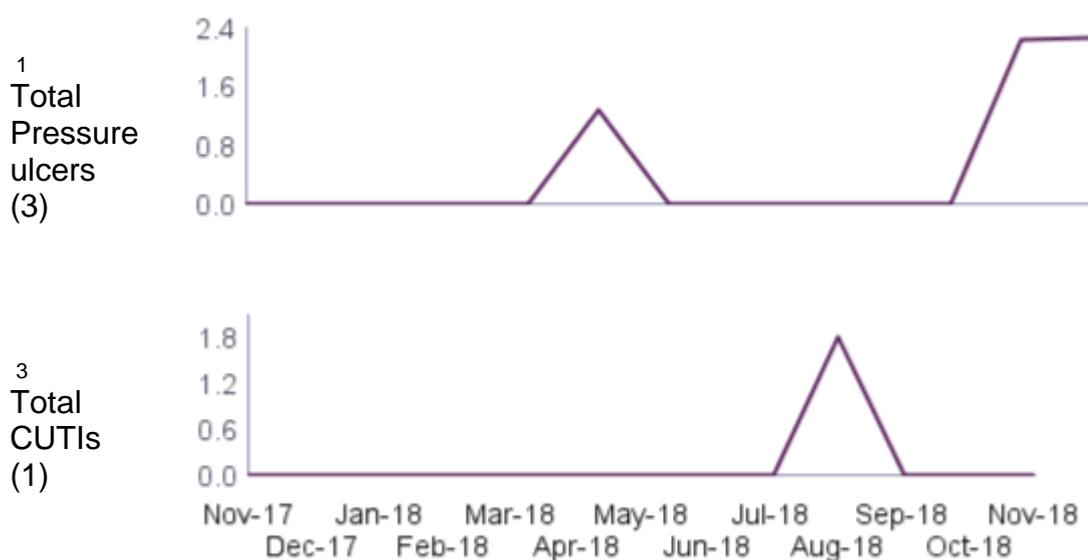
their elimination.

Data collection took place one day each month – a suggested date for data collection was given but wards can change this. Data was submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported three new pressure ulcers, no falls with harm and one new urinary tract infection in patients with a catheter from November 2017 to November 2018 for children's services across the trust.

Staff could access this information in the form of a monthly report that we were shown, but it was not displayed in patient areas. These pressure ulcers did not take place within the Hammersmith children's unit.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Imperial College Healthcare NHS Trust



- 1 Pressure ulcers levels 2, 3 and 4
- 2 Falls with harm levels 3 to 6
- 3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness

Due to the size and nature of the service, it did not participate in any national accreditation schemes.

At the time of our last inspection, we found that the service carried out a very limited range of audits to ensure the service was compliant with national guidance and best practice. Since our last inspection, we found some improvements had been made in this area. The service launched an ongoing consultant-led audit on re-attender figures, as well as several nurse-led audits. There was still scope for improvement in this area, but the band 7 nursing vacancy limited what audits could be implemented and monitored at the time of our inspection.

We reviewed some of the trust policies. The policies were up to date and based on national policy, including guidelines published by both the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH). NICE quality standards and guidance were discussed at monthly governance meetings.

Policies were available to all staff on the electronic intranet system and staff demonstrated they knew how to access them. The service followed NICE guidelines and quality standards for patients who presented with a history of epilepsies, type 1 diabetes and asthma.

Sepsis screening and management was done effectively, in line with national guidance. We saw 'sepsis 6' policy and procedures based on guidance from the Sepsis Trust and NICE guidance.

All children and young people received a comprehensive assessment when they presented to the unit. This involved being seen by a triage nurse who would assess whether the patient needed to be seen by a GP or a paediatrician. Staff showed awareness of these care pathways and we saw evidence of effective treatment plans in nursing and medical records.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

The service made adjustments for patients' religious, cultural and other preferences.

Due to the short stay nature of the department, patients weren't often provided with food. Where a patient was due to receive an echocardiogram, or a similarly lengthy procedure that required a stay of over four hours, they would receive a lunch option. The lunch option included a sandwich, a packet of crisps, a piece of fruit and a drink. Patient allergies were checked prior to ordering from the kitchen. Much younger patients were provided with age appropriate nutrition.

Breast feeding rooms were available for mothers on both ambulatory care and the outpatient department. The play specialist was also trained in assisting mothers with breast feeding queries. Support included going through how best to express and providing new mothers with pamphlets and practical guidance.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The service used an evidenced based pain scoring tool to assess the impact of pain. Play specialists and play leaders were available to provide distraction and emotional support to children whilst they underwent blood tests.

An adapted pain scoring tool was available for young children, those who did not speak English, or had communication difficulties. This involved the use of smiley/sad faces that the children could point at/gesture towards. For much younger children, the service utilised Face, Legs, Activity, Cry and Consolability (FLACC) score and a comfort pain score. The FLACC score is a measurement used to assess pain in young children or individuals that are unable to communicate their pain.

The scale is scored in a range of zero to ten, with zero representing no pain. Older children would use a numeric rating scale (NRS) to indicate their level of discomfort, from one (meaning no pain) to 10, meaning severe pain.

Pain assessment was always a part of the outpatient assessment.

We saw consistent pain assessment tools used across the department. We saw that nurses routinely asked patients about pain and patients told us that their pain had been managed appropriately during their stay. In all the patient records we reviewed we found that medicines charts showed that appropriate actions were taken when a patient experienced pain.

The play team were vital to communicating with non-verbal children regarding their pain. With children who had issues with communicating, a variety of communication tools were used to tailor to individual needs. We saw staff and play therapists use numerous distraction therapies and techniques throughout the children's services to help reduce the patients' pain and distract them from painful procedures.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

Senior leaders reported that they had explored submitting data to national audits, but that this was often not possible due to the small number of auditable cases, and the more novel set up of the unit, which was not an emergency department or inpatient service. For example, senior staff told us that they had recently tried to take part in the British Thoracic Society (BTS) audit of pneumonia, but that no suitable patients had presented at the unit in the catchment month.

The service undertook some local audits, in consultant-led topics such as 'audit of NICE guidelines: fever in the under 5s' (November 2018), which found 97% of cases were documented as having a clear focus for fever, but there was no space in the electronic patient record for nurses to document Capillary Refill Time (CRT). Learning from this included asking nurses to document CRT in the free text area of the record and to test urine even if cause of fever was clear, as good practice.

In September 2018, the service conducted a review of children seen at the ambulatory care unit who presented at St Mary's Hospital in the subsequent 72 hours. This found that children with chronic problems attended the unit and could re-attend if expectations about progress were not managed. Learning included arranging to follow up these children in clinic where there was more time and it was quieter. In May 2018, the same review found unscheduled re-attendances constituted 4.4% of patients, which was consistent with similar services (5%).

Other nurse-led audits focused on topics such as hand hygiene. The band 7 nursing vacancy limited what nurse-led audits could be implemented and monitored at the time of our inspection.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

From November 2017 to November 2018, 100% of required staff within children's services at Hammersmith Hospital received an appraisal compared to the trust target of 95%.⁸ The breakdown by staff group can be seen in the table below:

⁸ (Source: Trust Provider Information Request – Appraisal tab)

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met? (Yes/No)
Qualified Nursing and Health Visiting Staff	5	5	100.0%	Yes
NHS Infrastructure Support	4	4	100.0%	Yes
Support to doctors and nursing staff	2	2	100.0%	Yes
Support to Scientific, Therapeutic, Technical Staff	1	1	100.0%	Yes
Total	12	12	100.0%	Yes

In addition to the above figures, 100% of medical staff had completed their annual appraisal for the current year.

All paediatric staff had appropriate resuscitation training including Advanced Paediatric Life Support (APLS). There was at least one consultant paediatrician on the rota always. If the unit required specialist input, they could contact a specialist paediatrician via the telephone or email.

Both nursing and clinical staff received weekly training sessions on different topics. The training sessions were open to staff of all grades and were often consultant-led. We reviewed the session minutes from the three months prior to our inspection and found that sessions included emergency scenario training and case reviews. Staff informed us that they found the sessions “very helpful”, but that felt that they could be more formalised.

The junior doctors in the outpatient department had supervision with either a registrar or a consultant. The junior doctors performed six clinics each in their six-month rotation. Both junior doctors and GP trainees spoke very highly of their opportunities for growth and development. Staff reported that the environment was supportive, cultivating a sound understanding of paediatrics due to the level of input from consultants.

The administrative staff were managed by the administrative manager. The manager performed the appraisals for all staff. The administrative staff had a Friday meeting each week and discussed issues and rotas for the upcoming week here.

Nursing revalidation is the process by which registered nurses are required to demonstrate on a regular basis that they are up to date and fit to practice. The trust was actively supporting the nursing staff throughout the Nursing and Midwifery Council (NMC) revalidation process, as well as with competency assessments and further training.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

The unit had a weekly MDT meeting that took the form of a ‘safety huddle’. The meeting was attended by all staff on shift and topics discussed included: risks, incidents and bed management. Records we viewed showed evidence of input and discussion from various staff members. However, staff from the unit did not often attend wider directorate meetings due to the practicalities of travelling to St Mary’s Hospital and staffing considerations. Senior staff told us of plans to introduce video conferencing capability to the unit to enable greater unit involvement in wider directorate and divisional meetings.

All team members took responsibility for patients that attended the unit. The administrative staff were the first to take sight of all patients, before the triage nurse assessed whether a GP or a paediatrician would treat the patient.

The service made use of a play specialist and a play leader, both of whom worked on the unit and within the neonatal unit as required. The play specialist and leader would assist with aiding the nurses or phlebotomists in taking bloods, playing with children and siblings and comforting parents.

The service worked closely with the neonatal unit (NNU) to provide support and assistance to one another as required. The NNU could arrange for the review of discharged patients within the service to avoid readmission, or the unit would sometimes manage tests on their behalf in very busy periods. In return, staff from the NNU would attend the unit to support them in the case of a very sick new born baby.

The service worked with external stakeholders including social workers and local authority in the event of a patient requiring such input. The service had developed strong working links with local GPs through continuation of the 'Connecting Care for Children' initiative, designed to assist in the integration of child healthcare across primary, secondary and tertiary services. In addition, the service was part of an educational programme which aimed to create GPs who could be local child health leads. The recruited GPs worked alongside paediatricians in the unit, to the benefit of both them and the service. As a result, connections with community teams had been strengthened.

In the CQC Children and Young People's Survey 2016 the trust scored 8.5 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts.⁹

The unit had access to several specialists, including:

- Phlebotomists
- Play specialists
- Allergy specialists
- Neurology specialists
- Urology specialists
- Nephrology specialists
- Cardiology specialists

Seven-day services

Essential services were available on weekdays.

The unit was open Monday to Friday, 9am to 5pm. Outside of these hours, patients could use the urgent care centre. The service had access to x-ray, phlebotomy and a range of specialties. Pharmacy services were available during the opening hours of the unit.

The safeguarding team were available seven days a week, 9am to 5pm.

⁹ (Source: CQC Children and Young People's Survey 2016, RCPCH)

Health promotion

The service supported people to live healthier lives

The ambulatory care units main aim was to prevent hospital inpatient stays and provide a consultant paediatrician-led unit for patients who could not get a GP appointment.

The unit had continued the 'Connecting Care for Children' initiative that we saw at the time of the last inspection. One of the main aims of the scheme was to empower patients and their parents/carers to self-manage their own care, reducing unnecessary presentations or admissions to services.

There were health promotion leaflets available in the outpatient department on topics such as immunisation, management of meningitis and healthy diets. On the notice boards there was information on further topics such as eczema, acid reflux in babies, conjunctivitis, management of fever and the signs of vitamin D deficiency. Patients were provided information of what these ailments were, what signs to look for and how to get help if concerned. Posters were colourful, informative and well designed.

Parents and carers of patients were provided with information following minor procedures, such as tongue tied and audiology tests.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

The service did see some young adults. Staff could give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and Deprivation of Liberty Safeguards (DoLS).

We saw one set of records in outpatient with a consent form. This form was signed and legible. For the most part, patients parents provided staff with implied consent. The service had no past examples of where a child wanted to invoke Gillick/Fraser competency but staff were aware of the instances where this would be required.

Most patients seen at the service were under five years old (75%) therefore the service relied on implied consent to take bloods and carry out other minor tests. Invasive procedures and surgery were not performed in the unit. If parents were not thought to be competent to provide consent for their child, the unit would involve the safeguarding team. There were guidelines in place to follow in the case refusal of treatment by the child and management of life threatening behaviour.

The trust performed about the same as other trusts for all the five questions relating to effectiveness in the CQC Children and Young People's Survey 2016.

CQC Children's Survey questions, effective domain, Imperial College Healthcare NHS Trust

Question Number	Question	Age group	Trust score	RAG
21	Did you feel that staff looking after your child knew how to care for their individual or special needs?	0-15 adults	8.3	About the same
9	Did staff play with your child at all while they	0-7	8.1	About the same

	were in hospital?	adults		
19	Did different staff give you conflicting information?	0-7 adults	8.0	About the same
33	During any operations or procedures, did staff play with your child or do anything to distract them?	0-15 adults	8.0	About the same
54	Did hospital staff play with you or do any activities with you while you were in hospital?	8-11 CYP	6.3	About the same

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

The ten patients we spoke with all provided positive feedback about the care and treatment they received from the unit. Patients felt listened to and that nursing staff were "caring" and "very helpful".

The trust performed about the same as other trusts for all the 10 questions relating to compassionate care in the CQC Children and Young People's Survey 2016.

CQC Children and Young People's Survey 2016 questions, compassionate care, Imperial College Healthcare NHS Trust

Question Number	Question	Age group	Trust score	RAG
10	Did new members of staff treating your child introduce themselves?	0-7 adults	8.9	About the same
14	Did you have confidence and trust in the members of staff treating your child?	0-15 adults	8.7	About the same
22	Were members of staff available when your child needed attention?	0-15 adults	8.2	About the same
42	Do you feel that the people looking after your child were friendly?	0-7 adults	9.0	About the same
43	Do you feel that your child was well looked after by the hospital staff?	0-7 adults	9.0	About the same
44	Do you feel that you (the parent/carer) were well looked after by hospital staff?	0-15 adults	7.9	About the same
58	Was it quiet enough for you to sleep when needed in the hospital?	8-15 CYP	6.2	About the same
64	If you had any worries, did a member of staff talk with you about them?	8-15 CYP	7.9	About the same
74	Do you feel that the people looking after you were friendly?	8-15 CYP	9.3	About the same
75	Overall, how well do you think you were looked after in hospital?	8-15 CYP	8.9	About the same

(Source: CQC Children and Young People's Survey 2016, RCPCH)

The environment ensured privacy as care was provided in either clinic rooms in the outpatient

department, or bays with curtains in the ambulatory care unit. There was a single room with an ensuite bathroom for higher acuity patients. Nurses and doctors introduced themselves to children and their families and ensured they closed the curtains around bed spaces before carrying out treatments or examinations. Staff had a caring, compassionate and sensitive manner. We saw staff playing and laughing with children and talking to babies whilst performing observations.

We saw parents accompanying their children at the bedside throughout any investigations to lessen their anxiety. The feedback from parents was very complimentary about the care their children received. Parents we spoke with informed us that the staff were ‘very compassionate’, with one adding, “you want for nothing here”.

Patient experience was monitored via the friends and family test (FFT). Between April and June 2018, 100% of parents or carers stated that they would recommend the unit to friends and family. This was evidenced by the audit into ambulatory care activity which found that over 25% of attenders were recommended by family or friends.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Patients informed us that they received a lot of easy to understand information on admission and that staff were very supportive.

There was no onsite access to formal psychiatric support for children and young people. If a patient with mental health concerns presented requiring further assessment and possible admission, the children’s team at St Mary’s Hospital would be contacted, along with the safeguarding team, for advice and support. Contact could also be made with another local NHS trust who provided child and adolescent mental health services (CAMHS) via telephone and email for referrals and advice. Senior staff told us that they did not see many children requiring mental health support at the unit, mainly due to clear information as to what the service could feasibly treat, but that the more formalised support of a clinician psychologist could be useful, especially due to the long waiting list for referral to CAMHS. The trust recognised that there was inadequate psychology provision for children and young people within children’s services at the trust but was limited by resources. This had been added to their risk register.

A clinical psychologist (usually based at the St Mary’s Hospital site) attended the feeding clinic at the unit to provide support to new mothers.

The trust performed about the same as other trusts for all the five questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, emotional support, Imperial College Healthcare NHS Trust

Question Number	Question	Age group	Trust score	RAG
7	Was your child given enough privacy when receiving care and treatment?	0-7 adults	8.7	About the same
29	If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?	0-15 adults	8.4	About the same
45	Were you treated with dignity and respect by	0-7	9.1	About the same

	the people looking after your child?	adults		
65	Were you given enough privacy when you were receiving care and treatment?	8-15 CYP	8.7	About the same
67	If you felt pain while you were at the hospital, do you think staff did everything they could to help you?	8-15 CYP	8.3	About the same

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We saw staff involving patients and those close to them during assessments on the ward giving them time to ask questions or clarify comments. Written information leaflets were available for patients about a range of treatments and procedures. These were child friendly.

We saw both clinicians and nurses explaining procedures to patients. Patients could ask questions and parents felt as though they were able to challenge staff. Older children were encouraged to have their own input in care planning and informed us that they understood everything that was happening to them.

There were child friendly videos on the trust website regarding procedures and roles within CYP services. Child friendly patient information leaflets were also available.

The trust performed about the same as other trusts for all the 20 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People's Survey 2016.

The trust scored 7.6 out of ten for the question, 'Were the different members of staff caring for and treating your child aware of their medical history?' This was about the same as other trusts.

The senior clinicians informed us that the key to ensuring that patients were cared for appropriately was parental knowledge. To that end, the service ensured that they provided family members with relevant information and take away guidance. In the CQC Children and Young People's Survey 2016 the trust scored 9.6 out of ten for the question 'Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?' This was about the same as other trusts.¹⁰

CQC Children and Young People's Survey 2016 questions, understanding and involvement of patients, Imperial College Healthcare NHS Trust

Question Number	Question	Age group	Trust score	RAG
11	Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	0-15 adults	9.1	About the same
12	Did members of staff treating your child communicate with them in a way that your child could understand?	0-7 adults	7.7	About the same
13	Did a member of staff agree a plan for your	0-15	9.0	About the same

¹⁰ Source: CQC Children and Young People's Survey 2016, RCPCH

Question Number	Question	Age group	Trust score	RAG
	child's care with you?	adults		
15	Did staff involve you in decisions about your child's care and treatment?	0-15 adults	8.2	About the same
16	Were you given enough information to be involved in decisions about your child's care and treatment?	0-15 adults	8.8	About the same
17	Did hospital staff keep you informed about what was happening whilst your child was in hospital?	0-15 adults	8.4	About the same
18	Were you able to ask staff any questions you had about your child's care?	0-15 adults	9.0	About the same
31	Before your child had any operations or procedures did a member of staff explain to you what would be done?	0-15 adults	9.2	About the same
32	Before the operations or procedures, did a member of staff answer your questions in a way you could understand?	0-15 adults	9.2	About the same
34	Afterwards, did staff explain to you how the operations or procedures had gone?	0-15 adults	8.3	About the same
39	When you left hospital, did you know what was going to happen next with your child's care?	0-15 adults	8.0	About the same
41	Do you feel that the people looking after your child listened to you?	0-7 adults	8.5	About the same
59	Did hospital staff talk with you about how they were going to care for you?	8-15 CYP	8.6	About the same
60	When the hospital staff spoke with you, did you understand what they said?	8-15 CYP	8.7	About the same
61	Did you feel able to ask staff questions?	8-15 CYP	9.4	About the same
62	Did the hospital staff answer your questions?	8-15 CYP	9.2	About the same
63	Were you involved in decisions about your care and treatment?	8-15 CYP	6.3	About the same
66	If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?	12-15 CYP	N/A	N/A
69	Before the operations or procedures, did hospital staff explain to you what would be done?	8-15 CYP	9.4	About the same
70	Afterwards, did staff explain to you how the operations or procedures had gone?	8-15 CYP	8.9	About the same
72	When you left hospital, did you know what was going to happen next with your care?	8-15 CYP	7.6	About the same

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

Facilities and premises were appropriate for the services that were delivered. New services (such as the diabetes, dermatology and asthma services) were developed in line with the hospital's business plan, incorporating comments from patients and following consultations with consultants and nurses. The aim of the service was to act as an integrated platform between primary and secondary care.

The service audited the reasons for patients attending the unit and found that over 20% visited as they couldn't get a GP appointment. A parent we spoke to told us, "getting a GP appointment can be difficult but here my child can be seen by a paediatrician very quickly".

The unit had continued the 'Connecting Care for Children' initiative that we saw at the time of the last inspection. This initiative had been designed to assist in the integration of child healthcare across primary, secondary and tertiary services. The intention was to provide primary care providers with access to specialist paediatric advice, by way of the hospital team delivering community led surgeries incorporating education, training, professional support and outreach clinics. In addition, GPs could access consultant paediatricians via telephone and email, with a same-day response to help reduce the risk of unnecessary admission to hospital. The scheme aimed to empower patients and their parents/carers to self-manage their own care, to provide peer support to others and to engage with local GPs and primary care nursing staff by acting as practice champions.

Since the previous inspection, the service had built upon the success of the 'Connecting Care for Children' initiative and was now hosting an educational programme funded by Health Education England (HEE) as part of their 'Partnerships in Innovative Education' (PIE) initiative. This programme aimed to create GPs who could be local child health leads. The recruited GPs worked alongside paediatricians in the unit. As a result, these GPs were exposed to, and became comfortable managing, complex cases traditionally referred to secondary care. This programme also facilitated joint clinical development, diversified the staff mix at the unit, strengthened connections with community teams, and helped to establish further community initiatives.

At the time of the last inspection, we noted that the limited opening hours meant that the service could not always fully meet the needs of local people, and this remained unchanged. Whilst some clinics and afterschool appointments were offered, the early closure of the unit restricted the number of children that could be seen once they had finished their school day.

In the CQC Children and Young People's Survey 2016, the trust performed better than other trusts for none of the questions, worse than other trusts for two questions and about the same as other trusts for the remaining 15 questions relating to responsiveness.

The two worse performing questions were: 'Did your child like the hospital food provided?' and 'Did the hospital change your child's admission date at all?'. These questions relate to inpatient services and so are not applicable to the services provided at Hammersmith Hospital.

CQC Children and Young People's Survey 2016 questions, responsive domain, Imperial College Healthcare NHS Trust

Question Number	Question	Age group	Trust score	RAG
4	For most of their stay in hospital what type of ward did your child stay on?	0-15 adults	9.9	About the same
5	Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?	0-15 adults	8.4	About the same
25	Did you have access to hot drinks facilities in the hospital?	0-15 adults	7.8	About the same
26	Were you able to prepare food in the hospital if you wanted to?	0-15 adults	3.9	About the same
28	How would you rate the facilities for parents or carers staying overnight?	0-15 adults	7.4	About the same
55	Was the ward suitable for someone of your age?	12-15 CYP	8.0	About the same
8	Were there enough things for your child to do in the hospital?	0-7 adults	7.5	About the same
24	Did your child like the hospital food provided?	0-7 adults	4.6	Worse
37	Did a staff member give you advice about caring for your child after you went home?	0-15 adults	8.5	About the same
38	Did a member of staff tell you who to talk to if you were worried about your child when you got home?	0-7 adults	8.1	About the same
40	Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?	0-15 adults	7.4	About the same
56	Were there enough things for you to do in the hospital?	8-15 CYP	6.7	About the same
57	Did you like the hospital food?	8-15 CYP	6.2	About the same
71	Did a member of staff tell you who to talk to if you were worried about anything when you got home?	8-15 CYP	7.1	About the same
73	Did a member of staff give you advice on how to look after yourself after you went home?	8-15 CYP	8.3	About the same
2	Did the hospital give you a choice of admission dates?	0-7 adults	4.9	About the same
3	Did the hospital change your child's admission date at all?	0-7 adults	8.0	Worse

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Meeting people's individual needs

The service took account of patients' individual needs.

Patients families informed us that there was "no real wait" to access the service.

All the patients' families we spoke with informed us that they received several text/email reminders for their child's appointment in the outpatient department.

The unit did not have overnight beds but could refer patients that required further treatment to an appropriate unit at a different site. The electronic system was linked across all sites at the trust, allowing the service to maintain continuity of care and information across sites.

Most of the patients seen at the unit (75%) were under five years old, with most of these patients being under one year old. For patients requiring further neonatal support, the service could make use of the neonatal service, which was located nearby on the same site.

If the unit was concerned that any patients had mental health conditions or required psychiatric input, they would transfer the patient to St Mary's Hospital, where there was access to psychiatric support. The service could also request input from a clinical psychologist if a mother required breast feeding support.

The service could provide snack packs for patients who were in the unit for longer than a couple of hours. They could also provide snack packs for parents at their request.

The unit had access to play specialists who could assist with distraction therapy or keeping siblings of patients entertained. Staff on the unit spoke very highly of the play team, as did the parents that we spoke to. We saw play specialists assisting with patients' bloods being taken and soothing crying babies.

Children with learning disabilities or other additional needs were often known to the service. When these children became patients, they would receive additional support from the play team. A member of the play team informed us that anxious patients or patients with autism would make use of the quieter waiting area. Staff told us that the same members of staff were often used to see these patients to ensure they felt more at ease. If the child was not well known to the service, staff would call the family ahead of time and speak to the parents to anticipate any enhanced needs or requirements that needed to be considered.

Staff were aware of how to access both telephone interpreting and face-to-face interpreting services. We were told that staff members tried not to use families as interpreters as a rule, as they recognised the issues arising from this. In unplanned situations, staff would request the help of other professionals in the hospital with the required language skills where possible.

The service had access to several clinical nurse specialists (CNSs) including those with specialising in allergies, renal and neurology. These specialists were based at St Mary's Hospital but could be called for assistance and even come over to the unit to provide specialist input.

Access and flow

People could access the service when they needed it.

Although the ambulatory care unit was mainly for walk-in patients, patients could be referred via the community by either GPs, midwives or health visitors. The majority (70%) of total activity at the service was commissioned secondary care with the rest comprising of primary care activity.

Whilst the service did not formally audit wait times, we saw that patients had a minimal wait before they were triaged by a nurse.

Patients had access to urgent and next day clinics either via the clinics based at Hammersmith hospital or by being transferred to a neighbouring site within the trust. Since the last inspection, the outpatient department at the hospital had taken on some of the specialist clinics to relieve some pressure from St Mary's Hospital and further integrate the service.

A consultant paediatrician was available Monday to Friday, 9am to 5pm. Each patient that was seen in the unit was seen by either a middle grade doctor or consultant paediatrician within four hours. If a child required specialist input or had an acute medical problem they would be transferred to a neighbouring site within the trust. Between March 2018 and February 2019, a total

of 246 (2.9% of) patients were transferred to another hospital. The department also made use of immediate telephone advice from specialist consultants across the trust.

We saw that all patients were provided with discharge summaries that they could share with their GPs and other relevant healthcare professionals. Staff informed us that these summaries were provided within 24 hours of discharge.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The Department of Health states that health services should provide children and young people with appropriate information in a variety of languages and formats so they can make comments, compliments or complaints. Whilst on inspection we found that there were such pamphlets and posters for how to complain which provided primary contact details of the service senior staff.

From November 2017 to October 2018, there were 25 complaints about children's services across the trust. The trust took an average of 33 working days to investigate and close complaints. This is in line with their complaints policy, which states complaints should be completed within 40 working days. We saw that complaints were recorded in a formal way with accurate information stored throughout the process.

At Hammersmith Hospital, there were three complaints (12%), with no common theme reported in the same period.¹¹

Is the service well-led?

Leadership

Managers in the service had the right skills and abilities to run a service providing high-quality sustainable care, but there was currently a vacancy within the leadership team. However, staff survey results showed signs of disconnection with senior management.

The children's services at Hammersmith Hospital were overseen by a divisional director and general manager. The staff that we spoke with on ambulatory care spoke highly of their directors and informed us that they often walked round the department.

However, the NHS staff survey 2017 results showed that 67% of participants of the women's, children's and clinical support division felt that immediate manager took a positive interest in their health and well-being. The majority (88%) knew who their senior managers were, however, only 35% thought that senior managers tried to involve staff in important decisions.

Survey results for the children's directorate showed that only 25% of participants thought that communication between senior management and staff was effective and only 13% felt that senior managers acted on staff feedback. Both results were worse than organisational average. Actions taken in response included global emails to be used to share changes and ask for comments and additional monthly staff team meetings.

¹¹ (Source: Routine Provider Information Request (RPIR) – Complaints tab)

The ambulatory care unit was consultant-led. The lead consultant had oversight for the middle grade paediatricians and the junior doctors. The junior nursing staff were overseen by the band 6 nursing staff. At the time of our inspection, there was no one individual with oversight of the band 6 staff on the unit. The band 7 ward manager post had been vacant since September 2018. The previous unit manager had been on periods of long-term absence. Previously, this role had been cross site, but a new post had been created after consultation with staff and now each site had their own band 7 post. Although the post at St Mary's Hospital had been filled, senior staff told us that the band 7 vacancy had been out to advert twice and that successful candidates had been found, but neither of these appointments had come to fruition. The service was in the process of trying to recruit someone to fill this position but this post was still vacant at the time of inspection, leaving a gap in the leadership team of the service. Although senior staff told us that other service leads supported the unit as required, there were no formalised interim arrangements in place, leaving the unit with no senior nursing leader.

Both nurses and doctors told us of the improvements that had been made since the last inspection. They informed us of many ways that they had been supported locally by their managers. We received positive feedback from staff about the lead consultant at the unit, who encouraged a non-hierarchical environment where everyone's input was valued.

Our discussions with managers demonstrated that they were passionate and committed to delivering good care across the trust.

The children's services had board representation via the divisional director for the division of women, children and clinical support. There was also a children and young person's non-executive director who sat on the board and performed both announced and non-announced visits to children's services throughout the year.

Vision and strategy

The service did not have a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.

The trust paediatric services vision was: 'Children's health for life'. The overall strategy for children's services was to live the trust values, build their services in collaboration with local partners, improve the environment, train their teams and give children access to new and innovative treatments.

At our last inspection, we found that there was no formalised vision or strategy for the ambulatory care unit or children's outpatient department at Hammersmith Hospital.

The service still had no formalised or dated strategy in place. However, since the last inspection, the outpatient department at the hospital had taken on some of the specialist clinics to relieve some pressure from St Mary's Hospital and further integrate the service. Senior staff told us that there were plans to bring across further specialties, such as diabetes and dermatology, in the coming months. They also relayed plans currently in development that would allow community midwives to hold clinics in the ambulatory care unit and work alongside clinicians in the unit to provide medical advice and breastfeeding support to new mums.

The ambulatory unit had an aim to provide high quality family friendly care as close to home as possible. In addition, it aimed to provide effective paediatric education and support to local GPs and paediatricians in training.

Staff that we spoke with were aware of the trust vision and had personal visions to make the service the best it could possibly be.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Both senior and junior staff spoke very highly of the culture within their local areas and within the wider hospital. Staff told us there was an open culture where staff were encouraged and felt supported to report incidents to promote learning.

The service had long standing members of staff who enjoyed working there. Nurses we spoke with informed us that the environment was “highly supportive”, and “felt like a family”. The clinical staff also spoke highly of the support they received. Junior doctors informed us that the service was a “great place to learn with excellent consultant support”.

Staff told us that the trust had an open culture and were actively encouraged to report incidents when things went wrong. Staff informed us that whilst there were few formal incidents, they would receive learning and feedback from their managers when things went wrong.

Learning from incidents and complaints was shared at ‘safety huddles’ and trust wide communications were sent to all relevant staff through the divisional cascade system or through monthly quality and safety meetings.

There was an up-to-date whistleblowing policy, which outlined how to escalate any concerns. Two ‘Speak Up’ guardians had also been introduced in October 2016.

There is a focus on improving child health outcomes embedded in the culture of the service, demonstrated by the successful initiatives to work with GPs and strengthen the links between primary and secondary care.

Governance

The service improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

There were arrangements in place for governance and risk management. In September 2016, the trust had restructured the existing corporate safety and effectiveness team, the divisional governance leads, patient safety managers and administration teams to form a safety and effectiveness hub. This allowed for centralised oversight around use of resources and caseload distribution based on demand across the divisions.

The service held regular governance meetings where good practice was shared and informed us that good practice was also shared across sites. There were monthly divisional meetings, as well as the monthly CYP directorate committee and the monthly CYP quality and safety meeting. However, senior staff from the unit were not always able to attend all cross-site meetings because of staffing concerns and the band 7 vacancy. There were plans to enable video conferencing in the unit to improve attendance.

Staff could tell us about the department governance systems and which individuals had key lead roles and responsibilities within the department. Staff were clear about their individual roles and responsibilities and knew where to access information when needed.

We did however find there was a lack of quality measurement associated with the care of children who were seen in ambulatory care. The unit was not routinely collating data such as the time taken to triage and initially assess patients to identify areas for improvement. This had not improved since the time of our last inspection.

We found issues relating to governance with the trust safeguarding team. There was no central log for child safeguarding cases. The safeguarding consultant nurse lead told us that the safeguarding leads or the staff involved took the lead on individual safeguarding cases. This meant that there was a risk that issues could be missed. A member of the safeguarding team attended the Local Safeguarding Children's Board and shared learning with the wider team through email.

Management of risk, issues and performance

The service did not have good local systems to identify risks, or plan to eliminate or reduce them, in order to cope with both the expected and unexpected.

Whilst on inspection, we did not find a copy of the local risk register and were shown the monthly directorate quality and safety report when we asked staff for this. This contained the directorate risk register top themes, but those we saw did not seem to relate to the unit. Senior staff told us that any departmental risks would be raised at the local quality and safety meeting or emailed to the team at St Mary's Hospital, who would add to the register at the wider quality and safety meeting held there. Following the inspection, we formally requested a copy of the local risk register. This was not provided to us. We were not able to corroborate whether risks related to us on inspection, regarding the capacity of the unit and maintenance of estates, were formally recorded. We were therefore not assured that the service had a robust system ensuring oversight of the current risks specific to their service.

The divisional risk register contained some risks, such as the risk of inadequate mental health provision, estates issues and the overbooking of clinics, which were relevant to the unit. Those risks identified and placed on the risk register had mitigating actions documented.

The unit had a local risk meeting every Tuesday morning that was led by the risk nurse. Nurses, doctors and healthcare assistants were encouraged to attend. These meetings discussed active risks, incidents and learning from complaints.

Information management

The service used secure electronic systems with security safeguards.

Most patient records were electronic. Each member of staff had their personal login information to access the system. During inspection, we saw staff logging off before leaving computers and we did not see unlocked computer screens. This prevented unauthorised access to data.

The intranet was available to all staff and contained links to current guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and the information contained within.

All staff had access to their work email, where they received organisational information on a regular basis, including clinical updates and changes to policy and procedures.

Engagement

The service engaged well with patients, staff and the public to plan and manage appropriate services and collaborated with partner organisations effectively.

Patient experience was monitored via the friends and family test (FFT) and through informal feedback mechanisms. We saw a variety of 'thank you' letters and cards, as well as a 'you said, we did' board in the outpatient department. The 'Connecting Care for Children' project aimed to make children and parents partners in their care. Senior staff told us that there were plans to start working with the team at St Mary's Hospital involved in the Providing assessment and treatment for children at home (PATCH) service. They wanted to see if there was any learning or actions they could put into place to help them further promote education and confidence in parents.

The trust was unable to provide results of the staff survey relating specifically to the unit due to the small number of staff. The trust told us they ensured that staff working in the unit were given opportunities to share their views and be listened to, and that they received communications about how their views were considered and acted upon. In addition to informal communications, staff at the unit were invited to children's directorate meetings and cross site meetings. Staff at the unit could not often attend these meetings due to the practicality of travelling and staffing considerations. Senior staff told us that there were plans to introduce video conferencing facilities to allow greater cross site working opportunities and staff attendance at meetings.

The service engaged well with local schools in the borough. This ensured that the schools were aware of the best place to send a poorly child.

The hospital had both BME and LGBTQ+ network groups that met routinely.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong and promoting training.

The unit had continued the 'Connecting Care for Children' initiative that we saw at the time of the last inspection. This had been recognised through a recent Health Service Journal (HSJ) award. The approach led to reductions in outpatient appointments, emergency attendances and hospital admissions, and a similar model had now also been introduced for adults, following its success.

Since the previous inspection, the service had built upon the success of the 'Connecting Care for Children' initiative and was now hosting an educational programme funded by Health Education England (HEE) as part of their 'Partnerships in Innovative Education' (PIE) initiative. This programme aimed to create GPs who could be local child health leads. The recruited GPs worked alongside paediatricians in the unit. As a result, these GPs were exposed to, and became comfortable managing, complex cases traditionally referred to secondary care. This programme also facilitated joint clinical development, diversified the staff mix at the unit, strengthened connections with community teams, and helped to establish further community initiatives.

The service could show continuous improvement and learning through its audit system. A doctor led audit of re-attendances showed that the service had 4.4% of unscheduled reattendances over 500 attendances. From this, the service could look at the reasons for re-attendances and produce learning points that could be shared with all staff. For example, parents of children who present with a cough or tract infection would be provided with more written information of what to expect with respiratory illnesses and what signs may be a cause for concern.

Queen Charlottes and Chelsea Hospital

Imperial College Healthcare NHS Trust was formed on October 1, 2007 by merging St Mary's NHS Trust and Hammersmith Hospitals NHS Trust and integrating with the faculty of medicine at Imperial College London.

The trust has 12 registered locations and employs almost, 11,000 staff. The registered locations are:

- Queen Charlottes and Chelsea Hospital
- Western Eye Hospital
- Hammersmith Hospitals
- Northwick Park Renal Centre
- Ealing Renal Satellite Unit
- St Charles and Hammersmith Renal Centres
- West Middlesex Renal Centre
- Brent Renal Centre
- Charing Cross Hospital
- St Mary's Hospital
- Hayes Renal Centre
- Watford Renal Centre

The trust has an estimated range of population served is between 1,500,000 and 2,000,000 people.

- The trust has a total of 1004 inpatient beds spread across various locations
- 534 outpatient clinics per week.
- 297 day case beds.
- 38 Children's beds.
- No dedicated End of Life Care beds.
- 52 inpatient wards.

Maternity

Facts and data about this service

The Imperial College Health NHS Trust provides maternity services across two main hospital sites: Queen Charlotte's and Chelsea Hospital (QCCH) and St Mary's Hospital (SMH), along with some community clinics. Maternity service is also delivered at SMH and QCCH as part of Imperial Private Healthcare.

QCCH is a maternity, women's and level 3 neonatal care hospital. It provides antenatal, intrapartum and postnatal care to both low and high-risk women. It provides tertiary specialist services in obstetric medicine for pregnancies with complex medical diseases, fetal medicine with expertise in in-utero transfusions and laser therapy, and prematurity.

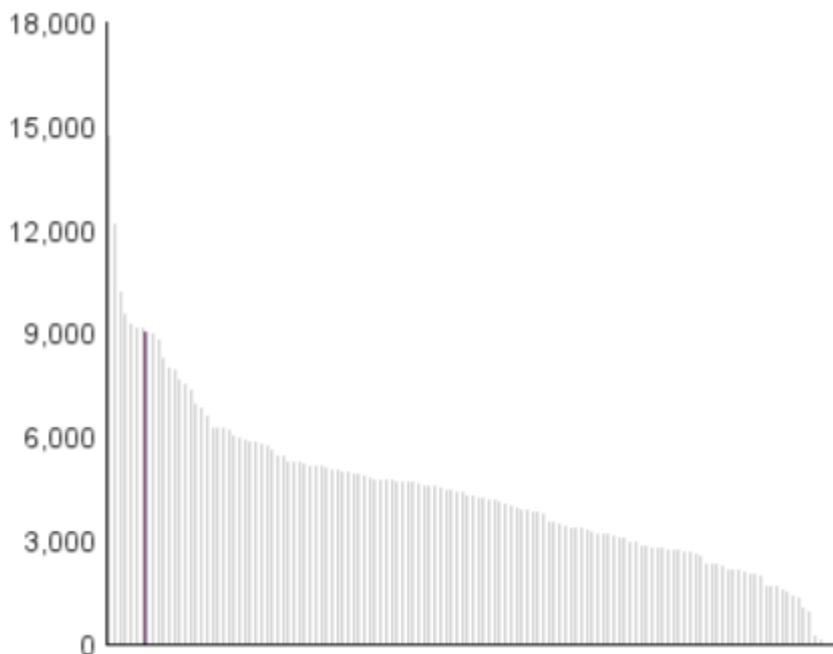
It has a high dependency unit where level 2 care is provided for pregnant women and for postnatal women. Midwifery-led services are provided in the co-located birth centre. QCCH also has a seven-bed private patient ward which is predominantly provides packages of postnatal care and is managed by the maternity service.

(Source: Routine Provider Information Request (RPIR) – Context acute)

From July 2017 to June 2018 there were 8,987 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at Imperial College Healthcare NHS Trust – Comparison with other trusts in England.



A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below.

Profile of all deliveries (April 2017 to March 2018)			
	IMPERIAL COLLEGE HEALTHCARE NHS TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Single or multiple births			
Single	9,031	98.5%	98.6%
Multiple	142	1.5%	1.4%
Mother's age			
Under 20	112	1.2%	3.1%
20-34	5,997	65.4%	74.9%
35-39	2,365	25.8%	18.1%
40+	699	7.6%	4.0%
Total number of deliveries			
Total	9,173		596,828

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

Gestation periods (April 2017 to March 2018)			
	IMPERIAL COLLEGE HEALTHCARE NHS TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Gestation period			
Under 24 weeks	*	*	0.1%
Pre term 24-36 weeks	*	*	7.8%
Term 37-42 weeks	2,938	93.7%	91.9%
Post Term >42 weeks	*	*	0.2%
Total number of deliveries with a valid gestation period recorded			
Total	3,134		498,704

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

To protect patient confidentiality, figures between 1 and 5 have been suppressed and replaced with "*" (an asterisk). Where it was possible to identify numbers from the total due to a single suppressed number in a row or column, additional numbers have also been suppressed.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The trust provides maternity services across two main sites, St Mary's Hospital and Queen Charlotte's and Chelsea Hospital. A breakdown by site/ward is shown below:

Queen Charlotte's and Chelsea Hospital

Ward/unit	Description of ward	Number of inpatient beds (if applicable)
Early pregnancy and gynaecology assessment unit	N/A	N/A
Stanley Clayton Ward	Post-natal ward run by Imperial Private Healthcare	7 beds
Labour ward	The labour ward has obstetric theatres, a recovery area, a high dependency unit and a bereavement room	20 beds
Birth centre	N/A	6 beds
Edith Dare ward	Post-natal ward	42 beds
Maternity ultrasound	N/A	N/A
Maternity day assessment unit	N/A	N/A
Maternity outpatient service	Outpatient clinics run by the division of Women, Children and Clinical support	N/A

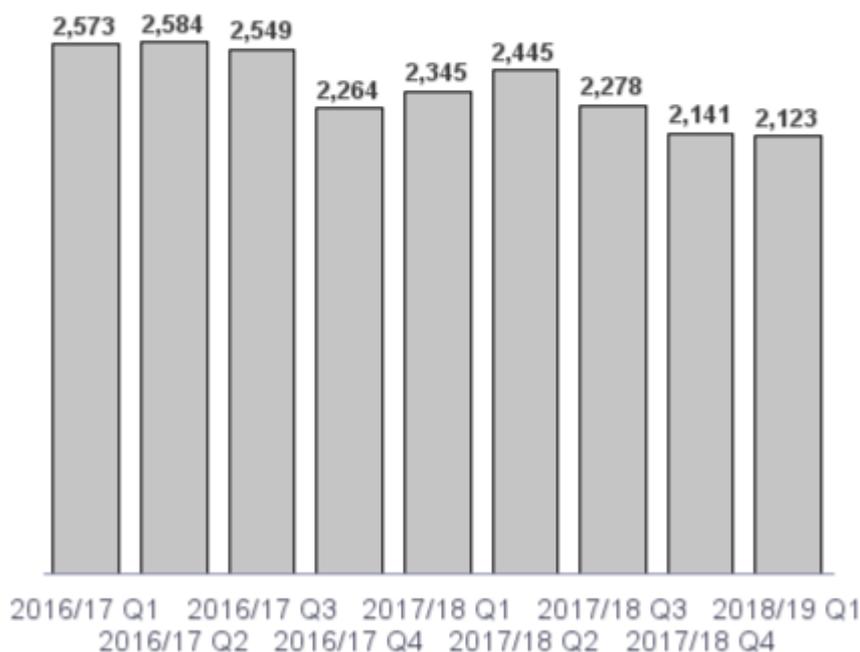
At Queen Charlotte's and Chelsea Hospital there are 75 inpatient beds across eight wards/units.

There is also the Lewis Suite antenatal ward, also referred to as D7 ward at Hammersmith Hospital, which has 16 inpatient beds.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at Imperial College Healthcare NHS Trust by quarter



The number of deliveries has seen a slight decrease over the period. In the latest quarter, April 2018 to June 2018, the number of deliveries was at its lowest number per quarter (2,123) in the last two years.

(Source: Hospital Episode Statistics - HES Deliveries (April 2016 - June 2018))

At Queen Charlotte's and Chelsea Hospital there were approximately 450 to 500 deliveries each month, approximately 65% of the total deliveries at the trust.

We carried out an announced inspection of the maternity service on 26 to 28 February 2019. During our inspection, we visited all clinical areas in the service including labour ward, theatres, antenatal and postnatal wards, the birth centre, transitional care, antenatal clinics, FMU, DAU and the Stanley Clayton ward. We spoke with six women and their relatives and approximately 50 members of staff, including midwives, consultants, anaesthetists, senior managers, pharmacist, matrons, midwifery risk leads, perinatal mental health team and support staff. We observed care and treatment and reviewed seven medical care records and prescription charts. We also reviewed the trust's performance data. We observed one multidisciplinary meeting, two handovers and part of one procedure.

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff.

The maternity service provided mandatory training in key skills to all staff, the mandatory training requirements for nursing and midwifery staff and medical staff is detailed in the tables below. Training was provided via e-learning modules or face-to-face sessions. Staff could access e-learning modules at work or home. Staff we spoke with confirmed they had undertaken mandatory training and had no concerns accessing training.

The trust set a target of 85% for completion of mandatory training.

Queen Charlotte's and Chelsea Hospital maternity department

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at Queen Charlotte and Chelsea Hospital for qualified nursing and midwifery staff in maternity services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Moving and Handling Level 1	173	175	98.9%	85%	Yes
Equality and Diversity	168	175	96.0%	85%	Yes
Resuscitation Level 2	168	175	96.0%	85%	Yes
Invasive Procedures Policy	167	175	95.4%	85%	Yes
Fire Safety Awareness	166	175	94.9%	85%	Yes
Conflict Resolution	165	175	94.3%	85%	Yes
Health and Safety	162	175	92.6%	85%	Yes
ANTT	161	175	92.0%	85%	Yes
Consent	161	175	92.0%	85%	Yes
Information Governance	161	175	92.0%	85%	Yes
Blood Transfusion	159	175	90.9%	85%	Yes
Nutrition	159	175	90.9%	85%	Yes

Moving and Handling Level 2	147	163	90.2%	85%	Yes
Medicines Management	157	175	89.7%	85%	Yes
Infection Prevention and Control Level 2	156	175	89.1%	85%	Yes
Venous Thromboembolism	155	175	88.6%	85%	Yes
Duty of Candour	45	51	88.2%	85%	Yes

In maternity services the 85% target was met for all 17 mandatory and statutory training modules for which qualified nursing and midwifery staff were eligible.

Midwives undertook an annual mandatory three-day midwifery education programme which included bereavement, skills and drills, perinatal mental health and care of the deteriorating woman (sepsis). At QCCH, compliance with this training was 85.5% against a target of 75%.

The compliance for training on cardiotocography (CTG) (CTG is the reading of the recordings of fetal heart beat and uterine contractions) for midwives was 98.6%.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at St Mary's Hospital and Queen Charlotte and Chelsea Hospital for medical staff in maternity services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Conflict Resolution	27	27	100.0%	85%	Yes
Equality and Diversity	27	27	100.0%	85%	Yes
Blood Transfusion	26	27	96.3%	85%	Yes
Consent	26	27	96.3%	85%	Yes
Fire Safety Awareness	26	27	96.3%	85%	Yes
Health and Safety	26	27	96.3%	85%	Yes
Infection Prevention and Control Level 2	26	27	96.3%	85%	Yes
Invasive Procedures Policy	26	27	96.3%	85%	Yes
Medicines Management	26	27	96.3%	85%	Yes
Moving and Handling Level 1	26	27	96.3%	85%	Yes
Resuscitation Level 2	26	27	96.3%	85%	Yes
Venous Thromboembolism	26	27	96.3%	85%	Yes
Duty of Candour	25	27	92.6%	85%	Yes
Information Governance	25	27	92.6%	85%	Yes
ANTT	24	27	88.9%	85%	Yes

In maternity services the 85% target was met for all of the 15 mandatory and statutory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at St Mary's Hospital and Queen Charlotte and Chelsea Hospital for doctors in training in maternity services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Blood Transfusion	51	51	100.0%	85%	Yes
Conflict Resolution	50	51	98.0%	85%	Yes
Consent	50	51	98.0%	85%	Yes
Equality and Diversity	50	51	98.0%	85%	Yes
Health and Safety	50	51	98.0%	85%	Yes
Infection Prevention and Control Level 2	50	51	98.0%	85%	Yes
Invasive Procedures Policy	50	51	98.0%	85%	Yes
Moving and Handling Level 1	50	51	98.0%	85%	Yes
Nasogastric Tube Placement	50	51	98.0%	85%	Yes
Medicines Management	49	51	96.1%	85%	Yes
Venous Thromboembolism	49	51	96.1%	85%	Yes
Fire Safety Awareness	47	51	92.2%	85%	Yes
Information Governance	47	51	92.2%	85%	Yes
ANTT	45	51	88.2%	85%	Yes
Resuscitation Level 2	42	51	82.4%	85%	No

In maternity services the 85% target was met for 14 of the 15 mandatory and statutory training modules for which doctors in training were eligible. The resuscitation level 2 training was slightly below the trust target.

(Source: Routine Provider Information Request (RPIR) – Training tab)

CTG teaching, skills and drills and sepsis management was included in all junior doctor induction sessions. The CTG compliance for medical staff at QCCH was 93%.

There were annual, announced and unannounced, multidisciplinary simulation “skills and drills” training to rehearse response to obstetric emergencies. Staff could access e-learning and could select bespoke course for their working area such as cord prolapse and dysphasia.

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.

Staff demonstrated a thorough awareness of safeguarding procedures and described how they had involved the safeguarding teams when they had concerns. Staff confirmed they had received training in safeguarding adults (level 2) and children (level 2 and level 3). Safeguarding training also covered female genital mutilation (FGM) and child sexual exploitation (CSE). The service ran a weekly clinic for women who had undergone FGM to ensure timely access to the specialist obstetrician, midwives and psychological support to ensure better birth planning. The service had designated FGM team which included the specialist midwives, FGM health advocate, counsellors and social worker who were available during the joint clinic appointment. Where mothers were identified as having suffered FGM or were at risk of FGM, cases were referred to the local authority.

The care of vulnerable pregnant women was provided by the caseload midwives. There were systems in place to track and support young women in the trust. Teenage mothers that were pregnant or had given birth were under the case loading midwives (a term used by hospitals for continued care received by a senior or specialist named midwife throughout pregnancy and birth) with support from the safeguarding teams. The service worked with the charity Redthread that

supported young people through the vulnerable transition of adolescence and Child and Adolescent Mental Health Services (CAMHS). Redthread is a local community-based charity which provides support to young people in their personal and social development. We noted this was not a service provided by the hospital, but a collaborative arrangement. The Redthread team also supported staff with concerns around child sexual exploitation, modern slavery and gangs. Children suspected of being subject to CSE or modern slavery were referred to the local authority and reported through national channels.

The trust set a target of 85% for completion of safeguarding training.

Queen Charlotte's and Chelsea Hospital maternity department

A breakdown of compliance for safeguarding training courses as at February 2019 for qualified nursing and midwifery staff in maternity services at Queen Charlotte and Chelsea Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults Level 2	161	175	92.0%	85%	Yes
Safeguarding Children Level 3	146	175	83.4%	85%	No

In maternity services at Queen Charlotte and Chelsea Hospital, the 85% target was met for one of the two safeguarding training modules for which qualified nursing and midwifery staff were eligible. The achievement for the second module was slightly below target.

A breakdown of compliance for safeguarding training courses as at February 2019 for medical staff in maternity services was not provided as site specific; compliance for staff at St Mary's Hospital and Queen Charlotte and Chelsea Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults Level 2	26	27	96.3%	85%	Yes
Safeguarding Children Level 3	26	27	96.3%	85%	Yes

The level 3 safeguarding training was developed in compliance with national guidelines, legislations and The Royal College of Paediatrics and Child Health (RCPCH) framework. Staff we spoke to told us the training was comprehensive and covered topics such as signs and symptoms of abuse, modern day slavery, child sexual exploitation, serious case review and learning, consent, parenting capacity, child death and procedures, domestic violence, referrals, and safeguarding in children, adolescence and maternity.

In maternity services at St Mary's Hospital and Queen Charlotte and Chelsea Hospital, the 85% target was met for both safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as at February 2019 for doctors in training in maternity services was not provided as site specific: compliance for St Mary's Hospital and Queen Charlotte and Chelsea Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults	47	51	92.2%	85%	Yes
Safeguarding Children Level 3	46	51	90.2%	85%	Yes

In maternity services at St Mary's Hospital and Queen Charlotte and Chelsea Hospital, the 85% target was met for both safeguarding training modules for which doctors in training were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The maternity service had a designated safeguarding team and specialist midwives who provided support, supervision, training and updates for staff and participated in serious case reviews. There was a safeguarding named nurse who worked cross-site and a named doctor for children.

Staff described situations where they had identified safeguarding issues and had taken action. For example, where a woman's partner was known to have links with gangs, the service had worked with other organisations to keep the woman and baby safe. Other examples included where staff saw partners being verbally or physically abusive to women on the ward. During the inspection we listened to a handover where staff raised a woman's previous history of domestic violence with a partner, the involvement of the safeguarding team as a risk factor and the actions taken during the current admission were shared with staff.

The service had expanded the caseload midwife team which provided continuity of care through antenatal care, delivery and postnatal care. The caseload midwives provided one to one care for mothers and babies who were identified as being at risk, for example, teenage mothers, women with learning disabilities or drug abuse. The case load midwives worked closely with the safeguarding teams to protect women and children.

We also saw how staff worked with the perinatal mental health midwife and team to safeguard women and babies.

Data provided showed between November 2017 to October 2018 for the trust wide maternity service there had been one adult safeguarding referral and 312 safeguarding children referrals. The trust had not been involved in any serious case reviews (where abuse or neglect had been a factor in a child's death) in the last 12 months, however they had reviewed learning from serious case reviews in other areas.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.

The maternity wards and clinics we visited at QCCH were visibly clean and tidy. Hand sanitiser dispensers were available at the entrance to the ward and located at appropriate places throughout the clinical areas to encourage frequent use by staff and visitors. We overheard a ward administrator advising and demonstrating to new visitors to the ward on the importance of appropriate hand hygiene.

All the staff we saw adhered to the national policy of bare below the elbows. Hand wash basins and personal protective equipment including gloves and aprons were available throughout the maternity departments. Staff had access to and used suitable personal protection clothing such as gloves, aprons and face guards to protect women and babies from a healthcare associated infection.

We observed staff washing their hands before attending to women and babies. Staff put on fresh aprons and gloves before giving personal care to patients and these were changed in between patients. We saw staff disposed of clinical waste safely.

In May 2018 the trust undertook a trust wide audit of hand hygiene and found some areas were performing very poorly, for example, the labour ward at QCCH compliance was 50%. In response

the trust implemented an improvement programme which involved an action plan and close monitoring to improve hand hygiene compliance. During our inspection we saw hand hygiene audit results were displayed on some wards, for example on the antenatal ward and labour ward the results for January 2019 showed 100% hand hygiene compliance.

We saw at least five pieces of equipment on each ward we visited, they had been cleaned and labelled to indicate the date and time of cleaning and they were ready for use. Midwives and support nursing staff cleaned and maintained specialised clinical equipment, such as the clinical and delivery trolleys and the neonatal resuscitation equipment in each delivery room and in the birth centre. All areas we visited had date labelled clean disposable curtains around bed spaces. We saw cleaning of rooms on the labour ward took place immediately after they had been vacated to prepare for the next patient.

The matron on labour ward said any issues with environmental cleaning were addressed immediately with the cleaners on site or with the supervisor on a weekly basis. The maternity service cleaning audit results for each ward between August 2018 and December 2018 showed consistent compliance of above 95%.

The service monitored postnatal readmission rates for infection. The infection rates were included as a safety metric on the maternity dashboard and broken down by site. QCCH reported 32 (0.7%) cases of puerperal sepsis within 42 days after delivery (sepsis following child birth) between April 2018 and January 2019, this performance was significantly better than the standard of 1.5%.

As of February 2019, there were zero cases of hospital acquired MRSA blood stream infection (antibiotic resistant bacteria) and Clostridium difficile in the last 12 months reported by the service.

Staff had access to the trust infection prevention and control policies, procedures and guidelines, on the trust's intranet site.

Environment and equipment

The service had suitable premises and equipment and looked after them well. There were systems to ensure equipment was checked daily, however, compliance with checking was inconsistent.

The antenatal clinic and maternity day assessment unit were located on the ground floor of the hospital, the inpatient wards and the birth centre were located on the first floor, triage department, labour ward, theatres, and fetal medicine unit were located on the second and third floors. The antenatal ward had been relocated closer to the labour ward to facilitate safe and quick transfer between the two areas.

There were two dedicated obstetric theatres, which was in line with safe practice and had necessary equipment needed. The theatres were located adjacent to the labour ward. One of the theatres was available 24 hours for emergency caesarean sections. The theatres were spacious in size and well equipped.

The labour ward and birth centre at QCCH accommodated rooms which were all en-suite this complied with the Department of Health's recommendation for birthing rooms (DH Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities, 2013.)

There was one room which contained a birthing pool on the labour ward and three rooms with birthing pools in the birth centre. The pools were well maintained. Nets were available to evacuate a woman from the pool safely in an emergency.

The maternity wards all had secure entrance doors which were monitored by CCTV. Staff entered with use of their swipe cards, other visitors were only allowed access by the ward administrator if they had a genuine reason for entering the ward. There was an intercom system to speak with the ward administrator and a sign in book to record visitors. On the labour ward and birth centre, exit from the ward by visitors was also controlled by the ward administrator to reduce risks to women and babies.

We reviewed five pieces of equipment on each ward we visited and found they had labels to indicate service dates. Staff said the wards were well equipped and they could not recall any problems with the quality or quantity of equipment. All of the equipment we saw had a recent service testing or medical engineering date. This meant equipment was maintained in line with relevant safety standard and staff could be assured it was safe to use. The trust had an assurance process to manage equipment maintenance which was monitored monthly on a trust-wide basis.

Staff had access to a fetal blood gas analyser and laboratory facility for bloods including a blood fridge available on the wards, which was in line with national recommendations (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007).

CTG machines were available for women who required continuous electronic fetal heart rate monitoring and to record uterine contractions during pregnancy and labour, which allowed early detection of fetal distress. In the labour ward the women were linked to equipment with monitors located in the ward meeting room which allowed the multidisciplinary team to keep track of women and babies remotely.

On the antenatal ward we saw the adult resuscitation trolley had not been recorded daily as planned. Nine daily checks were omitted from the record for 1 February 2019 to 27 February 2019. On the birth centre we saw daily checks of the neonatal resuscitation equipment and warming platform were not completed as planned, nine checks were omitted for the date range September 2018 to February 2019.

Suitable arrangements were in place for the management of clinical specimens and waste disposal. Clinical waste bins were emptied regularly, and contaminated sharps were segregated according to their nature. The room that contained the Control of Substances Hazardous to Health (COSHH) cupboard was lockable, however, during the inspection we saw the room had been left open and was quickly secured after we alerted the matron.

The community midwife lead said there had been problems with obtaining equipment, such as hand-held ultrasound devices and baby scales in the past but this had been resolved and all staff now had the necessary equipment they needed to provide appropriate care for women and babies in the community.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Community midwives undertook a detailed assessment of women at their initial booking appointment, which took account of their medical, obstetric, family histories, mental health and social circumstances. The booking record was kept in the hand-held records and an electronic copy was created. Copies of any ultrasound scan reports and results of any blood tests were kept as part of the hand-held record.

From the records reviewed, we also saw that staff continually obtained and assessed patients' medical, social and mental health history to identify possible risk throughout the antenatal period. We saw that staff assessed and documented high-risk pregnancy, pre-operative checklist, patient allergy, birth plan, fetal anomaly screening, smoking status, booking risk, Growth Assessment Protocol measurement, new born early warning tracker and trigger (NEWTT) and MRSA swab, on patient notes which were in line with national guidance.

Staff completed venous thromboembolism (VTE) risk assessments which was used to determine a patient's risk of developing a blood clot, in line with national recommendations. The service audited compliance with the trust's VTE screening tool. Data from the maternity scorecard showed between January 2018 and January 2019 compliance met the standard of 95% for seven months out of 13 months. The lowest compliance was 93.4% in February 2018.

These assessments, together with the medical and obstetric history, were used to classify the woman as 'low' or 'high' risk. Low risk women continued with midwifery-led care, whilst high risk women were referred to consultant-led care.

At each antenatal contact women's individual risks were reviewed and reassessed. Women risk assessed as low risk were given the option of giving birth in the midwifery-led birth centre or within their own home.

The service had an antenatal and postnatal mental health pathway that guided staff on steps to take where patient was at risk of committing suicide or harming others. Staff assessed and monitored women using 'Whooley questions' (tool used for screening depression) and the 'feelings and questionnaire tool' at risk of depression and anxiety. Where concerns were identified, referrals were made to the perinatal mental health team and specialist midwife. We saw evidence that referrals had been made and patient care was well managed in the patient's record we reviewed. Safeguarding and mental health issues were flagged up on the system and where a woman with severe mental health issues did not engage with staff this was flagged up as a safeguarding concern. During inspection, on the patients' records, we saw that staff had completed the mental health assessments, which were very detailed when mental health issues were identified.

Women were advised of the services they could contact if they had any concerns about their pregnancy. Specific information was provided for women to ensure they sought the correct help depending on the length of their pregnancy and the concerns they had, for example, if a woman experienced reduced fetal movements and was more than 20 weeks pregnant she would be advised to immediately call or visit the triage service.

Staff attended regular obstetric emergency drill training to ensure they could respond appropriately in an emergency.

One woman we spoke with told us she had attended the antenatal clinic for a routine 20-week scan and due to a complication, which had been identified she had an emergency procedure carried out the same day to reduce the risks to her and her baby. Another woman we spoke with said she had undergone a planned caesarean section due to a medical condition during her pregnancy. Both women and their partners said they had complete confidence in the way staff had provided care during their pregnancies and deliveries.

The maternity service used the modified early obstetric warning score (MEOWS) tool to monitor patients and detect signs of deterioration. MEOWS was designed to enable staff to identify and respond to a woman whose health was deteriorating and summon obstetrician or other medical staff if required. Midwives and junior doctors said there was good access to consultants and registrars when needed. This enabled early medical intervention to prevent deterioration of the woman in labour and the baby in utero. We reviewed five MEOWS charts, staff were completing them fully and accurately calculating the scores and were escalating appropriately when the tool

indicated a concern about a woman's wellbeing. The service provided data from a recent spot check audit of MEOWS and neonatal MEOWS charts in 2019 which showed 100% compliance for both.

If women's health deteriorated on the antenatal or postnatal wards they were transferred to the high dependency unit on the labour ward until they were stabilised.

The maternity service used the World Health Organisation (WHO) surgical safety checklist for women having a C-section or other obstetric surgical procedure, such as instrumental delivery, to prevent or avoid serious patient harm in the operating theatre. This was in line with national recommendations (NPSA Patient Safety Alert: WHO Surgical Safety Checklist). The checklist was completed by the anaesthetist and also completed after spinal and catheter procedures. The results of the WHO surgical safety checklist audits for the period of April 2018 to January 2019 showed compliance had steadily improved from 67% in April 2018 to 100% in January 2019. From observations and record reviews we saw that WHO checklist were fully completed by staff.

Midwives were trained to recognise when a woman's condition or the fetal cardiotocograph chart indicated signs of fetal distress. Staff understood when to follow the escalation procedure and call for medical help and assistance.

Staff used the new born early warning trigger and track (NEWTT) tool, designed to identify babies at risk of clinical deterioration following birth. This initiated prompt investigation and intervention. From the EPR records reviewed, we saw that staff completed NEWTT appropriately in line with the trust guidance. Pulse oximetry was performed on all new-born babies (to measure the oxygen levels) which helped identify babies whose heart and lungs were less healthy.

There was a buddy system (fresh eyes) in place for review of CTG interpretation, with guidance for escalation where needed. Fresh eyes involved a second midwife checking a CTG recording of a baby's heart rate to ensure it had been interpreted correctly and if necessary to take appropriate action. This was in line with national recommendations. The service had a safety stream tasked with improving fetal monitoring through updating clinical guideline, full implementation of the electronic fetal central monitoring station on the labour ward, human factor training for staff and undertaking additional two-day fetal monitoring training for labour ward coordinators and medical staff. The new system is a fetal and maternal monitoring system that allows data flow from medical devices in order to facilitate the clinician's display needs in critical and outpatient environments. Since the new system was introduced the trust reported there had been no CTG related incidents.

Women booked for elective caesarean section were seen in antenatal clinic for a pre-operative assessment, where blood tests and screening were performed.

There were twice daily handovers for medical and nursing staff. The medical handover included multidisciplinary attendance by consultants and the anaesthetists. We attended the morning midwives' handover followed by the doctors' handover in the labour ward. The midwives' handover was short and preceded the more detailed multidisciplinary doctors' handover. All the patients were discussed, highlighting treatment, progress and plans in particular for the high-risk patients.

The service had a fetal medicine unit called 'the centre for fetal care', which supported women who had complications or abnormalities in their pregnancy. In line with the NHS Better Births programme, staff asked women about their baby's movements at each antenatal contact to reduce the risk of still birth. Staff advised women to contact the maternity helpline, day assessment unit or triage unit if they had any concerns about their baby's movements.

The trust used an alert on the patient's electronic record to identify vulnerable or high-risk patients. The trust had reviewed their sepsis guidelines and staff received training on sepsis management in line with Sepsis Six. The electronic record incorporated a sepsis alert. Staff referred women to the perinatal mental health midwife and to the case load team as needed, for example, women with needle phobia.

The service tested their security procedures by undertaking training exercises. For example, a security drill in January 2019 enacted an attempted baby abduction from the labour ward. Lessons learnt from the exercise were highlighted to staff to improve security on the unit.

Midwifery and nurse staffing

The service had enough midwifery and nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The trust reported their qualified nursing, midwifery and health visiting staffing numbers for St Mary's Hospital and Queen Charlotte's and Chelsea Hospital below as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
St Mary's Hospital	122.7	108.3	88.3%
Queen Charlotte's and Chelsea Hospital	180.2	166.2	92.2%
Total	302.9	274.5	90.6%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 9.8% for qualified nursing and midwifery staff in maternity at Queen Charlotte's and Chelsea Hospital. This was lower than the trust target of 10%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 10.2% for qualified nursing and midwifery staff in maternity at Queen Charlotte's and Chelsea Hospital. This was lower than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 5.3% in maternity services at Queen Charlotte and Chelsea Hospital. This was higher than the trust target of 3%. Staff said the high sickness rate was due to a small number of long-term sickness and was being managed.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Queen Charlotte's and Chelsea Hospital

From October 2017 to September 2018, the trust reported 55,037 (18.8%) bank hours and 6,654 (2.3%) agency hours at the trust were filled by qualified nursing and midwifery staff in maternity. There were 18,094 hours (6.2%) that were not filled by bank/agency staff.

A ward breakdown is shown below:

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Edith Dare	50,467	11,895	23.6%	691	1.4%	1,198	2.4%
Midwifery Education Team	14,733	0	0.0%	0	0.0%	5,814	39.5%
Midwifery Management Team	18,773	0	0.0%	0	0.0%	3,743	19.9%
Antenatal Clinic	13,959	2,040	14.6%	8	0.1%	Over-filled by 173	Over-filled by 1.2%
Birth Centre	27,113	3,421	12.6%	108	0.4%	424	1.6%
Caseload Midwives	10,163	6	0.1%	0	0.0%	504	5.0%
Early Pregnancy Assessment Unit (EPAU)	3,383	9	0.3%	0	0.0%	306	9.1%
Labour Ward	109,125	30,028	27.5%	5,261	4.8%	3,759	3.5%
Lewis Ward	19,962	2,210	11.1%	44	0.2%	391	2.0%
Triage/Day Assessment Unit	15,542	3,529	22.7%	535	3.4%	2,338	15.0%
Sir Stanley Clayton	8,909	1,899	21.3%	8	0.1%	Over-filled by 209	Over-filled by 2.4%
Total	292,127	55,037	18.8%	6,654	2.3%	18,094	6.2%

A lower proportion of hours were unfilled (average of 2.4%) on ward areas compared to the triage/day assessment unit (15%). There was high bank usage on Edith Dare (postnatal ward) and the labour ward (average 25%), to ensure safe staffing levels. During the same period the day assessment unit and triage had undergone a reorganisation in the way services were provided since June 2018. Staff told us triage was a very busy service, particularly at night and weekends when the maternity day assessment unit (MDAU) was closed. The service activity was kept under review weekly and senior staff said they only allocated experienced band 6 midwives to cover triage where possible.

During the same period, the trust reported 11,635 (13.7%) bank hours and 24 (0.0%) agency hours were filled by nursing assistants in maternity. There were 3,894 hours (4.6%) that were not filled by bank/agency staff.

A ward breakdown is shown below:

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Edith Dare	22,967	3,354	14.6%	12	0.1%	450	2.0%
Antenatal Clinic	2,063	1,058	51.3%	0	0.0%	Over-filled by 1,421	Over-filled by 68.9%
Birth Centre	8,573	794	9.3%	0	0.0%	153	1.8%
EPAU	1,778	8	0.5%	0	0.0%	210	11.8%
Labour Ward	20,004	855	4.3%	12	0.1%	1,166	5.8%
Lewis Ward	9,045	1,611	17.8%	0	0.0%	132	1.5%
Triage/DAU	11,454	2,245	19.6%	0	0.0%	3,243	28.3%
Sir Stanley Clayton	9,040	1,711	18.9%	0	0.0%	Over-filled by 38	Over-filled by 0.4%
Total	84,923	11,635	13.7%	24	0.0%	3,894	4.6%

The trust confirmed that the over-establishment reflects actual v planned for months where the actual was greater than the planned (for example over established due to specialising or enhanced care). The trust report that the bank staff usage was mainly attributed to vacancies. (Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

From July 2017 to June 2018, the trust had a ratio of one midwife to every 29.9 births. This was similar to the England average of one midwife to every 25.5 births. (Source: Electronic Staff Records – EST Data Warehouse)

In 2018 the service undertook a full Birth rate plus assessment. The national Birth rate plus acuity tool, in line with guidance from the National institute for Health and Care Excellence (NICE) Safe Midwifery Staffing, 2015. (Birth-rate plus is a tool used to calculate midwifery staffing levels, based on the ward activity and needs of the women. Acuity is the measurement of the intensity of nursing care required by a woman). The Birth rate plus review had identified a gap in the staffing establishment of approximately 16 whole time equivalent (WTE) midwifery staff across the service as a whole, it recommended the staffing levels at QCCH to be enhanced from the current ratio of 1:28 to 1:26.

Senior staff informed us a paper has been sent to the trust executive with the detail of what is required to meet the recommended ratio at QCCH, and this has been submitted as a cost pressure for 2019/2020. However, during the inspection no staff we spoke with expressed any concerns about staffing levels and women we spoke with said although staff were busy they did not feel there were not enough staff on the wards to meet their needs.

According to national recommendations, all women should expect to receive one-to-one care in established labour (RCOG Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, 2007). For the period of April 2018 to January 2019 one to one midwifery care during established labour was met for every month and for the same period trust data showed 100% of women cared for had a named midwife.

Planned and actual staffing levels were displayed on quality and safety boards on the wards. The staffing levels on the wards were as follows: Labour ward: 11 midwives, Birth Centre: three midwives and one maternity support worker (MSW), antenatal ward: two midwives and one MSW, post-natal ward: eight midwives and four MSW. Staff generally worked 12-hour shifts.

Staffing levels were monitored closely by managers, labour coordinators; a daily cross site safety huddle call took place to discuss staffing and safety issues at both sites. The lead midwives and coordinators were supernumerary. During the inspection we noted that all maternity areas were well staffed and rated green (indicated met safe staffing levels). The safety huddle meetings improved cross-site MDT communication to identify patient flow and patient safety issues. This in turn helped improve clinical practice to achieve good outcomes for women and their babies.

Each ward had a band 7 matron who was supernumerary. On the labour ward a band 7 matron was the ward co-ordinator, they were supernumerary which enabled them to support staff and cover their breaks. During the inspection staff we spoke with did not express any concerns about staffing levels on the wards except for HDU cover. We requested the actual staffing levels for HDU for February 2019 and found all shifts had been covered by HDU trained staff. The trust informed staff were always redeployed to provide HDU cover and other areas were back filled.

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The trust reported their medical staffing numbers at Queen Charlotte's and Chelsea Hospital below as at October 2018.

Location/Site	Planned Staff WTE	Actual Staff WTE	Staffing rate as at October 2018
Queen Charlotte's and Chelsea Hospital	2.0	0.0	0.0%

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From November 2017 to October 2018, the trust medical staffing at Queen Charlotte's and Chelsea Hospital maternity services were over-established by 15.0%, compared to the trust target of 10% vacancy. The trust overall vacancy rate for all staff in maternity at QCCH was 10.9%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 0.0% in maternity at Queen Charlotte's and Chelsea Hospital, compared to the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 0.41% in maternity for medical staff working cross sites. This was lower than the trust target of 3%. The trust did not submit sickness data for medical staffing broken down by site.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From November 2017 to October 2018, the trust reported 2,230 hours were filled by medical locum staff in maternity. The trust was unable to confirm the number of locum or agency hours that were unfilled.

A breakdown of agency usage by site is shown below:

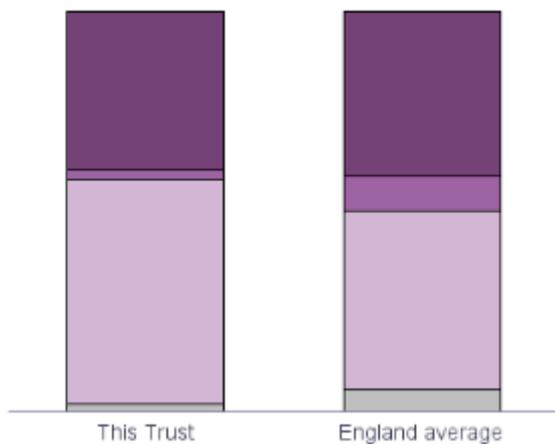
Location	Locum/Agency Usage
	Hrs
St Mary's Hospital	53
Queen Charlotte's and Chelsea Hospital	2,177
Total	2,230

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

In September 2018, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff reported to be working at the trust was lower.

Staffing skill mix for the 102.9 whole time equivalent staff working in maternity at Imperial College Healthcare NHS Trust.

	This Trust	England average
Consultant	40%	41%
Middle career^	2%	9%
Registrar group~	56%	44%
Junior*	2%	6%



^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

There was 98 hours obstetric consultant labour ward presence seven days a week from 8am to 11pm on weekdays and 8.30 am to 8pm on weekends on the labour ward". This was in line with the safer childbirth/Royal College of Obstetricians and Gynaecologists (RCOG) recommendations for the minimum number of hours of consultant presence on the Labour ward per week. Outside of these hours the consultant obstetricians worked an on-call system. A senior speciality registrar was on site 24 hours a day to attend the maternity unit when required. The obstetric teams also included additional registrars and junior doctors who provided 24-hour cover.

There was consultant on call at night and there was registrar and senior house officer (SHO) cover. All consultants were within 30 minutes from the hospital when needed at night. Triage was covered by a registrar.

A team of anaesthetists provided cover 24 hours a day, seven days a week; an anaesthetist was always available immediately for the maternity unit and was free from other duties.

We were told and saw handovers were multi-disciplinary and the on-call consultant obstetricians and anaesthetists usually attended, together with more junior doctors and a midwife co-ordinator.

Midwifery staff on the wards and in triage told us they did not experience any problems in requesting medical review of women when needed. Junior doctors we spoke with told us their supervisors were available when needed and they had not missed any teaching sessions due to staff shortages.

Records

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

The trust had implemented an electronic patient records (EPR) system which had been in use three years. In some areas, such as antenatal clinics, there was a mix of paper and electronic records.

Women were given their own set of hand-held antenatal care records at the initial booking appointment to have available at every antenatal appointment. Staff recorded every contact within these records. The hospital also held medical records relating to each woman. Women's booking and delivery details were recorded electronically. Women were given the national personal child health record (also known as the 'red book') by staff on discharge after birth. The red book is a

national standard health and development record and is used to monitor growth and development of the child, up to the first four years of life.

A summary of care was included in the postnatal notes for the community midwife following discharge from hospital. A discharge summary was included in the notes to be sent to the GP and health visitor prior to discharge from the community midwife.

The service had introduced the role of an information technology (IT) midwife since the introduction of the new electronic system. The IT midwife trained colleagues on electronic records, responded to email queries, corrected errors on system and attended a weekly meeting for the fetal and maternity monitoring system and data correction.

Staff used both electronic and paper-based methods for recording the handover of a woman's care. They used the Situation, Background, Assessment and Recommendation (SBAR) forms for handover when women were moved from any of the wards, labour ward and after a shift change. SBAR is a technique that can be used to facilitate and prompt appropriate communication especially amongst healthcare professionals. An audit in 2018 of the use of the SBAR electronic tool from one practitioner to another during intrapartum care was found to be 44.5%. The action plan in response included update training for midwives and improved processes to make the SBAR tool more accessible. A re-audit to check compliance was planned for April 2019.

We reviewed seven records and found they had been completed in line with national standards (NMC The Code: Professional standards and behaviour for nurses and midwives, 2015). The records reviewed also included prescriptions, mental health, safeguarding and termination of pregnancy. The records we reviewed were contemporaneous, and entries were legible, signed and dated. Regular clinical assessments by the multi-disciplinary team (MDT) were evident in the maternity records we reviewed. Clinical assessments of social, medical, obstetric and mental health had been documented. We saw that staff communicated effectively with community staff where there were safeguarding, domestic violence and specific mother or baby concerns. We saw evidence of SBAR handover in the patient notes.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

Medicines were supplied by the onsite trust pharmacy. Staff ordered, dispensed and disposed of medicines safely and securely. Arrangements were in place to facilitate medicines supplies out of hours.

There was effective process in place for managing medicines including controlled drugs (CDs) and emergency medicines used in the community during home birth. CDs were stored and managed appropriately. CDs were checked twice daily by two midwives. Some areas checked CDs more frequently. We saw that controlled drugs were stored and managed appropriately. Medicines reconciliation were completed and recorded while identified areas of discrepancy were actioned and processes were audited.

The service uses a computer-based prescribing and administration records system for the mothers. The records were completed and notes were made when any non-administration had taken place. We checked seven electronic medicines administration records and saw that they were accurate, completed fully with no missing administrations. Allergy statuses of people, weight and venous thromboembolism (VTE) risk assessment outcomes were routinely recorded on the electronic

medicines administration records. Staff understood their responsibilities for ensuring accurate electronic medication records were kept. Staff felt the computerisation of medicines worked well and reduced safety incidents.

We saw that where babies were prescribed medicines that required additional monitoring that this was documented as being completed.

Patient group directions (PGDs) were available for all midwives trained and permanently employed at the trust. These are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. All PGDs had been reviewed and were up to date.

Arrangements were in place to ensure adequate supplies of emergency medicines and equipment were available, especially out of hours.

We saw that there were current versions of the British National Formulary (BNF) and BNF Children available and staff could also access the online version.

The pharmacy team provided advice, strategic direction and governance to optimise the use of medicines and the management of medicines across the ward. The pharmacy team carried out medicines audits routinely to monitor sustained compliance with medicines security, medicines reconciliations, allergies, antibiotic breaches, VTE risk assessments, oxygen prescribing and dose omission. The pharmacists checked stocks regularly and the senior midwives also checked medicines weekly and carried out stock drugs audit. All medicines were reviewed during consultant led ward rounds which were attended by a clinical pharmacist where possible.

We observed that discharge summaries detailed the verbal and written information provided to patients about the medicines they were given. Staff provided appropriate medicines counselling on wards including discharge and all high-risk medicines.

The trust medicines matter audit for the period of 4 October 2018 to 18 February 2019 showed 98% compliance on the medicines' fridges audit and the medicines storage and security.

A missed dose 2018 audit was completed across all sites of the trust which highlighted an omission rate of approximately 3% for critical medicines which was better than the national average (7%).

The trust pharmacy medicines reconciliation rates audit highlighted the need to improve the timeliness of medicines reconciliation in some clinical areas. There was good assurance that timely (less than 24hrs) medicines reconciliation occurred within acute (non-elective) admissions areas within the trust where workforce was prioritised. Following this audit, a medicines management safety stream had been established to co-design a number of products and guides for clinical staff on how to manage medicines in clinical areas. This included the on-going production of updated fridge temperature monitoring and action algorithms, guide for disposal of CDs, new CD key fobs and clear guidance on roles and responsibilities.

Medicines were stored in locked cabinets, fridges and trolleys within locked clinical treatment rooms and only relevant clinical staff could access them. Medicines used for internal use and external use were stored separately.

Fridge temperatures and clinical room ambient temperatures were monitored and recorded daily. During inspection we saw that fridge and room ambient temperatures were generally monitored by staff in all maternity areas.

We saw where anti-microbials were prescribed they were reviewed in line with the trust policy. The trust antibiotic review group (ARG) met every two months, to optimise effective use of antimicrobials and review and update the antibiotic policy. A trust-wide antibiotic stewardship programme was embedded to address antimicrobial resistance, optimise the treatment of infection, including sepsis, and to improve outcomes.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. 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.

All patient safety incidents which were reported on the trust incident reporting system and reviewed and investigated locally, with actions developed in response. Incidents were reviewed locally at risk meetings during and after the investigation process to ensure any learning was embedded. Themes from incidents were reviewed at the directorate quality and safety committees and fed through into the divisional quality and safety committees. The minutes of these meetings were reviewed at the trust quality and safety sub-group, chaired by the medical director to allow trust wide themes to be identified, monitored and included in the safety improvement priorities workstreams.

All patient safety incidents graded moderate and above were reviewed weekly by the divisional management teams and then at the weekly panel, chaired by the medical director. This allowed timely declaration of serious incidents (SI) as well as executive oversight of emerging safety risks and their mitigations.

From 1 February 2018 to 31 January 2019 the maternity service reported 1002 incidents of which 578 (58%) were categorised as no harm, 299 (30%) as low harm and 13 (1%) as moderate harm and the remainder as near miss.

The top three categories of incidents were:

- labour and delivery (469, 47%), for example, unexpected admission to the neonatal unit, third or fourth degree tears and post-partum haemorrhage
- Infrastructure mainly staff shortage (62, 6%) and
- Unexpected readmissions (51, 5%).

Staff we spoke with were aware of how to report incidents through the trust's electronic incident reporting system and were encouraged to do so by senior staff. The risk governance team had oversight of all incidents.

Where SIs had occurred, we saw root cause analysis investigations had taken place to identify the underlying causes and if there were any lessons from the incident.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From January 2018 to December 2018, the trust reported one incident which was classified as a never event for maternity. This was for maternity/obstetric incident meeting serious incident (SI) criteria: mother only (retained foreign object) at Queen Charlotte's and Chelsea Hospital. We saw

the changes that had been implemented following the incident of the retained swab.
(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from January 2018 to December 2018.

Of these, the types of incident reported were:

- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) with six (54.6% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother only with two (18.2% of total incidents).
- Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) with two (18.2% of total incidents).
- Major incident/ emergency preparedness, resilience and response/ suspension of services with one (9.1% of total incidents).

Site specific information can be found below:

- Queen Charlotte's and Chelsea Hospital: seven incidents
(Source: Strategic Executive Information System (STEIS))

We reviewed the serious investigation reports for three maternity incidents across the service and saw there had been a full investigation with input from the multi-disciplinary team. Learning from the incident had been recorded along with agreed actions, for example reviewing guidelines or changes to practice and escalating concerns to senior medical staff.

The service held monthly perinatal mortality and morbidity (M&M) meetings which were attended by multidisciplinary team staff and chaired by a consultant obstetrician. The circumstances and management of each neonatal death was discussed to determine if it was avoidable or unavoidable and any learning or action points shared if appropriate. All still births and neonatal deaths were investigated and reported to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) in line with the national guidance.

From 30 April 2018 the Secretary of State for Health and Social Care had appointed the Healthcare Safety Investigation Branch's (HSIB) to investigate all cases of early neonatal deaths, term intrapartum stillbirths, cases of severe brain injury in babies (Each Baby Counts cases) and maternal deaths in England. During the inspection we noted that the risk team also invited all teams to their bi-monthly meeting where HSIB maternity investigations were discussed. Senior managers told us they were pleased about HSIB and investigations as their reports helped to improve quality of services. Staff we spoke with were happy about this new process and support received from the trust with these investigations. Staff told us the HSIB reports took approximately six months to produce and they ensured they communicated with families promptly during this process.

Learning from incidents was shared with staff through a variety of means including at daily handovers, safety huddle and weekly risk review meetings for the service to disseminate learning from incidents quickly.

The service also produced a detailed account of learning and actions taken following serious incidents in the service bi-monthly newsletter, 'Risky Business in our Maternity Units'. Staff we spoke with were familiar with the learning from the recent never events in maternity (July 2018 and January 2019); both related to an SI of a retained swab.

The trust had identified nine key safety priority areas for 2018/19 to address the most frequently occurring clinical risks reported by staff, which included fetal monitoring. Each safety stream was

underpinned by a service improvement methodology and was chaired by a senior leader in the trust. Progress was reported quarterly to the trust's quality and safety sub-group and included a reduction in incidents and complaints relating to CTG misinterpretation through investment in a new monitoring systems and staff training.

Common themes across all safety streams include reviewing and refreshing trust policies, undertaking audit and developing a robust communications strategy in support of improvement work.

Staff we spoke with understood their responsibilities about the Duty of Candour (DoC) regulation and were aware of the trigger for the application of DoC, which was for moderate harm and above. DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. We saw DoC had been carried out in our review of the three RCAs.

Staff had e-learning training and system to ensure DoC was applied through a weekly medical director's incident review panel. Between 1 November 2017 and 31 October 2018 DoC was applied 37 times in the service.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The service did not participate in the maternity national safety thermometer. The maternity safety thermometer is a national system designed to record and support improvements in women's care and experience. However, similar data on the proportion of mothers who experienced harm associated with maternity, such as perineal trauma, abdominal trauma, postpartum haemorrhage and infection was recorded on the maternity scorecard/ dashboard and reviewed across the division and trust to identify areas for improvement. Every ward also recorded data on metrics which contributed to the monthly harm free care report. This included data on falls, pressure ulcers, hand hygiene, MRSA and C.diff rates, medication errors and staffing levels. We reviewed the harm free care reports for October 2018 to December 2018 for the maternity service at QCCH, the reports showed generally showed 100% harm free care, the exceptions were when inadequate staffing was reported or medication errors had occurred.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

There was a trust-wide process of ensuring local policies and guidelines were written in line with evidence-based standards and guidance from professional bodies such as the National Institute for Health and Care Excellence (NICE), Nursing and Midwifery Council (NMC) and the Royal College of Obstetricians and Gynaecologists (RCOG). The trust maternity specific guidelines and pathways included breastfeeding and artificial feeding, sepsis, antenatal management of diabetes (NICE Diabetes in pregnancy: management from preconception to the postnatal period), baby

abduction, anaesthesia for operative deliveries, multiple pregnancies (NICE Multiple pregnancy: twin and triplet pregnancies), pain relief, new born physical examination and jaundice. The development of guidelines was governed and reviewed by the clinical audit and effectiveness group which consisted of an obstetrician, neonatologist, midwife and anaesthetist. Regular guidelines committee meetings were held by the clinical audit and effectiveness group to review and renew guidelines before publishing and there was a flag system in place when a guideline was due for review. New guidelines were cascaded via the weekly staff newsletter, 'Risky Business' newsletter and discussed at staff training days. The service also held annual audit meetings where audits were discussed and professionals like doctors, midwives, midwifery support workers (MSW) and children nurses could attend.

Midwives and medical staff we spoke with described how their practice was informed by up to date evidence and guidance. They learnt about updated guidelines and policies by email and at team/academic meetings. Staff could access policies and guidelines on the trust intranet and they showed us how they did this. We reviewed eight guidelines and found them to be version controlled and within their specified review date.

The maternity service used current evidence-based guidance and quality standards to inform the delivery of care and treatment for women and babies. The maternity service clinical audit programme for 2018/2019 included 22 audits specific to the maternity service, three of which were national audits.

The service held weekly clinics for women with mental health needs, substance misuse and complex needs. The service also held FGM and bereavement clinics. We saw that staff followed the NICE guidelines on antidepressants in pregnancy. Women's records contained complete record of antenatal test results and referrals. Women's record also contained a completed comprehensive mental health assessment of patients' needs at booking and where patients required further input from the perinatal mental health team their plans of care was personalised and included details of action to be taken out of hours if the patient became unwell. This was in line with national guidance and standards.

Staff carried out hourly 'fresh eyes' on the CTG traces. 'Fresh eyes' is an approach which requires a colleague to review fetal monitoring readings as an additional safety check to prevent complications from being missed. The process is recommended by NHS England's Saving Babies Lives; A care bundle for reducing stillbirth. We reviewed the summary of a records audit from November 2018, which included documentation of the use of a Pinard stethoscope or sonic aid and the woman's pulse prior to starting the CTG and the use of the 'fresh eyes' in labour. The audit results showed 48% of records had the use of a Pinard or sonic aid recorded, 78% of records had a recorded 'fresh eyes', and 95% had the maternal pulse recorded.

The service had implemented the continuity of care model from Better Births (Implementing Better Births: continuity of care: NHS England, December 2017) to increase the number of women who experienced continuity of care from booking through to post-natal care in the birth centre and was working to expand the service to include more women.

Staff managed the care of women who needed a caesarean section (C-section) appropriately in accordance with NICE guidance. For example, vaginal birth after caesarean section support and counselling was offered to all women who had had a previous c-section if no medical condition or complication were identified. This provided women with the opportunity to discuss birth options in their current pregnancy.

Pregnant women at risk of gestational diabetes were referred to the weekly diabetic clinic for glucose tolerance testing and those with pre-existing diabetes were referred for retinopathy

screening in the first trimester (weeks one to 12 of pregnancy). Diabetic retinopathy is a condition that can lead to sight loss. We noted that staff monitored and assessed women's blood sugar to prevent gestational diabetes, hyperglycaemia or hypoglycaemia. This was in line with national recommendations (NICE Diabetes in pregnancy: management from preconception to the postnatal period). The service had two diabetic specialist midwives that supported women and were involved in development of guidelines relating to diabetes.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

The maternity service at QCCH had level-one accreditation in the UNICEF Baby Friendly initiative (BFI). The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding and raise standards of care for all babies. The UNICEF UK Baby Friendly Accreditation has four levels which starts with a certificate of commitment. Stage one assessment is building a firm foundation, stage two is an educated workforce and stage three is full accreditation. The service was planning for the BFI level two inspection due in April 2019.

Women were offered light refreshments, such as biscuits, sandwiches, water and hot or cold drinks during labour and after delivery or caesarean section. There were also hot foods available to women admitted on the inpatient wards.

We saw posters, promoting breastfeeding, on display in clinics and ward areas. Staff supported and advised women on breastfeeding their babies, including positioning and attachment, and hand expression during the antenatal and postnatal period. Data provided by the trust showed between February 2018 and January 2019 breast feeding rates at birth and discharge for babies born at QCCH were on average 87%. However, the trust stated the data was under review to improve accurate recording.

Women and babies at risk of hypoglycaemia were regularly monitored following delivery to ensure they were well and their blood glucose levels were maintained within the normal range. We observed the maternity wards had hypoglycaemia box which contained dextrogel, glucose juice and glucose-tablets which were given to patients during diabetic emergencies. Women with pre-existing or gestational diabetes were referred to a dietician with advice given on diet to help control blood sugar levels and weight, in line with national guidance (NICE Diabetes in pregnancy: management from preconception to the postnatal period).

Staff monitored women's hydration levels during labour and post-delivery and were corrected with oral or intravenous hydration techniques when indicated using the fluid chart, in line with national guidance.

Women were given advice on fasting before their elective caesarean section which was in line with national guidance (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services).

Staff in antenatal clinic gave women advice on their nutrition and hydration including iron rich diet.

The service used a gestational related optimal weight (GROW) assessment tool which was a customised birth weight centile to plot baby's weight accurately including weight loss and gain. The weight centile result informed the health promotion and care plan of the baby. Nutrition advice and referrals were given based on the result of the baby's birth weight centile.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Women were provided with evidence-based care and information about the availability and provision of different types of analgesia. This was in line with national recommendations (OAA/AAGBI Guidelines for Obstetric Anaesthetic Services, 2013). Pain relief and control was discussed with women during their birth plan appointment and women were able to choose their choice of pain relief.

During the inspection women told us they could access pain relief during birth and post operatively in a timely manner. Women we spoke with were happy with the options they had been given for pain relief and did not report a long waiting time for any pain relief.

Standard medicines for pain management were prescribed for women. If pain was not controlled staff referred to the pain management team and anaesthetist. This would involve transfer to the labour ward to manage the pain before return to the antenatal ward.

Epidurals (an injection of anaesthetic into the spinal area) were available for women on the labour ward 24 hours per day, seven days per week. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance states the average waiting time for women requesting an epidural to receiving one should be within 30 minutes. The audit results for QCCH for the previous 12 months showed 89% women waited less than 30 minutes, 10% waited less than 60 minutes and 1% waited over 60 minutes. Where there had been delays the service reported this was due to emergency cases which took priority.

Between April 2018 and February 2019 100% of women who had elective (702) or emergency caesareans (725) received regional anaesthesia. This performance was better than the national standards.

An assessment of pain was included and scored on the MEOWS chart and we saw staff escalated to anaesthetists if they were caring for women and could not control their pain, for example post caesarean section.

Nitrous oxide (a pain-relieving gas) was piped in all birthing rooms on the labour ward. Stronger painkiller by injection was available for women who required stronger pain relief.

Women had the option of using the birthing pools in the birth centre or in the labour ward to ease pain during labour.

The trust maternity division carried out a pain audit in November 2018 which covered the paediatric and maternity service. The audit covered pain assessment for adults (74%) and children (27%). The result showed that 85% of patient had at least one pain score in 24 hours, while 15% had no pain score. The result highlighted that 65% of patients were assessed as part of the clinical observation, poor prescription in 72% of cases, low as required medicines (28%) and the documented reason for moderate or severe pain. The target was met for having no more than mild pain. As a result of this audit the hospital had created a pain task and finish group to improve the pain assessment and provision in the directorate.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The service maintained a maternity quality dashboard, which reported on clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008. We reviewed the dashboards which included 10 months rolling data from April 2018 to January 2019. Performance was monitored for a range of outcomes such as deliveries, instrumental deliveries, caesarean section deliveries, still birth rate, neonatal death rate and the number of third and fourth degree perineal tears.

The regional dashboard collated the trust performance, broken down by site, on 52 measures, of which 32 were red, amber, green (RAG) rated and had North West London targets to allow comparison with other maternity providers in North West London. Measures were categorised into clinical activity, clinical outcomes (maternal and neonatal), workforce and risk. Comparable regional metrics included maternal mortality, maternal admission to ITU, third and fourth degree tears, women having personalised care and offered choice of birth setting, women booked by 12 weeks, normal and instrumental deliveries, women offered smoking cessation at booking, women with a named midwife, one to one care in labour, and post-partum haemorrhage. For some metrics the trust had local targets only or as well as regional targets.

Between April 2018 and January 2019 performance on the following targets was as follows:

- The service met the 95% standard for the proportion of women with booking appointments within 12 weeks and six days for each quarter.
- The proportion of normal vaginal deliveries at QCCH was consistently above or near the target of 55% for the previous 11 months, this performance compared well with other NHS trusts in NW London.
- The proportion of instrumental deliveries was 18.1%, this was slightly higher than the NW London standard of less than 16.9%.
- The standard for the proportion of women experiencing perineal trauma; 3rd and 4th degree tears was below 3%, the service performance was better for this measure as it achieved 1.7%. Following concerns raised by staff on the prevention and treatment of significant perineal trauma, an audit was carried out in 2018 to assess maternity staff views on perineal repair. The audit showed that staff were positive about the implementations of several policies on perineal tear and had recommended areas of improvement. This included: antenatal education on perineal massage, introduce a policy on 'fresh eyes' on complex perineal repairs, use of warm compresses on the labour ward and urgent training for all staff on perineal support in advance of anticipated roll out of Obstetric Anal Sphincter Injury (OASI) care bundle. Staff also recommended that managers should feedback to the named staff who performed a repair if a tear or complication occurred. The service planned to seek staff feedback in six months after implementation of the policies and recommendations. As a result of this audit the trust had introduced a quality improvement project on the prevention and treatment of perineal trauma.
- The local standard for post-partum haemorrhage of more than 1.5 litres was below 2.8%; the service did not meet this standard for any quarter; it achieved an average of 3.5%, however this was below the NW London standard of 3.6%.
- The standard for emergency caesarean rate was less than 16%, on average this was achieved for each quarter.

- The trust target for breast feeding initiation was 90%, QCCH fell slightly short at 88%, however the trust reported there were data quality issues which were being investigated. The trust BFI level 2 inspection was due in April 2019.
- We noted that performance on the continuity of care model was similar in the region and none of the trusts had met their target.
- The pre-term birth rate percentage for QCCH was 9.2%, this was above the red target of 8%; senior staff told us that most women that would or were at risk of having pre-term birth in the region had their babies in the trust due to the facilities and provision offered in the trust compared to other maternity service in the region, which was reflected in the dashboard.

Queen Charlotte's and Chelsea Hospital

In the 2017 National Neonatal Audit Queen Charlotte's and Chelsea Hospital's performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 171 eligible cases identified for inclusion, 90.8% of mothers were given a complete or incomplete course of antenatal steroids.

This was better than expected when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit's recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

There were 91 eligible cases identified for inclusion, 80.2% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was higher than the national aggregate of 43.5% and put the hospital in the top 25% of all units.

(Source: [National Neonatal Audit Programme](#), Royal College of Paediatrics and Child Health)

From April 2017 to March 2018 the total number of caesarean sections was as expected. The standardised caesarean section rates for elective sections and emergency sections were both as expected.

Standardised caesarean section rate (April 2017 to March 2018)					
Type of caesarean	England	IMPERIAL COLLEGE HEALTHCARE NHS TRUST			
	Caesarean rate	Caesareans (n)	Caesarean rate	Standardised Ratio	RAG
Elective caesareans	12.4%	1,440	15.7%	98.7 (z=-0.1)	Similar to expected
Emergency caesareans	15.9%	1,561	17.0%	102.4 (z=0.2)	Similar to expected
Total caesareans	28.3%	3,001	32.7%	100.6 (z=0.1)	Similar to expected

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.

Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from April 2017 to March 2018, the table below shows the

proportions of deliveries recorded by method in comparison to the England average:

Proportions of deliveries by recorded delivery method (April 2017 to March 2018)			
Delivery method	IMPERIAL COLLEGE HEALTHCARE NHS TRUST		England
	Deliveries (n)	Deliveries (%)	Deliveries (%)
Total caesarean sections ¹	3,001	32.7%	28.3%
Instrumental deliveries ²	1,423	15.5%	12.4%
Non-interventional deliveries ³	4,749	51.8%	59.3%
Total deliveries	9,173	100%	100% (n=596,828)

Source: Hospital Episode Statistics, April 2017 to March 2018

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

¹Includes elective and emergency caesareans

²Includes forceps and ventouse (vacuum) deliveries

³Includes breech and normal (non-assisted) deliveries

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

As of December 2018, the trust reported no active maternity outliers. However, the local inspection team are following up action plans for puerperal sepsis and other specified puerperal infections (July 2017).

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

The trust took part in the 2018 Maternal, Newborn and Infant Clinical Outcome Review Programme MBRRACE -UK Audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 6.70.

Comparing this trust to others with similar service provision, this was worse than expected and is up to 10% higher than the average for the comparator group rate of 6.20. There is currently no aspirational standard for this audit. (Source: MBRRACE UK). The trust had reviewed their MBRRACE audit results and responded that the MBRRACE data was not risk adjusted and none of the 2016 neonatal deaths on detailed review were avoidable (complex congenital pathologies) reflecting the high-risk population as a tertiary centre for fetal disease. The neonatal intensive care unit (NICU) also participated in the Vermont Oxford Network (VON) that risk adjusts and benchmarks key performance indicators (KPI) including mortality of 950 NICU around the world (containing outcome data on about 60,000 very low birth weight infants per year) and showed that the trust performance against KPIs was comparable to other tertiary centres.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held individual meetings with them to provide support and monitor the effectiveness of the service.

Staff were supported by their managers to maintain their professional skills and experience through internal and external training, study days and career progression. Staff had access to internal and external training to ensure their competence and development. Staff told us courses were advertised and managers encouraged them to attend training. Study time was negotiable depending on the course.

Staff including the student midwives and junior doctors were given protected time to attend regular teaching and learning schedules in place for staff such as CTG weekly teaching meetings, SIMS training, away days, bereavement teaching sessions.

Staff were trained on the assessment of fetal growth and used gestational related optimal weight (GROW), conflict resolution, bereavement and NHS newborn and infant physical examination (NIPE) screening programme. The service had a list of all midwives who were trained and conducted NIPE and refreshers were also set up for these midwives to keep their skills current.

Staff had attended study days on perinatal mental health and had an hour training with the mental health team and IAPT (Improving access to psychological therapies).

The service offered a bespoke incidents training for senior staff and staff had received swab training as a result of recent never events. The service had plans to start the human factors training. Senior managers had received trained on investigating incidents to improve their skills and competence in the daily reviews of incidents.

Midwives received support through the professional midwifery advocate (PMAs) which replaced the supervisors of midwives. All the previous supervisors of midwives had or were receiving the bridging programme for the PMA role. All midwifery staff in the trust were offered restorative clinical supervision and safeguarding supervision by the PMAs.

All maternity staff underwent a trust and maternity specific inductions and orientation programme, which included mandatory and role specific training. The maternity specific induction included tour of the service area and teaching on topics such as breastfeeding, obstetrics and consenting to mortem. Staff told us the induction and orientation for new starters was useful and well organised. Staff were given time to complete their mandatory training. Students and new midwifery staff were given a supernumerary period and rotated in different maternity clinical areas. The student midwives had opportunity to do their placement in all the maternity areas and neonatal unit.

Midwifery and medical staff we spoke with within the maternity service were up-to-date with their professional revalidation. Consultants and medical staff were involved in serious incidents investigation and this formed part of their appraisal and revalidation process. Midwives told us the PMA and other senior staff supported them with revalidation. This meant the service had appropriate measures in place to ensure all midwives and doctors were up-to-date and fit to practice.

All midwives were trained to give BCG vaccination which meant midwives vaccinated their own patients. Two midwives were trained to give whooping cough and flu vaccines and were based in the antenatal clinic. There were three immunisation midwives across sites and the trust had secured a training package by Public Health England to train more midwives.

The service had a competency-based pack to assess staff competence and development. For example, there was a theatre clinical competency pack for midwives and scrub nurses in the service.

Sonographers and antenatal screening co-ordinators attended staff meetings and held teaching sessions with staff.

All staff underwent a trust induction and orientation programme, which included mandatory and role specific training. Staff told us that they had two weeks of induction, three weeks supernumerary and orientation as new starters and had found them useful and well organised. Bank and agency staff were inducted at the start of their shift in the maternity wards. There was a local induction checklist which was completed by agency, bank and medical locum staff.

The majority of midwives could work anywhere in the maternity service which ensured their skills and competence were up to date.

The service offered a bespoke one-year preceptorship programme and staff were assigned for six months on the labour ward, three months on the postnatal ward and three months at the birth centre or community. Staff told us the preceptorship programme attracted newly qualified midwives who were mainly student midwives to apply for jobs in the service. Preceptorship programme included of administration of intravenous (IV) antibiotics to babies. Staff were required to witness five antibiotics and observe five antibiotics been given before been signed off to administer neonatal IV injections to ensure their competence.

Queen Charlotte's and Chelsea Hospital

From November 2017 to November 2018, 90.1% of required staff within maternity at QCCH received an appraisal compared to the trust target of 95%. This was slightly below the trust target. The breakdown by staff group can be seen in the table below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target met? (Yes/No)
Qualified Allied Health Professionals	16	16	100.0%	Yes
Qualified Nursing and Health Visiting Staff	7	7	100.0%	Yes
NHS Infrastructure Support	47	45	95.7%	Yes
Support to doctors and nursing staff	48	44	91.7%	No
Qualified Nursing Midwifery Staff	184	160	87.0%	No
Total	302	272	90.1%	No

(Source: Routine Provider Information Request (RPIR) – Appraisals tab)

The trust did not undertake formal clinical supervision for medical or nursing staff. Nursing and midwifery staff were supported to reflect on their practice as part of their portfolio preparation, which was linked to the revalidation process. All midwifery staff in the trust were offered restorative clinical supervision individually or in groups by the professional midwifery advocates.

Safeguarding supervision focused on unborn babies and children. Formal safeguarding supervision was provided for nurses and midwives in maternity services at least every six weeks, additional supervision was available on request.

We spoke with a midwife who had been in post less than a year, she told us she had received a thorough induction into the trust and service and was supernumerary for the first four weeks in the ward. She said she was satisfied with the support and training she had received since starting on the unit.

The midwife education team provided midwives with annual three-day updates.

Midwives with high dependency skills staffed the high dependency unit (HDU) on the labour ward. Data provided by the trust showed 15 midwives at QCCH had completed the HDU training. This was in line with the requirements of the Obstetric Anaesthetist Association, Maternity Enhanced Care guidance (2015).

Community midwives were encouraged to work one shift on the birth centre every month to maintain their skills.

A perinatal consultant psychologist was available to advise staff when needed. The perinatal midwives provided training two to three times a year open to all staff.

Doctors we spoke with said they had good opportunities for training for example, elective caesarean sections under supervision of consultants. Junior doctors told us there was plenty of teaching sessions at QCCH for them to attend.

The 2018 GMC training survey results for doctors in training at Imperial College Healthcare NHS Trust in the speciality of obstetrics and gynaecology showed all the results were in line with the national average.

Multidisciplinary working

Staff on the wards and community worked together as a team to benefit women. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff worked closely with others in different teams or organisations to involve them in care planning depending on the needs of the woman and baby.

Multidisciplinary handover meetings occurred twice a day and involved obstetric, anaesthetics and midwifery staff who shared information in the planning and delivery of care to women and babies, sharing. The handover included discussions regarding women throughout the unit including those for planned and continuing induction of labour and elective caesarean section.

There was close working with specialist services such as fetal medicine consultants and case load midwives to support high risk women. For example, neonatal teams worked with obstetricians and fetal medicine specialists during the antenatal period to produce care plans for babies. There was a weekly antenatal referral meeting where the perinatal mental health nurse specialist attended together with the consultant psychiatrist and the consultant psychologist.

We saw there was strong multidisciplinary working between the midwives, obstetricians, neonatal staff and physiotherapists.

Community and hospital staff liaised for continuity of care for women during and after delivery. Staff liaised closely with social services and other hospitals where necessary.

There were also weekly meetings where the multidisciplinary teams discussed intra-partum management together with CTG analysis or fetal monitoring.

Seven-day services

The maternity services were available seven days a week.

The triage area and diagnostic service was accessible 24 hours a day, the day assessment unit was open 8am to 8pm Monday to Friday. The antenatal clinic, fetal medicine centre and ultrasound department were open Monday to Friday 9am to 5pm.

Community midwives made home visits and held antenatal and postnatal visits seven days a week and were available 24 hours per day, seven days per week to facilitate home births.

Consultant obstetricians and anaesthetists were either resident on the unit or on-call 24 hours per day, seven days per week. In addition, labour ward had access to middle grade obstetric staff 24 hours a day

The obstetric theatres were always available for emergency procedures and there was a dedicated middle grade anaesthetist for the maternity unit.

Pharmacy services were available Monday to Friday between 9am to 7pm. At weekends pharmacy services were available for five hours each day. Outside of these hours an on-call pharmacist was available for clinical advice and urgent supplies of medicines.

Health promotion

Staff provided health promotion advice supported women and families appropriately.

At the initial booking appointment midwives screened for risk factors such as raised body mass index, low blood haemoglobin levels and smoking. These were discussed with the woman and used to inform care planning and advise the woman accordingly. All women were offered smoking cessation therapy before delivery.

We saw women were offered vaccinations in antenatal clinics to protect them against whooping cough (pertussis) and flu vaccinations during the winter season.

Pregnant women were screened for perinatal mental health using the Whooley guidance tool, a recognised tool to assess mental health in the perinatal and post-natal period.

We saw posters in the antenatal clinic promoting a range of parent education classes, including antenatal and postnatal exercise classes and a diastasis clinic (separation of the abdominal muscles in pregnancy).

Saw a range of health promotion leaflets available in the antenatal clinic and wards, flu vaccine, breast feeding, stop smoking, 'healthy pregnancy classes',

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Staff understood their responsibilities regarding consent and the Fraser guidelines and Gillick competence assessment. Medical staff informed women about the risks and benefits of obstetric procedures, such as emergency caesarean sections or instrumental deliveries. Written consent was obtained from women prior to surgery and checked by theatre staff prior to commencing procedures. We saw staff documented when consent for procedures had been gained. We saw that appropriate consent was obtained before treatment began and this was recorded in the women records.

In the antenatal ward, we saw the consent forms that had been signed and dated by the consultant obstetrician and the patient prior to elective caesarean operations for two women.

Staff asked for verbal consent from women prior to any procedures or care, where written consent was not warranted such as taking blood samples.

At the time of our inspection, staff we spoke to told us there were no patients receiving treatment that were subject to the Mental Health Act 1983 (MHA). Staff knew the correct process on how to refer patients to the mental health and perinatal mental health teams when required. Midwives told us that it was extremely rare to have a woman attend the service or deliver at the hospital who was under section under the Mental Health Act.

Staff confirmed they had had training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). MCA and DoLS data was included in the mandatory training module on consent. Data provided by the trust showed that the maternity service had exceeded the trust target of 85% for mandatory training: 92% of maternity staff had undertaken consent training.

Staff told us there were no patients receiving treatment that were subject to the Mental Capacity Act 2005. Staff knew the correct procedure to follow if a DoLS application was required.

Is the service caring?

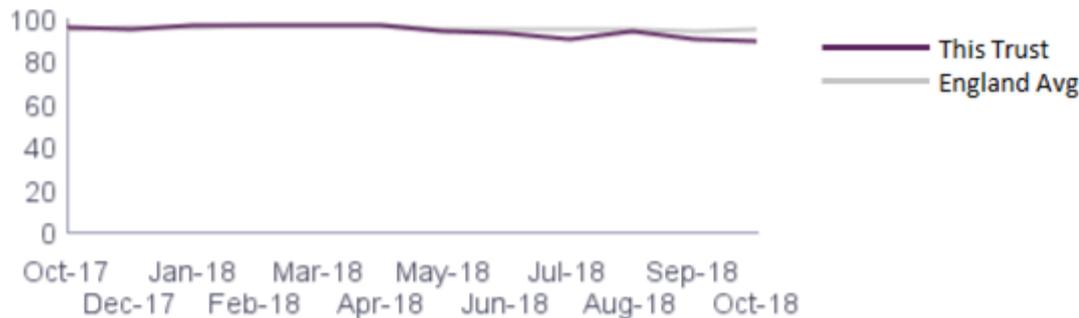
Compassionate care

Staff cared for women with compassion. Feedback from women and relatives confirmed that staff treated them well and with kindness.

We saw staff treated women with kindness, compassion, respect and dignity. All women and partners we spoke with stated they had received compassionate and considerate care throughout their pregnancy. Comments from women and their partners were mostly positive including for example; "The staff have been so professional and caring", "Staff are awesome" and "Through and through, really good experience."

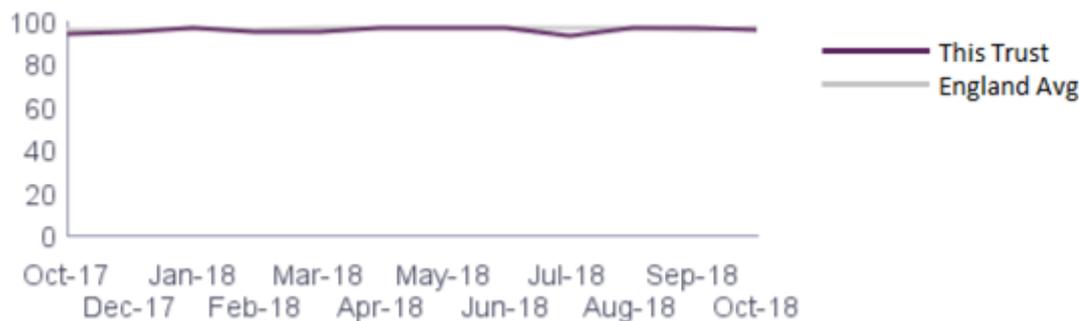
Friends and family test performance (antenatal), Imperial College Healthcare NHS Trust

From October 2017 to October 2018, the trust's maternity Friends and Family Test (antenatal) performance (% recommended) was similar to the England average. In the latest period, September 2018, performance for antenatal declined and was 90%, compared to the England average of 95%.



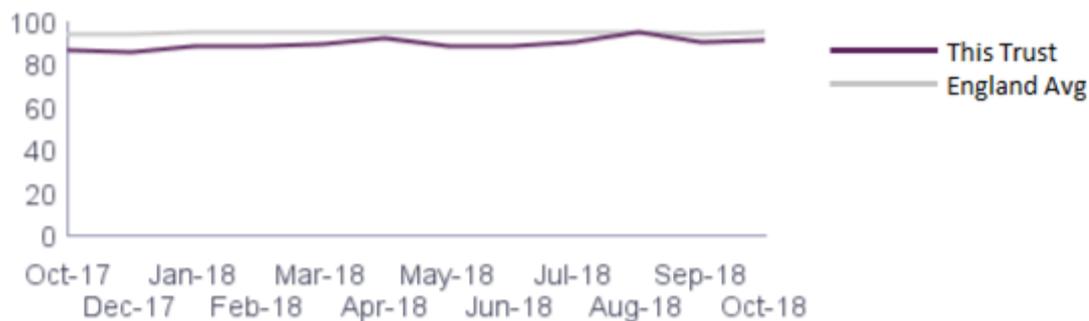
Friends and family test performance (birth), Imperial College Healthcare NHS Trust

From October 2017 to October 2018, the trust's maternity Friends and Family Test (birth) performance (% recommended) was similar to the England average. In the latest period, September 2018, performance at the trust was 96% compared to the England average of 97%.



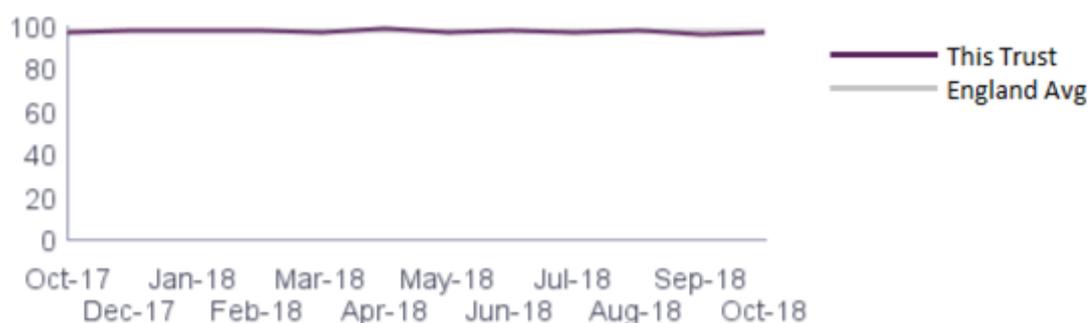
Friends and family test performance (postnatal ward), Imperial College Healthcare NHS Trust

From October 2017 to October 2018, the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was slightly worse than the England average. In the latest period, September 2018, performance at the trust was 91% compared to the England average of 95%.



Friends and family test performance (postnatal community), Imperial College Healthcare NHS Trust

From October 2017 to October 2018, the trust's maternity Friends and Family Test (postnatal community) performance (% recommended) was similar to the England average. In the latest period, September 2018, performance at the trust was 97% compared to the England average of 98%.



(Source: NHS England Friends and Family Test)

The trust performed better than other trusts for one question and similar to other trusts for the remaining 18 questions in the CQC maternity survey 2018. The question that scored better than other trusts was "If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?".

Area	Question	Score	RAG
Labour and birth	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	8.9	About the same
	During your labour, were you able to move around and choose the position that made you most comfortable?	7.6	About the same
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	9.2	About the same
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.9	Better
Staff during labour and birth	Did the staff treating and examining you introduce themselves?	9.1	About the same
	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	7.3	About the same
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	8.4	About the same
	If attention was needed during labour and birth, did a staff member help you within a reasonable amount of	8.6	About the same

	time		
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.3	About the same
	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	8.6	About the same
	Thinking about your care during labour and birth, were you treated with respect and dignity?	9.3	About the same
	Did you have confidence and trust in the staff caring for you during your labour and birth?	9.0	About the same
Care in hospital after the birth	Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?	7.2	About the same
	Looking back, was there a delay in being discharged from hospital?	4.9	About the same
	Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?	7.4	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	8.0	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	8.5	About the same
	Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?	8.3	About the same
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	8.6	About the same

(Source: CQC Survey of Women's Experiences of Maternity Services 2018)

All women we spoke with told us they were treated with respect, dignity and had their privacy needs considered. Curtains were pulled around the beds to give women privacy, as well as the use of modesty sheets when patients were being examined. We observed there was a check-in kiosk in place in the antenatal clinic which promoted patient confidentiality by ensuring they could self-check-in without going to the receptionist and confirming their personal details with other people present. One woman told us that, "Staff treated me with dignity and respected my privacy throughout my stay." However, some staff raised privacy concerns in relation to the new triage area as patients or relatives waiting in the area, may potentially overhear staff giving advice on the phone to women calling in.

Six women we spoke with had previously given birth at QCCH and chosen to return to the unit. Four stated that they would use the service again for their future pregnancies.

We saw 'thank you' cards and positive comments displayed in the wards. This meant that parents had taken the time to thank staff in writing.

Women discharged home were provided with detailed information on the signs and symptoms that they should look for in case of any complications and how to seek advice.

Emotional support

Staff provided emotional support to women to minimise their distress.

We spoke with a range of women who were accessing either antenatal or postnatal care. They spoke positively about the care they received, as well as speaking positively about the support their partners had received. One woman told us that "All the doctors and midwives were very helpful."

All women we spoke with told us they could choose who they wanted to support them whilst in labour and had chosen parents, siblings or their life partners depending on their situation.

The initial antenatal assessment identified women who may be prone to postnatal depression. The pre-discharge assessment included an assessment of the woman's emotional wellbeing.

There were two specialist bereavement midwives and perinatal mental health team cross-site that helped couples with emotional and practical support. The specialist bereavement midwives also provided training and support to other midwives to build their skills and confidence in this area.

One of the bereavement midwives informed us that parents of deceased infants could spend as much time as they wished with their baby in the dedicated bereavement room. The hospital also offered memory boxes including hand and foot prints, clay imprints and photo printing.

Bereaved women were supported in a number of additional ways, which included a regular bereavement clinic run by the bereavement midwife to support. Bereaved women and their families could access six sessions of 'Petals' (for baby loss and trauma) counselling facilitated by the 'Petals' team. The clinic ran three times a week, with the team contacting women within 72 hours of the referral to book them in.

Support was offered to parent to make funeral arrangements from the patient affairs department and the trust chaplaincy service. In all cases of under 24 weeks gestation the chaplaincy team could make appropriate arrangements for cremation or burial. The mother could make her own arrangements if she wished. Chaplains for people of different faiths, or none, could provide an individual funeral service free of charge, religious and non-religious, depending on people's wishes that was free to mothers. All the options were in line with the guidance of the Human Tissue Authority (HTA).

Staff were able to link with various charities and external support groups within the community. For example, baby loss support and services for the Jewish community, West London Still Birth and Neonatal Death Charity (SANDS), Petals and Children of Jannah.

There was an annual memorial service for those of all faiths and none. The bereavement midwife told us that this was well-attended by families, some returning for a number of years after their baby's death.

There was a National Bereavement Midwife Forum at the hospital. The forum was made up of 120 bereavement midwives from across the UK who joined together to discuss concerns and exchange best practice tips, with the aim of standardising maternity bereavement care. Representatives from the National Health and Safety Executive, the Department of Health, and the Royal College of Midwifery and the Ministry of Justice, amongst others, attended this forum.

Understanding and involvement of patients and those close to them

Staff involved women and those close to them in decisions about their care and treatment.

All partners we spoke with told us that they were made to feel welcome and involved in their partner's pregnancy, labour and birth. They were able to stay with their partner and baby on the birthing unit and postnatal ward.

All women we spoke with agreed that staff had explained what was happening during the course of labour. This, along with presenting the options and choices available to them as the situation changed, had helped them cope when outcomes were different to those they had expected.

We saw positive interactions from all staff with women and their partners. Staff were seen to be

calm and compassionate. We heard staff providing advice and encouragement regarding breast feeding and about the general well-being of the mother and her baby.

We spoke with two high risk women on the antenatal ward. Both said that they saw the doctor daily and both felt they had been involved in their care. The women said: "Being at Queen Charlotte's Hospital has given me peace of mind", and "Staff have been fantastic".

The trust used hand held devices in most inpatient areas to collect local patient feedback, enabling almost real-time viewing of patient comments. For patients who found the hand-held devices difficult, paper copies of surveys were made available. In the antenatal clinic, we saw a volunteer encouraging and supporting expecting parents to complete these.

Professional midwifery advocates provided a de-briefing service and birth reflection sessions to gather feedback about women's birth experiences.

Is the service responsive?

Service delivery to meet the needs of local people

The hospital planned and provided services in a way that met the needs of local people.

Women were given a choice of times and dates for antenatal clinic appointments.

Between April 2018 and January 2019, 100% women had a named midwife whom they saw at their first appointment. Women might not see that midwife at every following appointment but would see one of a small team at that clinic.

Antenatal and postnatal care was provided and easily accessible to pregnant women and mothers. Care delivered was tailored to meet the needs of women and the local community in line with the NICE guidance on antenatal care.

Postnatal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The red book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the child until five years of age.

The postnatal ward had a 15-bedded area for transitional care which enabled women and babies to remain together, rather than being cared for in the neonatal unit. We spoke with two women on the ward and both spoke positively of the care provided to them and their babies.

Interpreting services were provided both face-to-face, and via telephone interpreters. There was also access to sign language interpreters for people with hearing and speech difficulties. Midwifery staff reported that translation services were easily accessible and they could 'block book' face-to-face interpreters for all future appointments. Between April 2017 and April 2018, the trust fulfilment rate for all interpreting requests was 99% across all services.

The trust website could be translated to 103 languages from different ethnicity and continents including European, Asian and African. The languages included Turkish, Polish, Japanese, Greek, Swahili, Yoruba and Urdu, amongst others. The trust's website contained blogs, questions and answers, specific maternity topics and link to external resources such as NICE. The website also had information on hospital location and directions, visiting times, places to eat, wi-fi and chaplaincy service. The maternity section of the trust website covered information such as service pathways and provision, self-referrals, interpreting service, FGM clinic, perinatal mental health and how to self-refer, screening information, pregnancy tips, choosing trust, ask your midwife, your pregnancy,

giving birth, perinatal referral, postnatal care, meet the team with names and pictures of consultants, referrals and special midwives. The website also included information on the North West London (NWL) mum and baby app which was created by midwives and doctors in the NWL network for women to explore local maternity services, track appointments and care notes which was available to download on mobile phones and other electronic devices. The trust website also directed women to the private health care website for the maternity service in the Sir Stanley Clayton ward and how they could choose this service. Women that accessing private care at QCCH were given list of consultants and expertise at booking which enabled them to choose consultant that would managed their care.

There was various information displayed on the notice boards within the clinic and wards. All information was clearly displayed, in easy to read format. Images on the display boards were reflective of workforce or demographics and met the accessible information standards. Various patient information leaflets were available on the trust website, including information for women paying for private services.

The private midwifery team on Sir Stanley Clayton Ward offered post-natal community follow-up service to women in the local area for up to 10 weeks or a three weeks intense support package at home.

As part of the postnatal discharge process to community services, discharge letters were sent to women's GPs, health visitors, and family nurse partnership and community midwives, to facilitate continuity of care. This was in line with best practice and national guidance.

Meeting people's individual needs

The service took account of patients' individual needs.

The maternity services at QCCH had a model of care where vulnerable women were looked after by a caseload midwifery team. Referral criteria included: safeguarding concerns, physical or learning disability, substance or alcohol misuse, sexual abuse, women under 16 years old at the time of booking and domestic abuse. Vulnerable women were seen if accepted by the team, who then provided all antenatal, labour and postnatal care up to 28 days.

Specialist midwives supported women with infections such as HIV and hepatitis, women with multiple pregnancies, women with mental health conditions and those who had perinatal loss. Community midwives could refer women to these services.

The fetal medicine service provided a specialist referral service that cared for women experiencing complicated pregnancies. For example, women with high-risk first trimester screening results, those with complex twin pregnancies and women with a personal or family history of complications in previous pregnancies.

The maternal medicine service provided outpatient and inpatient care for women affected with any medical disease in pregnancy. A multidisciplinary team of specialist doctors and midwives offered pre-pregnancy counselling and provided assessment and management of women throughout pregnancy, labour and following birth.

Patients were offered a choice of meals. Specialist meals were available, such as halal and vegetarian. We received mixed feedback regarding the food provided. The women we spoke with were happy with the standard of the food provided to them. One woman said, "The food tastes wonderful". However, one woman commented on the small portion size and another raised a concern about being offered non-halal food options; this was later resolved.

Women were given an informed choice about where they gave birth, in conjunction with consideration of their potential risk. Midwifery-led care was offered to women with an uncomplicated pregnancy and included a home birth or delivery in the birth centre, in line with the NICE antenatal

care guidance. Women with a previous medical condition or had experienced previous complications in pregnancy or labour, were advised to have their baby on the labour ward, which was obstetric-led.

A maternity helpline was available from 10am to 5.30pm, Monday to Friday. This was operated by experienced midwives, providing women and their families with direct and easy access to maternity-related information.

A birth centre with seven rooms was located below the labour ward. The rooms had birth stools. Three birth pools were available that could be used during delivery to aid comfort. The rooms also had pull-down beds which could be stowed away to create more space if the women decided to walk around the room during labour. There was a dedicated lift to transfer women from the birth centre to the labour ward if required. The service had commenced the 'continuity of care' project in January 2019, as part of the 'better birth' initiative. This project involved women from the booking stage through to the postnatal period, which met women's needs and helped to develop trusting relationships.

The maternity services had birthing balls, birthing pools and stool to promote comfort of women in labour.

A partner and an additional named birthing support person were allowed to be present during labour. Partners could visit women at any time, and this enabled new parents to spend time with their babies. Partners could stay overnight providing it did not disrupt other women unnecessarily. General visiting times on the antenatal ward and the high dependency unit were 9am to 8pm. These were 3pm until 8pm on the Edith Dare postnatal ward. The maternity service also accommodated partners of either gender in the unit.

Each ward we visited had coffee, tea and hot chocolate making trolleys and we observed partners using those facilities. On Edith Dare postnatal ward, a kitchen with a fridge and microwave was also available. The wards had 'breakfast rooms' for women to use as required. Women had access to snacks between meals and we saw tea, coffee and water was easily available. Snack boxes were available for women in MDAU if needed.

A designated room was provided for the care and support of women and their respective partners following loss of a baby. This was located towards the end of the main corridor on labour ward, so bereaved women and their partners could not hear labouring women and crying babies. However, it was still possible to hear such noise if the delivery room directly next to the bereavement room was in use. Staff told us that they ensured all members of the clinical team were aware when the bereavement room was occupied, so that all efforts could be made to ensure that the environment was as peaceful as possible.

A memory box was provided to women who had suffered a loss. The service had two types of memory boxes they could give to women. The smaller memory box was given to women for the deceased babies under 24 weeks gestation and included items such as a teddy bear, an angel, a tea light candle, a tag, a book and a scroll. The larger boxes were for deceased babies over 24 weeks gestation, and contained a photo frame pack, two teddy bears, a scroll, an angel, a book and a remembrance card. Bereaved families were also given a black and white picture and a USB stick with an image of their deceased baby as keep sake. The memory box included photographs and hand and foot prints, in line with national recommendations (Sands Stillbirth: how professionals can make a difference, 2015).

There was a Muslim pack given to women and families which contained a prayer book, diary, gift of hope, leaflets, journals, poems, prayers and Imams helpline with prayer. Staff told them an imam was available seven days a week to support family and ensure the deceased was buried in a timely manner in accordance with the Muslim rite.

The service provided Jewish families a Jewish leaflet through the Chana organisation. The Jewish organisation also supported and counselled families with funeral if the deceased family were from a Jewish faith.

The trust had a chaplaincy service, which provided spiritual care and religious support for patients, partners and relatives as needed. Multi-faith options were available. Staff told us there was chaplaincy support available for a number of religions that reflected their patient population.

People with a learning disability who choose to have their babies at the trust would be assessed to see what reasonable adjustments were necessary. For example, the hospital could allow more time, in the form of double consultation periods, thus avoiding noisy, busy periods, or offer these patients the first or last appointment. The trust worked in partnership with expectant mothers with learning disabilities and their carers, allocating them to caseload midwives. This helped to provide continuity of care throughout the pregnancy and delivery. There was also an inclusion and vulnerability officer, who supported all patients with learning disabilities. This post holder was part of the patient experience team and worked closely with both the safeguarding and discharge teams. There was an email alert system in place to notify the inclusion and vulnerability officer, discharge team and head of patient experience, of any hospital admissions or A&E attendances of people with learning disabilities.

There was a female genital mutilation (FGM) specialist clinic, which looked after all women who had experienced this procedure. Professionals could refer women to other specialist clinics where appropriate. For example, long term pain management clinics.

Access and flow

Women could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Women in the local area could self-refer by telephone, or by completing a form on the hospital's website. GPs and other health professionals also made referrals to the service. NICE guidance recommends that women are seen by 10 weeks of pregnancy, so that the early screening for Downs Syndrome (which must be completed by the 13 weeks and six days of pregnancy), can be arranged in a timely manner. Evidence submitted showed that between April 2018 and January 2019, 72% of women were seen by a midwife before 10 weeks and 96% were seen by 12 weeks and six days of pregnancy (excluding late referrals).

We spoke with four women who were waiting for an antenatal appointment. Two of them reported that they were frustrated with the long wait in the antenatal clinic. The antenatal clinic matron informed us that long wait times had been a problem for a few months. To tackle this, 'clinic lists' were introduced, where each morning patients were allocated to each midwife running the clinics. This enabled the midwives to manage their own workload for the day and they were able to support other clinics if there were any delays. There was no formal audit of waiting times within the antenatal clinic, although real time waiting times were written and updated regularly on boards for women to be kept informed of these.

There were two dedicated maternity theatres available 24 hours a day, staffed by a dedicated theatre team. There was one elective caesarean section list per day, with three to four operations on each list typically. Senior staff informed us that cancelling or postponing elective caesarean sections was a rare occurrence. If a caesarean section was cancelled, this was invariably due to high clinical activity or acuity resulting in a significant delay to the elective list and could otherwise result in a woman being fasted until mid-late afternoon. If significant delays to the elective caesarean section list were anticipated, the option of rescheduling was always discussed with the woman and her birth partner. In 2018, eight (1.1%) elective caesarean sections were cancelled on the scheduled day and postponed to the following day. In addition, five women were

transferred with consent to St Mary's Hospital on the day to enable their elective Caesarean section to proceed on the same day.

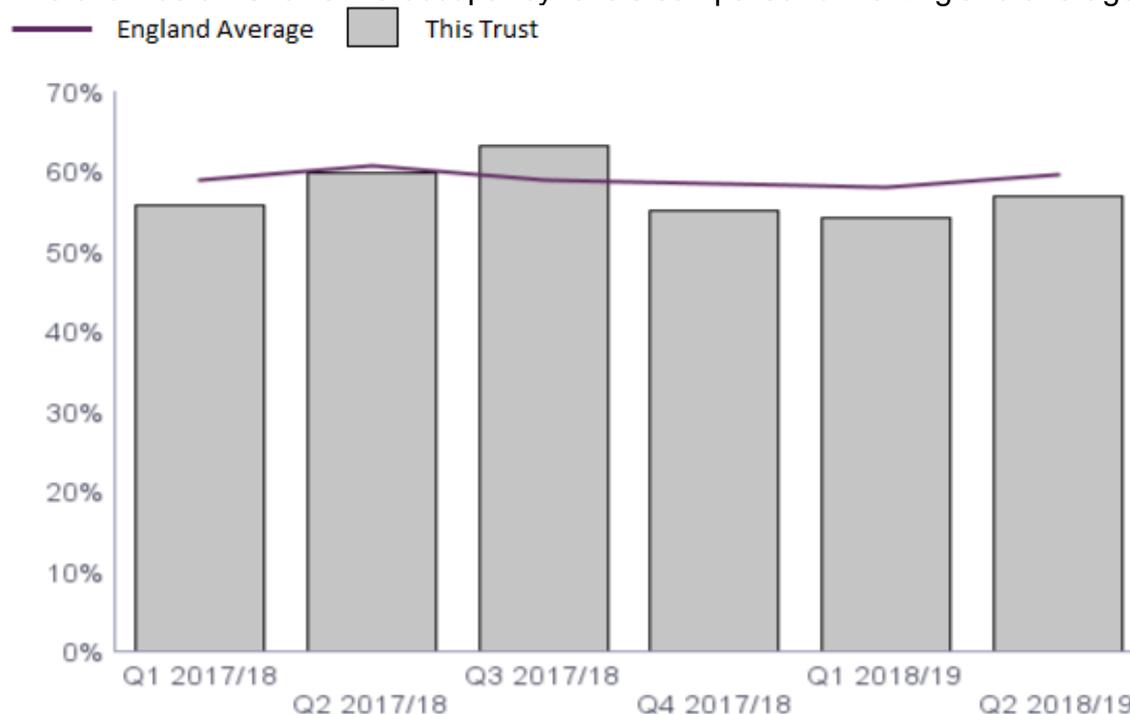
At the last inspection in 2014, we found that patient discharge was sometimes delayed when there were midwifery staff shortages on the postnatal ward. Two weeks prior to this inspection, a separate discharge lounge was opened with a newly appointed dedicated midwife to manage discharges and improve patient flow. Women who were ready to be discharged could stay in the discharge lounge while waiting for prescriptions or paper work to be completed. Staff reported they had already seen the positive difference in patient flow in these two weeks.

We saw written documentation which confirmed women were supported to make a choice about their place of birth. We saw that women were risk assessed at the time of booking, with low risk women defaulting to a low risk pathway.

In November 2018, the maternity service moved and co-located the emergency maternity triage with labour ward to improve access. All staff spoke positively about this change, which meant staff from labour ward were able to review women quickly with in the triage area if required.

From April 2017 to September 2018, the bed occupancy levels (this includes all maternity beds i.e. recovery, day assessment and labour rooms) for maternity were lower than the England average, with the exception from October 2017 to December 2017, where bed occupancy was higher, (63.2% compared to the England average of 59%). In the latest quarter from July 2018 to September 2018, bed occupancy was 56.8%, compared to the England average of 59.6%.

The chart below shows the occupancy levels compared to the England average over the period.



(Source: NHS England)

The average length of stay was 1.9 days on Edith Dare ward, 1.5 days on delivery suite and 0.7 days on the birth centre.

There was an 'enhanced recovery programme' for women undergoing caesarean section, which shared pre-delivery planning between the physiotherapy team, infant feeding specialists, anaesthetists and obstetricians. This multidisciplinary approach was used as reduction in fasting time, early mobilisation and directed bladder care were all key parts of enhancing faster recovery. This pathway for caesarean section allowed women to go home the day following a procedure.

The trust target for the maternity outpatient 'Did Not Attend' (DNA) rate was 11%. Between February 2018 and February 2019, the unit did not meet this threshold in seven out of 13 months, with the DNA rate ranging between 3.3% and 15.4%. The lead midwife for the antenatal clinics informed us that women were automatically given an appointment if they went beyond their due date. Subsequently, a significant proportion of these women would deliver before these appointments and not attend, leading to the high DNA rates at the beginning of 2018. She told us much work had been done to improve the DNA rate and to ensure appointments were cancelled once a woman had given birth (unless still required for medical reasons) and the DNA rates had improved since these changes were made. Further, she reported it remained a challenge to cancel pre-made appointments for women who miscarried elsewhere and had not informed the trust of this. There were effective systems in place and all DNAs were followed up by a telephone call. Women received texts to remind them of appointments. For any vulnerable cases, the clinic would liaise with the relevant teams and with the community midwives to visit the women at home to check their welfare.

Between February 2018 and February 2019, the hospital-initiated outpatient cancellation rate (with less than six weeks' notice) was in the range of 3.1% to 9.1%. This was within the trust target of less than 10%.

In January 2019, 99.2% outpatient appointments were made within five working days of receipt.

The maternity unit had not closed between January 2017 and December 2018. Staff told us that they were fortunate to have cross site cover and if there was a need, the service could move women across to St Mary's Hospital site.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

From November 2017 to October 2018, there were 84 complaints about maternity, with 83 of these closed. The trust took an average of 36.5 working days to investigate and close complaints. This was in line with their complaints policy, which states complaints should be closed within 40 working days.

At Queen Charlotte's and Chelsea Hospital, there were 38 complaints, with the main themes of clinical treatment (10) and values and behaviours (10).

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Complaints were handled in line with trust policy. Women could complain directly to staff or were advised to go to the Patient Advice and Liaison Service (PALS) if they did not want to discuss their concerns with maternity staff.

All staff clearly understood and were able to give us examples where they had applied duty of candour. All staff we spoke with had a positive attitude to complaint resolution and wanted to ensure that concerns were dealt at an early stage.

We saw complaints and PALS leaflets readily available in all areas we visited. Two women we spoke with told us that they had no concerns or complaints and that staff were always there to answer any queries.

From November 2017 to October 2018, there were 24 compliments within maternity services at Queen Charlotte's and Chelsea Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

The maternity service had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The maternity service which was referred to as the maternity directorate was under the division of women's, children's and clinical support (WCCS) and had a clear management structure with defined lines of responsibility and accountability.

The maternity directorate was led by the clinical director, interim general manager, head of midwifery and consultant midwife. They reported to the divisional director of WCCS within the WCCS division wide structure triumvirate. The other leaders in the WCCS division wide structure included the divisional director of operation and divisional director of nursing. The WCCS and maternity triumvirate were responsible for the St Mary's Hospital and the Queen Charlotte's and Chelsea Hospital (QCCH) and worked cross site. The head of midwifery reported to the divisional director of nursing on governance around midwifery staff.

There was a clear hierarchical structure with close working arrangements across both sites at directorate and divisional level to support collaboration and consistency. During our interviews with the senior leaders in the maternity service we saw mutual co-operation and an emphasis on joint working as one service.

Frontline staff said they were well supported by the leadership team at all levels. Staff had opportunities to attend listening events with senior leaders in the organisation. Staff said their leaders were visible and approachable to hear about experiences of staff on the 'front-line'.

The trust offered a range of leadership and development programmes for medical, nursing and midwifery staff as part of on-going development. We saw posters on wards informing staff of these opportunities during our visit.

The divisional director was part of the trust executive committee and ensured the trust board was kept apprised of issues relating to the maternity service.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The 2018-19 maternity clinical and safety strategy included measurable outcomes under the themes of clinical outcomes, safety, patient experience, training, staff wellbeing and research. The strategy focused on continuous improvement on the care provided to women during pregnancy, childbirth and their postnatal care. The strategy also focused on current and relevant challenges.

Senior leadership informed us the divisional strategy for the maternity service was formulated through engagement with staff and other stakeholders during an away day event in 2018.

The vision for the maternity service was to be aligned to 'Better Births', the report of the National Maternity Review, published by NHS England in 2016 and the Maternity Transformation

Programme. Service leads told us of the work streams currently being undertaken, working with other providers and commissioners in the local maternity system (LMS).

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The trust documented values were kind, expert, collaborative and aspirational. During the inspection we saw these values displayed in the way staff behaved towards patients, each other and the inspection team.

All midwifery and medical staff we spoke with told us they were proud of working at QCCH and they felt their strength was excellent multidisciplinary working and care centred around the woman and baby. There were good working relationships among the matrons, consultant obstetricians, midwives, junior doctors, allied health professionals and support staff. Matron gave us examples of where midwives had challenged medical staff when they felt it was in the woman's best interest and to comply with the woman's wishes as detailed in their birth plan.

Junior doctors told us they were well supported by their seniors and by midwives on the unit. Three junior doctors we spoke with said they felt they worked in a "High stress environment" but support was available from their peers and senior staff. The same staff said they never had to seek out support "It was always offered."

Staff we spoke with said that after a serious incident they were all offered counselling and they had excellent support from within the team and management.

The trust had a designated freedom to speak up guardian (FTSUP) who encouraged and enabled staff to speak up safely within the workplace. Services also had nominated freedom to speak up champions; staff we spoke with were aware of who the champion was in their service and what their role was.

Staff were commended and recognised for their service in the areas they worked, for example, through awards such as 'Midwife of the month' on antenatal ward and 'Make a difference' badge on labour ward.

Governance

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust had an integrated quality performance framework. This involved the measurement of a number of core indicators, agreed annually, at different levels of the organisation. The indicators were split into CQC's five quality domains, safe, effective, caring, responsive and well-led. This fed the metrics that were included in the integrated quality performance reports (IQPR), which was reported at monthly trust board meetings. For example, patient safety incidents, staffing fill rates, infection prevention and control, medical devices management, mortality, sickness absence, bank and agency spend, FFT, national operational standards, in month variance to plan and cost improvement programme delivery.

Monthly directorate and divisional scorecard reports gave an integrated view of ward to board performance and were reviewed at each level to inform decisions about delivery of services.

A trust-wide framework to support regulatory compliance was also in place. Key components of the framework include statutory notifications, responding to concerns and complaints raised about the trust with the CQC and a ward accreditation programme (WAP-nursing peer review programme) which has been in place for 3 years. The WAP covered an assessment of the areas of leadership, communication, record keeping, environment, medicines, nutrition and responsiveness. Evidence of achievement of the minimum standards in area was reviewed and contributed to the rating of white (no evidence) to bronze, silver and gold. Areas for improvements were collated into an action plan. The birth centre, post-natal ward, antenatal ward and private ward had all achieved gold status at their previous rating visit in 2018 or 2019. Labour ward had improved to achieve silver status and the antenatal clinic had achieved bronze status. Staff we spoke with were all proud of their ratings and described the actions taken from previous visits which had resulted in an improved rating.

There was a monthly divisional quality and safety meeting, monthly risk management meeting, poor outcome risk meeting and weekly cross-site critical review meeting, Weekly Avoiding Term Admissions Into Neonatal units (ATAIN) meeting, monthly risk maternity meeting and the medical directors meeting. The service also had a cross site quality and safety meeting that was held every two months.

We reviewed several sets of minutes from the maternity quality and safety meetings and saw all aspects of governance were scrutinised, including incident reporting and management, infection prevention and control, complaints, friends and family data, clinical document control and the risk register. We saw there was a clinical governance action log, to ensure all agreed actions were completed and closed.

All wards held quarterly staff meetings or more frequently. We reviewed the last three minutes of each ward meeting and saw safety and quality issues were raised in every meeting.

There were daily cross-site safety huddle where issues around staffing, acuity and access and flow were discussed and escalated.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Directorate and divisional scorecards and the 'harm free care report' contributed to the IQPR. The trust's risk management framework described how risks from ward level were escalated and recorded on the trust risk register. There was a clear process for identifying risks, taking immediate actions to mitigate the risk, grading the risk, monitoring it and recording it on the risk register. maternity divisional risks were incorporated into the trust wide risk register and could be easily filtered for each site.

In December 2018, there were 15 risks relating to the maternity service and five specific to QCCH.

Risks relating to the maternity service were captured in the divisional risk register for women, children and clinical support. Some of the risks were long standing and ongoing, for example, midwifery staffing levels and the risk that babies could be abducted from the unit. These risks were reviewed at least every 6 months and controls in place to mitigate the risks. Other risks which we had been informed of during the inspection had been on the register for a shorter period of time, such as the delays to maternity triage and we saw the actions taken by the service in the last 12 months to reduce the risk.

We spoke with the risk and governance leads for the maternity service. They described how risks were identified, mitigated and graded. Our review of the maternity monthly risk management meetings showed trends and themes from incidents were discussed, actions and learning from serious incidents and other risks in the service.

The service maintained a maternity quality dashboard, which reported on clinical outcome indicators including those recommended by the Royal College of Obstetrics and Gynaecology (RCOG) 2008. The service performance was closely scrutinised at directorate meetings. From our review of the minutes of the clinical governance meetings, we saw the dashboard formed part of the discussion. Monthly cross-site directorate meetings took place chaired by the clinical director for maternity services. Our review of the notes of the meetings (November 2018 to January 2019) showed the meetings had a strategic focus to review, assess and develop the maternity service provided by the trust; a wide range of issues were discussed: quality and safety, risks, incidents, performance metrics, staff training, equipment and feedback from the NW London LMS. An action log was maintained to track progress. Directorate assurance reports were presented to the monthly divisional quality and safety committee.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The maternity service collected data around activity and outcome. Service performance measures were reported and monitored through the trust maternity dashboard and also on the NW London maternity services scorecard to enable comparison and benchmarking with other providers in NW London.

The trust had a major investment programme over the past few years to implement the electronic patient record. The trust was announced as a Global Digital Exemplar by NHSE in 2016/17 and was awarded £10m over two years to make further advances. The trust was working in partnership with another NHS provider to implement the existing system across both organisations to better serve the population of North West London.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The service worked closely with the commissioners and other providers as part of the North-West London local maternity system. We saw notes of meetings which demonstrated how the service was engaging partners in the area to stream line services, share good practice, mitigate risks and make improvements to benefit patients, such as the development of the NW London app for 'Mum and Baby' which supported women to choose where they wanted to give birth in NW London and information and personalised plans for their pregnancy, birth and new baby.

The maternity service had an active Maternity Voices Partnership (MVP). The MVP is an NHS working group of women, families, commissioners, midwives and doctors working together to improve local maternity care. The Imperial MVP held meetings every two months at various sites across the locality to encourage wider participation. We saw posters in clinics and wards displaying information about National Maternity Voices and meeting dates. MVP information was also accessible via the newly launched 'Mum and Baby' app.

The 2018 “Our Voice’ engagement survey” received 3,164 staff responses which was an increase of 357 from 2017. The overall engagement has improved in the national survey for the last three years. The overall engagement score has increased from a position of ‘lowest 20 per cent’ in 2015 to ‘above Average’ in 2017. The trust local survey results indicated relative consistency in the engagement score (78%) across the trust in 2018. The result showed positive findings on staff satisfaction with the quality of work and care they can deliver, quality of appraisals and training, learning and development. Staff were clear about the values and behaviours expected of them at work (95%) and clear about their own objectives (93%). The areas of improvement that was highlighted in the national and local staff survey included staff experiencing discrimination, bullying and harassment, staff working extra hours, senior leadership communication and visibility, estate and facilities, IT systems and effectiveness, enough time to complete work, staff health and wellbeing, career progression and witnessing potentially harmful errors, near misses or incidents. However, a new question in the trust local survey showed that 92% of staff felt they knew the processes to report any concerns they had on errors or incidents.

The female genital mutilation (FGM) health advocates engaged and worked with women that had accessed the service who now campaigned against FGM in the local region and the UK.

One of the matron’s told us a recent welcome development had been to share the directorate performance report at matron level and invite matrons to directorate quality and safety meetings. The service offered listening opportunities for staff where they could meet and engage with senior leaders

The trust ran a quality improvement initiative known as ‘Big Room’ once a week; staff and women were invited to discuss issues and ideas for improving services and we saw how this had developed the triage service at QCCH.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

There was a strong culture and focus of continuous learning, innovation, research and improvement in the service to improve patient outcomes. Staff and management were committed to improving services by learning from when things went well and making changes in practice through shared learning, external reviews, promoting training, research and innovation.

The trust was part of the Imperial College Academic Health Science Centre in partnership with two other NHS trusts and colleges, and one of the 11 academic health science centres in the UK.

Throughout the inspection we saw a range of posters describing the clinical research and service quality improvement projects the maternity service was involved with.

The trust had adopted the ‘Big Room’ approach to improve the antenatal pathway across areas including communication, maternity self-referral process, vaginal birth after caesarean section pathway and the quality and safety in emergency and urgent obstetric services (maternity triage and day assessment). The ‘Big Room’ quality improvement approach encourages maximum engagement with a multidisciplinary team, patients and stakeholders to process map, collect data and support ideas to enhance efficiencies in the system.

The service was working with the North-West London maternity transformation programme to agree on guidelines for birth centres within North West London. The trust worked in partnership with service users, in a holistic and inclusive manner to provide high quality safe maternity care to families residing in the local geographical area as part of the NHS England Better Birth Strategy.

Other projects included fetal monitoring safety stream: reducing the number of incidents relating to misinterpretation of CTG results through introduction of new software, education and training and introducing 'fresh eyes' as a second check to interpret CTG. Other safety improvement work streams in the trust during 2018/19 addressed the most frequently occurring clinical risks reported by staff. Maternity involvement across sites for these included abnormal results, recognising and responding to the very sick patient, safer surgery, fetal monitoring, safer medicine, positive patient confirmation and reducing falls with harm'.

The service had reconfigured its services to improve access by co-locating triage with antenatal and near the labour ward.

The service was promoting 'normal' births on the Labour Ward to improve number of normal births across both birth centres and the labour ward.

The Woman Centred Induction of Labour (WOCIL) QI project aimed to improve women's experience of induction of labour by reducing inefficiencies and overall induction of labour time. Review of induction of labour with the use of alternative medicines which have demonstrated positive benefits for women and a reduction in time on the antenatal and labour wards.

The service had undertaken a two-week pilot of implementation of a discharge lounge to facilitate faster and smoother discharge process

The service was part of the Early Adopters programme - The Early Adopters project launched in January 2017, after a successful bid for funding from NHS England to fast-track the implementation of some of the key recommendations set out in Better Births – The National Maternity Review. The recommendations are to provide personalised care, continuity of carer, safer care, better postnatal and perinatal mental health care, enhance multi-professional working, better collaborative working across boundaries and a fairer payment system.

The service was part of the National Maternity and Neonatal Collaborative; a programme which brings together stakeholders who are able to network using quality improvement models aiming to improve the safety and outcomes of maternal and neonatal care by reducing unwanted variations, reducing rate of still births, neonatal deaths and birth injuries occurring during or soon after death by 20% by 2020

The maternity service was innovative in adopting the electronic patient record and it now also includes the fetal monitoring functionality which provides central surveillance of all babies being monitored in labour which increasing scrutiny and safety. The electronic system (which digitally stores the recordings within the mother's record for all fetal monitoring activity during labour and providing long term archiving capacity) will be rolled out into the antenatal clinical areas in mid-2019.

The service had reviewed and improved ante-natal class provision for private patients and commenced be-spoke tailored post-natal visits for private patients.

The trust was leading on a number of national and international studies to identify fetal growth restriction, examining the feasibility and value of ultrasound in labour, research in partnership with the Institute of Cancer Research and Cambridge University to offer non-invasive fetal surgery for twin-twin transfusion in 2020.

The service was involved with a study to introduce the customised growth chart/birth centiles for early detection of babies small for gestational age and reduce still births

The service was involved in research to introduce fetal genotyping to reduce unnecessary invasive testing for women

A number of eminent consultants have been awarded substantial clinical grants for their research into their specialist

Neonatal services – Queen Charlotte’s and Chelsea Hospital

Facts and data about this service

Imperial College Healthcare NHS Trust (ICHNT) was part of the London Neonatal Operational Delivery Network (ODN). The neonatal service was made up of neonatal units at Queen Charlotte’s and Chelsea Hospital (QCCH) and at St Mary’s Hospital. The neonatal service provided specialist care for babies born prematurely, predominantly in the North West London sector but also took referrals from other neonatal networks.

The neonatal unit at QCCH was divided into a special care unit with eight cots and a neonatal intensive care unit with 16 cots. The units were specialised in caring for premature babies as well as complex term babies requiring intensive care.

There were 5849 deliveries in 2017 at QCCH and 533 admissions to the neonatal unit. The neonatal unit at QCCH specialised in extremely preterm infants born before 27 weeks gestation. There were approximately 80 to 90 babies admitted each year born before this gestation.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff.

The trust provided a target of 85% for completion of mandatory training.

Queen Charlotte’s and Chelsea Hospital – Nursing staff

A breakdown of compliance for mandatory training courses as at February 2019 for qualified nursing staff in neonatal services at Queen Charlotte’s and Chelsea Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Blood Transfusion	54	54	100.0%	85%	Yes
Duty of Candour	10	10	100.0%	85%	Yes
Medicines Management	54	54	100.0%	85%	Yes
Conflict Resolution	53	54	98.1%	85%	Yes
Consent	53	54	98.1%	85%	Yes
Invasive Procedures Policy	53	54	98.1%	85%	Yes
Moving and Handling Level 1	53	54	98.1%	85%	Yes
Aseptic non-touch technique (ANTT)	52	54	96.3%	85%	Yes
Equality and Diversity	52	54	96.3%	85%	Yes
Health and Safety	52	54	96.3%	85%	Yes
Infection Prevention and Control Level 2	52	54	96.3%	85%	Yes
Venous Thromboembolism	52	54	96.3%	85%	Yes
Fire Safety Awareness	50	54	92.6%	85%	Yes
Information Governance	44	54	81.5%	85%	No

In neonatal services the 85% target was met for 14 of the 15 mandatory and statutory training modules for which qualified nursing and midwifery staff were eligible.

Queen Charlotte's and Chelsea Hospital – Doctors

A breakdown of compliance for mandatory and statutory training courses as at February 2019 at Queen Charlotte and Chelsea Hospital for medical staff in neonatal services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
ANTT	18	18	100.0%	85%	Yes
Blood Transfusion	18	18	100.0%	85%	Yes
Conflict Resolution	18	18	100.0%	85%	Yes
Consent	18	18	100.0%	85%	Yes
Duty of Candour	18	18	100.0%	85%	Yes
Equality and Diversity	18	18	100.0%	85%	Yes
Health and Safety	18	18	100.0%	85%	Yes
Infection Prevention and Control Level 2	18	18	100.0%	85%	Yes
Information Governance	18	18	100.0%	85%	Yes
Invasive Procedures Policy	18	18	100.0%	85%	Yes
Medicines Management	18	18	100.0%	85%	Yes
Moving and Handling Level 1	18	18	100.0%	85%	Yes
Resuscitation Level 2	18	18	100.0%	85%	Yes
Venous Thromboembolism	18	18	100.0%	85%	Yes
Fire Safety Awareness	17	18	94.4%	85%	Yes

In neonatal services the 85% target was met for all 15 mandatory and statutory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses as at February 2019 for doctors in training staff in neonatal services is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Equality and Diversity	42	42	100.0%	85%	Yes
Fire Safety Awareness	42	42	100.0%	85%	Yes
Health and Safety	42	42	100.0%	85%	Yes
Moving and Handling Level 1	42	42	100.0%	85%	Yes
Resuscitation Level 2	42	42	100.0%	85%	Yes
Blood Transfusion	41	42	97.6%	85%	Yes
Conflict Resolution	41	42	97.6%	85%	Yes
Consent	41	42	97.6%	85%	Yes
Infection Prevention and Control Level 2	41	42	97.6%	85%	Yes
Medicines Management	41	42	97.6%	85%	Yes
Nasogastric Tube Placement	41	42	97.6%	85%	Yes
Venous Thromboembolism	41	42	97.6%	85%	Yes
Information Governance	40	42	95.2%	85%	Yes
Invasive Procedures Policy	40	42	95.2%	85%	Yes
ANTT	35	42	83.3%	85%	No

At Queen Charlotte's and Chelsea Hospital, in neonatal services the 85% target was met for 14 of the 15 mandatory and statutory training modules for which doctors in training were eligible.

Staff we spoke with confirmed they participated in mandatory training relevant to their role. A practice development nurse monitored uptake of mandatory training. Staff received email reminders when training updates were due and the matron had oversight of mandatory training compliance. Staff were supported to undertake training during work time. Training was delivered by e-learning (most modules) or in a classroom or clinical setting.

Safeguarding

Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust provided a target of 85% for completion of safeguarding training.

Queen Charlotte's and Chelsea Hospital – Nursing staff

A breakdown of compliance for safeguarding training courses as at February 2019 for qualified nursing and midwifery staff in neonatal services at Queen Charlotte and Chelsea Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Children Level 3	54	54	100.0%	85%	Yes
Safeguarding Adults Level 2	50	54	92.6%	85%	Yes

In neonatal services at Queen Charlotte and Chelsea Hospital, the 85% target was met for both safeguarding training modules for which qualified nursing and midwifery staff were eligible.

Queen Charlotte's and Chelsea – Doctors

A breakdown of compliance for safeguarding training courses as at February 2019 for medical staff in neonatal services at Queen Charlotte and Chelsea Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults Level 2	18	18	100.0%	85%	Yes
Safeguarding Children Level 3	18	18	100.0%	85%	Yes

In neonatal services at Queen Charlotte and Chelsea Hospital, the 85% target was met for both safeguarding training modules for which medical staff were eligible.

A breakdown of compliance for safeguarding training courses as at February 2019 for doctors in training in neonatal services at Queen Charlotte and Chelsea Hospital is shown below:

Name of course	Staff trained	Staff eligible	Completion rate	Trust target	Target met?
Safeguarding Adults Level 2	40	42	95.2%	85%	Yes
Safeguarding Children Level 3	40	42	95.2%	85%	Yes

In neonatal services at Queen Charlotte and Chelsea Hospital, the 85% target was met for both safeguarding training modules for which doctors in training were eligible.

Staff we spoke with were aware of the safeguarding leads within the hospital and knew how to access the team for support. The safeguarding team provided an on-call service for out of hours

and weekends. Staff were aware of how to access the safeguarding policies on the trust's intranet. All staff we spoke with were aware of their responsibilities to protect vulnerable adults and children and would take the appropriate action if they were concerned about a patient. For example, by contacting senior staff on duty, the safeguarding team and submitting a report on the electronic incident reporting system. A suspected child abduction policy was available, which contained action cards for different staff groups.

There was information on the trust's safeguarding procedure displayed on the notice boards on the unit for staff to refer to, including the contact details for the safeguarding team. There were arrangements to safeguard adults and children from abuse and neglect which took account of relevant legislation and local requirements. Staff worked in partnership with other agencies to ensure patients were helped, supported and protected.

Cleanliness, infection control and hygiene

The service controlled infection risk well and used control measures to prevent the spread of infection. However, hand hygiene audit results did not always meet expectations.

All clinical areas we visited looked visibly clean and tidy. Cleaning of the premises was provided by an external company following a cleaning schedule. We saw cleaning staff at work during inspection and completed cleaning schedules. The matron and risk and audit nurse undertook weekly cleaning audits of the whole neonatal unit. The most recent compliance rates before inspection were 99% for the special care unit and 98% for the neonatal intensive care unit.

Cleaning of equipment was completed by hospital housekeeping staff who followed instruction sheets with guidelines in how to clean medical equipment, for example incubators. There was a separate cleaning room in the unit where housekeeping staff would clean medical equipment. It also contained a washing machine and tumble dryer for baby clothes. Equipment we checked was clean and had 'I am clean' stickers to demonstrate when they had been sanitised.

Breast milk pumps were cleaned daily by health care assistants and parents were advised to use disinfecting wipes before and after use. Pump accessories were washed and air dried according to recommendation by the infection prevention and control team.

We observed staff complying with trust policy in relation to hand washing and remaining bare below the elbows. Staff and visitors washed and sanitised their hands immediately after entering the neonatal unit and upon entering nurseries. Throughout the unit we saw sufficient hand wash facilities and wall mounted hand sanitiser dispensers. Attention was drawn to these with hand hygiene notice boards. Staff in all areas had access to personal protective equipment (PPE) such as gloves and aprons. Staff and parents we spoke with were aware of hand hygiene procedures and confirmed they would challenge anyone not complying with it.

The infection prevention and control (IPC) team conducted weekly hand hygiene compliance audits. Data provided showed 74%, 75% and 72% compliance rates for December 2018, January and February 2019 respectively.

There was an infection prevention and control policy and an infection prevention and control (IPC) lead nurse, supported by two IPC link nurses for the neonatal unit. The IPC nurses were available to support staff with IPC related topics, undertake IPC reviews, offer advice and provide teaching.

The neonatal unit reported a *Pseudomonas* outbreak in July 2018, although 14 babies tested positive for *Pseudomonas aeruginosa* colonisation on routine screening results, there had been no case of *Pseudomonas* infection. *Pseudomonas aeruginosa* is a bacterium that could potentially lead to serious infections in immunocompromised patients. Water samples obtained from nurseries contained similar typing of *Pseudomonas*. The service had undertaken multiple actions

to eliminate contamination and all water taps in the neonatal unit underwent regular testing for Pseudomonas. Troughs, taps and sinks had been upgraded throughout the unit and pipework had been cleaned. The service had arranged thermal disinfection, system pasteurisation, installation of flow conditioners and fitting of tap filters. Managers told us that some water taps still tested positive for Pseudomonas despite all measures and at the time of inspection one of the nurseries in the special care unit was closed due to this. The service had planned works to increase turnover and flow of hot water as well as installation of thermal disinfection valves in all clinical areas of the unit. Staff was repeatedly instructed to use disinfectant hand gel after hand washing and all taps were flushed daily. Enhanced weekly swabs were taken from all babies and sent for microbiology testing. There were monthly meetings with the IPC team to discuss progress and updates.

Staff told us that all babies were screened on admission and weekly for Meticillin Resistant Staphylococcus Aureus (MRSA) in line with local policy. From January to December 2018, there had been one case of MRSA infection.

Waste management practices were observed and complied with the hospital policy and good practice guidelines for segregation of waste. Sharps bins were labelled and dated, linen was bagged appropriately. Waste bags were colour coded for different types of waste. Large waste containers were kept in a storage area outside the neonatal unit with a separate entrance for waste collectors.

Environment and equipment

The service had suitable premises and equipment and looked after them well. However, there was a lack of space around cots and the roof terrace was unkempt.

The neonatal unit was well organised, clean and well lit. The entrance was swipe card secured and visitors had to ring the bell and wait for the ward clerk or a member of staff to open the door.

There was limited space for chairs around the cots in nurseries in the neonatal intensive care unit, which did not encourage parents to sit next to their baby. However, staff assured us that a comfortable chair for parents could be brought next to the cots at any time. We saw several comfortable reclining chairs within the neonatal unit, which parents used for skin-to-skin contact with their baby. Screens were available for parents requesting privacy, for example for breast feeding.

Mothers could use a breast milk expressing room, which was equipped with electric breast pumps. Pump accessories were provided for mothers and could be washed and air dried in a clean room next to the expressing room. All milk bottles were single use. There was a separate milk kitchen on the unit used by staff to prepare milk, which could be warmed at the cot-side in nurseries.

Parent sleeping accommodations were located adjacent to the unit, including a family day room, kitchen and roof terrace. The roof terrace contained plants, seating and a play house for children. However, the area looked unkempt and the play house did not look clean. Senior staff told us there were plans for refurbishment of this area in current development.

Equipment was serviced by hospital technicians who checked medical equipment after it had been cleaned. All equipment we checked had stickers with last service dates. We did not see any expired equipment. Staff told us they had sufficient equipment available at all times and knew who to contact if equipment broke or needed replacement.

Emergency equipment, including resuscitation trolleys on the special care unit and the neonatal intensive care unit, had been checked and were ready for use. Tamper proof seals on resuscitation trolleys were present, as required by trust policy and changed regularly.

Assessing and responding to patient risk

Patient risk was assessed and managed accordingly.

The neonatal unit admitted premature babies as well complex term babies requiring intensive care. Neonatal consultants provided on site cover for the unit 24 hours and seven days a week, supported by doctors in training at different levels and clinical fellows. Nursing staff told us that if they had concerns relating to a baby's condition, one of the doctors would be available for assessment. Staff told us doctors were easy to reach and responded immediately. Nurse staffing was organised according to acuity and staff competencies and nurses with post-graduate qualification in neonatal care would be allocated to look after complex babies in the neonatal intensive care unit. The service did not use a neonatal early warning score as nursing staff were trained and experienced to recognise a deteriorating baby and a senior doctor would always be available for review.

There was a standard operating procedure for in utero or ex utero referrals to maternity and neonatal services. It outlined the process for the referral pathway, inclusion criteria and contraindications. Maternity and neonatal staff worked closely together, coordinating the different teams.

The service had implemented a 'golden hour' policy and guidelines to help improve outcomes for babies born at less than 32 weeks gestation. Staff made preparations accordingly prior to delivery to achieve optimised management of these babies in line with standardised practices detailed in guidelines.

There were resuscitation trolleys available in the special care unit and the neonatal intensive care unit and staff knew where they were located.

Neonatal nursing staff (band 5 and above) and all neonatal medical staff were required to complete neonatal life support (NLS) training. Trainee compliance was 100% for medical staff. The nursing workforce breakdown was as follows; band 8 compliance 100%, band 7 compliance 87.5%, band 6 compliance 100% and band 5 compliance 77.8%. Band 5 nurses who were not enrolled in the neonatal course pathway and did not complete NLS training.

Nurse staffing

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, nurse vacancy rates were above trust target.

The trust has reported their nursing staffing numbers below for the period as at March 2018 and as at October 2018 for neonatal services at Queen Charlotte's and Chelsea Hospital.

Ward/Site	As at March 2018			As at October 2018		
	Planned staff (WTE)	Actual staff (WTE)	Fill rate	Planned staff (WTE)	Actual staff (WTE)	Fill rate

Neonatal Milk Bank	3.0	3.0	100.0%	3.0	3.0	100.0%
Neonatal Unit	58.7	49.8	84.9%	60.7	49.9	82.2%
Total	61.7	52.8	85.6%	63.7	52.9	83.0%

(Source: Routine Provider Information Request (RPIR) - Total staffing tab)

From November 2017 to October 2018, the trust reported a vacancy rate of 15.1% for qualified nursing staff working in neonatal services at Queen Charlotte's and Chelsea Hospital. This was higher than the 10% trust vacancy target rate.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From November 2017 to October 2018, the trust reported a turnover rate of 13.1% for nursing staff working in neonatal services at Queen Charlotte's and Chelsea Hospital. This was slightly higher than the trust target of 12%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From April to December 2018, the trust reported a sickness rate of 2.7% in neonatal services at Queen Charlotte's and Chelsea Hospital.

From August 2017 to July 2018, the trust reported 13,807 (14.7%) bank hours and 1,353 (1.4%) agency hours at the trust were filled by qualified nurses in neonatal services at Queen Charlotte's and Chelsea Hospital. There were 1,334 hours that were over-filled by bank/agency staff.

A breakdown is shown below:

Ward/unit	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Neonatal	93,612	13,807	14.8%	1,353	1.5%	Over-filled by 1,709	Over-filled by 1.8%
Neonatal Outreach – Neonatal	375	0	0.0%	0	0.0%	375	100.0%
Total	93,987	13,807	14.7%	1,353	1.4%	Over-filled by 1,334	Over-filled by 1.4%

During the same period, the trust reported 115 bank hours (1.7%) and no agency hours were filled by nursing assistants in neonatal services. There were 104 (1.5%) hours that were not filled by bank/agency staff.

Site/ward	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Neonatal	6,912	115	1.7%	0	0.0%	104	1.5%

The trust confirmed that the over-establishment reflects actual v planned for months where the actual was greater than the planned (i.e. over established due to specialising, enhanced care, etc.). The trust reported that the bank staff usage was mainly attributed to vacancies. (Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Bank and agency staff underwent an induction process before starting their work. Staff told us they tried to fill shifts with regular bank or agency nurses.

The recommendation of the British Association of Perinatal Medicine (BAPM) was a 1:1 ratio of nursing care for neonatal intensive care. However, it was recognised by the specialist

commissioners that this was not always achievable, and babies defined as intensive care by BAPM were often stable and could be safely managed with 1:2 nursing care. The neonatal service had a standard operating procedure (SOP) for safe staffing, which contained clear guidance in identifying intensive care babies requiring 1:1 care to ensure safe staffing. The service followed BAPM recommendations for high dependency 1:2 care and special 1:4 care.

A trust-wide policy for the provision of safe nurse staffing and skill mix establishments outlined principles, processes and responsibilities of nurse staffing. Staffing and acuity levels were reviewed daily and the nurse in charge determined the number of nurses required for each shift taking into consideration the acuity of the babies, the number of babies requiring 1:1 nursing care and the number of nurses with appropriate post registration qualification. The nurse in charge was supernumerary.

On the neonatal unit, 73% of band five, six and seven nurses were qualified in specialty (QIS) and had completed the Special Care Baby Module, Neonatal High Dependency Module and the Neonatal Intensive Care Module. This was better than the minimum requirement of 70%, recommended by the Department of Health toolkit for high-quality neonatal services.

During our inspection, the neonatal unit was safely staffed with enough nursing staff. Staffing rotas we looked at confirmed this and allowed for required rest periods. The service followed recommended minimum of 70:30 registered to unregistered staff in special care, and a minimum of 80:20 registered to unregistered staff in high dependency and intensive care. There was a minimum of two registered children’s nurses on shift, of which at least one was QIS. Staff told us the service had successfully reduced nurse vacancy rates by improving staff retention and recruitment through a neonatal training and development programme for band 5 nurses and other training opportunities.

The neonatal service was supported with 1.8 WTE dieticians to support ward rounds, follow-up, attend multidisciplinary ward rounds and support the feeding clinic. The service was also supported by 1.1 WTE speech and language therapists. In addition, the 2.0 WTE lactation nurses who were part of the neonatal outreach team provided support where required.

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The trust reported their medical staffing numbers for doctors in training below as at December 2018 for neonatal services at Queen Charlotte’s and Chelsea Hospital. The trust’s vacancy target rate was 10%.

Ward/Site	As at December 2018		
	Planned staff (WTE)	Actual staff (WTE)	Vacancy rate
Imperial medical neonatal	36	35	3%

As at July 2018, the trust reported a turnover rate of 4.7% in neonatal services at Queen Charlotte’s and Chelsea Hospital. This was lower than the trust target of 12%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From November 2017 to October 2018, the trust reported a sickness rate of 0.4% in neonatal

services at Queen Charlotte and Chelsea Hospital. This was lower than the trust target of 3%.

From August 2017 to July 2018, the trust reported 5,544 (4.2%) locum hours were filled in neonatal services at Queen Charlotte's and Chelsea Hospital.

A breakdown of locum usage is shown below:

Site/Ward	Total hours available	Agency Usage	
		Hrs	%
Neonatal Intensive Care Unit (NICU) - Consultants	40,976	2,232	5.5%
Neonatal Intensive Care Unit (NICU) - Juniors	89,856	3,312	3.7%
Total	130,832	5,544	4.2%

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Medical staffing was in line with recommendations by the British Association of Perinatal Medicine (BAPM) standards, suggesting the minimum resident level of medical staffing is a tier one - junior trainee ST1 -3 or advanced neonatal nurse practitioner (ANNP), and a second tier of senior trainee ST4-8 or appropriately trained speciality doctor or ANNP. This therefore forms the basic minimum level of care. As throughput increases in a NICU, the level of cover needs to increase accordingly. Augmentation at tier one is provided by extending nurse practice and/or a second junior doctor or ANNP. Augmentation at tier two is provided by a second trained doctor or suitably trained ANNP or resident consultant.

Neonatal services were consultant led and delivered, providing daily ward rounds. The neonatal unit at QCCH was covered 24 hours and seven days a week by a consultant on site. At the time of inspection, a team of 16 neonatal consultants provided cover for both neonatal units across both hospital sites. The clinical lead told us that two additional consultants had recently been recruited, leaving one vacant consultant post at the time of inspection.

The unit was supported by junior doctors at different levels of training. Two registrar level doctors covered the special care unit and the neonatal intensive care unit at all times, supported by two or three senior house officers.

Records

Staff kept detailed records of patients' care and treatment.

The service used an electronic patient records (EPR) system that all relevant staff had individual access to. Access to the computers and patient confidential information was password protected, with staff having access via personal logins and passwords. Doctors, nurses and allied health professionals documented electronically with personal logins. The EPR contained all clinical documentation, including clinical observations, vital signs, lab results or clinic letters. The five EPRs we looked at during inspection were comprehensive and complete.

Computers to access the EPR were located within nurseries, at nurses' desks and in offices.

Some clinical documentation was paper based, such as prescription charts or consent forms. Those would be scanned and added to the EPR after discharge.

The EPR was connected to the National Neonatal Audit Programme (NNAP) and data would be transferred for analysis automatically. This helped ensure data quality.

Discharge summaries were created electronically and sent out to the patient's GP on discharge to ensure continuity of care within the community. Parents also received a copy of the discharge letter with the latest medicine prescription to share with the GP.

Medicines

The service followed best practice when storing, prescribing, giving and recording medicines.

We found medicines and fluids were stored neatly and securely in cupboards within a locked clinic room, including medicines which needed to be stored in refrigerated conditions. The treatment rooms were clean and had adequate handwashing facilities available, as well as adequate space to prepare medicines. There were appropriate facilities for the disposal of medicines.

Controlled drugs (CDs) were stored in appropriate locked CD cabinets, secured to the wall within a locked treatment room. The keys were held by the nurse in charge. We checked CD registers and found appropriate record-keeping regarding checks and administration. Staff were aware of protocols for the administration of controlled drugs as per the Nursing and Midwifery Council.

We saw that where babies were prescribed medicines that required additional monitoring that this was documented as being completed. We saw that vaccinations were documented as being administered

Breast milk was stored in fridges in each nursery and in large freezers in a separate locked storage room. Milk bottles were labelled and dated and kept in different labelled drawers. There were processes in place regarding administration of breast milk. Nurses would retrieve frozen milk bottles and de-freeze them within the nursery after cross checks.

Temperature checks had been carried out daily on fridges and freezers in all areas we visited and we found documented temperatures to be within recommended range.

We made observational checks with respect to ordering, storage, administration and disposal of medicines in the unit. Staff told us there was daily contact with pharmacists. We saw that there was a current version of the British National Formulary for Children available and staff could also access the online version.

The service used a paper based prescribing and administration records system. The records were completed and notes were made when any non-administration had taken place. Anti-microbials were seen to be reviewed in line with the trust policy.

Prescribing, including regular medicines, as required, and take-home items, was undertaken by medical staff. We looked at seven paper prescription charts and found no delayed or omitted doses of medication. Allergies were clearly documented in prescription charts.

Incidents

The service managed patient safety incidents well.

Management of incidents was highlighted as an area of concern during last inspection. Since then, the neonatal service had recruited a risk and audit nurse whose role was to ensure incidents were dealt with in an appropriate and timely manner and share learning from incidents. The hospital used an electronic incident reporting system. All staff we spoke with were familiar with how to

report incidents on the system. New incidents and shared learning from previous incidents were shared with staff through emails, newsletters, at safety huddles and departmental meetings.

The trust reported 192 clinical incidents for neonatal services at QCCH between February 2018 and January 2019. Of these incidents, 16 (8%) were classified as near miss, 171 (89%) resulted in no harm or low harm, 4 (2%) resulted in moderate harm and 1 (0.5%) resulted in major harm. A third of incidents (33%) were related to medication, other themes were implementation of care (17%) or infrastructure (7%).

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From January 2018 to December 2018, the trust reported no incidents which were classified as never events for neonatal services.

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents meeting SI criteria about sub-optimal care of the deteriorating patient in neonatal services at Queen Charlotte's and Chelsea Hospital which met the reporting criteria set by NHS England from January 2018 to December 2018. (*Source: Strategic Executive Information System (STEIS)*)

Serious incidents (SI) are those that require investigation. Evidence submitted relating to the occurrence of SI demonstrated that a root cause analysis (RCA) investigation of the SI was undertaken. Recommendations were made following the investigation. We saw an example of a comprehensive RCA undertaken related to chemical burns caused by Chlorhexidine. The RCA contained detailed information how the incident occurred, points of discussion and analysis, identified root cause, learning and action plan.

An example of learning from incidents was related to pressure sores to cheeks from breathing support securing tapes. Staff were unfamiliar with the process for referring to tissue viability nurses. As consequence, the correct process was reiterated to staff and a reference poster of how to contact the team was put up. The service also developed a neonatal tissue viability guideline to support knowledge and practice of staff in the neonatal unit in relation to pressure limiting aids and appropriate dressing selection.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were aware of the requirements and we found that it was embedded into practice in the service. We saw one example of duty of candour being applied and handled with according to regulations with letters containing an explanation of the situation and apology.

Mortality and morbidity (M&M) meetings took place regularly to discuss cases when babies had deceased. There were monthly joint neonatal and obstetrics M&M meetings at QCCH and monthly cross-site neonatal M&M meetings where obstetricians would be invited. Deaths were reviewed and lessons learned and actions were documented and shared. We saw minutes of M&M meetings, which we found well attended and comprehensive. The service also participated in annual network M&M meetings.

Major incident awareness and training

There was suspected child abduction policy in place which included action cards for different groups of staff. Staff we spoke with were aware of the policy.

There was a building evacuation plan in case of fire and we saw fire escape routes marked with signs.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Staff followed local guidelines and policies, based on National Institute for Health and Care Excellence (NICE) and Royal College of Paediatrics. There were pathways and protocols of management for various medical conditions and staff knew how to access them. The policies we reviewed confirmed this and were within date of next review. Staff had access to most recent guidelines and policies on the trust wide intranet.

There was local clinical audit programme to support and monitor implementation of recommended practice, such as the 'golden hour' audit or nutritional audits. Hearing screening audit results for January to September 2018 showed compliance rates above 99%.

The neonatal unit advocated skin-to-skin holding, which is the practice where the baby is laid on the parent's bare chest. For neonatal units, this practice played a role helping parents to bond with their baby, as well as supporting better physical and developmental outcomes for the baby. There was a guideline for skin-to-skin holding which outlined the process for a neonatal intensive care setting.

The service participated in national benchmarking clinical audits, such as National Neonatal Audit Programme (NNAP) or the Maternal Newborn and Infant Clinical Outcome Review Programme provided by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK). The service participated in the London Neonatal Operational Delivery Network (ODN) and in the Vermont Oxford Network (VON), a non-profit voluntary collaboration of health care professionals, comprising of almost 1000 neonatal intensive care units around the world.

A Quality Surveillance Team (QST) neonatal peer review took place in January 2018. It highlighted one concern regarding capacity of the neonatal outreach team. In response, the service had strengthened the outreach team from two to six members.

The service was working towards Baby Friendly Initiative (BFI) accreditation. The Baby Friendly Initiative (BFI) is a global programme of the World Health Organisation (WHO) and UNICEF to improve practice for infant feeding in health care settings. A set of standards had been formulated by the BFI for neonatal services to achieve accreditation. The neonatal service at QCCH was awaiting the stage two BFI accreditation review in April 2019.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Dietitians supported the neonatal team in enteral or parenteral nutrition of babies. When appropriate, staff provided advice and support for mothers to provide breast milk or breast feed. Speech and language therapists and lactation nurses supported parents wishing to breast feed. All nursing and medical staff were offered breastfeeding training to enable them to advise parents.

Results of the National Neonatal Audit Programme 2017 showed 90% of babies born at less than 33 weeks gestation received some of their mother's milk (either exclusively or with another form of feeding) at time of discharge from neonatal care. This was better than the national average of 60%.

There were guidelines regarding storage of breast milk, supporting lactation and breastfeeding, breastfeeding during maternal illness and decontamination of breast pump accessories, that supported the practice regarding breastfeeding in the neonatal service.

There were processes in place for administration of breast milk to babies. However, there had been three milk error incidents in 2018 where the wrong milk had been given. Incidents were related to not following protocol and labelling errors. Staff told us that milk error incidents did occur despite reinforcement of the checking procedure and raising staff awareness in handovers and safety huddles. The service was looking at this as an area for focussed quality improvement in relation to the possibility of introducing a bar-coding or scanning process for the administration of milk to babies.

An audit undertaken in 2018 reviewed local compliance with initiation and progression of enteral feeds in preterm infants. Results showed that 100% of infants commenced enteral feeding within 24 hours, guideline followed for progression of feeds in 48% but deviations in guideline based on clinical status of infant and fewer infants compared to previous audit being sole mother's milk as first enteral feed.

Other audits reviewed prescribing of parenteral nutrition and nutritional intake in babies on parenteral nutrition.

The neonatal unit operated a milk bank, which was one of 16 donor milk banks in the UK and part of the UK Association for Milk Banking. There was a process of receiving, screening, pasteurising and distributing donor breast milk. This process was supported by donor breast milk guidelines and the NICE protocol for donor breast milk.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. However, staff did not use pain assessment tools.

A prevention and management of pain in neonates policy contained strategies to reduce pain, including assessment of pain and stress using Neonatal Infant Pain Scale (NIPE), reduction of painful events and non-pharmacologic pain prevention, such as skin to skin, breastfeeding, non-nutritive sucking, facilitated tuck (holding the arms and legs in a flexed position), swaddling, and developmental care, including limiting environmental stimuli, positioning, use of supportive bedding and attention to behavioural clues. The policy also listed the use of premedication for intubation, the use of lidocaine for certain procedures, the use of morphine and clonidine for ventilated infants and the use of paracetamol for chronic pain.

Staff used oral sucrose as means of reducing the pain response for minor procedures, such as heel prick screening. Oral administration of sucrose has been shown to reduce pain scores observed during procedures. Trust guidelines for managing neonatal pain using oral sucrose were available for staff.

Staff we spoke with demonstrated good understanding of pain assessment and management in neonates. We observed staff assessing babies' pain and saw documentation of pain assessments in patient records. However, not all staff utilised a pain scoring tool for assessment, although the

electronic patient record contained a table to enter different pain scores. There was reliance on individual interpretation of clinical and observational signs, in place of objective pain scoring tools.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

The service participated in the National Neonatal Audit Programme (NNAP). Results of 2017 showed the service performed better or within expected range compared to the national aggregate.

QCCH's performance in the six measures was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 171 eligible cases identified for inclusion, 90.8% of mothers were given a complete or incomplete course of antenatal steroids.

This was better than expected when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital met the audit's recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

There were 91 eligible cases identified for inclusion, 80.2% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was higher than the national aggregate of 43.5%, and put the hospital in the top 25% of all units.

- **Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5°C-37.5°C?**

There were 123 eligible cases identified for inclusion, 56.4% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

This was within the expected range when compared to the national aggregate where 61.0% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

The hospital did not meet the audit's recommended standard of 90% for this measure.

- **Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?**

There were 422 eligible cases identified for inclusion, 97.5% of these cases had a first consultation with parents by a senior member of the neonatal team within 24 hours of admission.

This was a positive outlier when compared to the national aggregate where 90.5% of cases had the first consultation within 24 hours of admission.

The hospital did not meet the audit's recommended standard of 100% for this measure.

- **Do all babies <1501g or a gestational age of <32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP)**

There were 70 eligible cases identified for inclusion, 96.5% of babies with a weight of <1501g or a gestational age of <32 weeks at birth received the appropriate ROP screening.

This was within the expected range when compared to the national aggregate where 94.2% of cases received the appropriate ROP screening.

The hospital did not meet the audit's recommended standard of 100% for this measure.

- **Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age?**

There were 19 eligible cases identified for inclusion, 68.4% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age.

This was higher than the national aggregate of 61.2%, and put the hospital in middle 50% of all units.

The hospital did not meet the audit's recommended standard of 100% for this measure.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

The trust submitted data for the 2017 Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK) audit (neonatal surgical provision and level 3 neonatal intensive care unit) and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 6.70 which was up to 10% worse than the comparator group. None of the neonatal deaths appeared to be avoidable on detailed review by the neonatal consultant body. The trust's result in the 2016 audit was 5.78. There was no national aspirational standard for this audit.

Medical staff told us that all deaths were reviewed as individual structured judgement reviews and increased mortality rate in the 2017 MBRRACE audit could be explained with a higher number of neonates with cardiac problems.

The Vermont Oxford Network (VON) is a non-profit voluntary collaboration of health care professionals and comprised of almost 1000 neonatal intensive care units around the world. Annually, data was submitted on over 50,000 very low birth weight (less than 1500g) babies. In comparison to VON 2017, the neonatal unit at QCCH treated a higher number of babies who were preterm (<32 weeks gestation) and/or very low birth weight, but the risk adjusted standard mortality was within expected range given the characteristics of infants treated at the unit.

The service also undertook audits regarding the use of nitrous oxide, blood transfusions and several nutrition audits.

An audit in 2018 reviewed compliance with recommendations of the 'golden hour' policy; time to admission, blood glucose, time to antibiotics and fluids and admission temperatures of babies born less than 32 weeks gestation admitted to the neonatal unit. Results had been used to monitor and improve the service and actions had been formulated accordingly.

The service ran routine follow-up clinics for complex babies, two-year follow-up clinics for preterm babies to assess development and chronic lung disease clinics for babies with severe chronic lung disease and on home oxygen. Children were seen by a consultant, physiotherapist, dietitian or another member of the neonatal outreach team as appropriate.

Competent staff

The service made sure staff were competent for their roles. However, managers did not always appraise all staff's work performance.

From November 2017 to November 2018, 88.4% of staff within neonatal services working at Queen Charlotte's and Chelsea Hospital received an appraisal compared to a trust target of 95%.

A breakdown by staff group is shown below:

Staff group	Individuals required (YTD)	Appraisals complete (YTD)	Completion rate	Target rate	Target met? Yes/No
NHS Infrastructure Support	5	5	100.0%	95%	Yes
Support to doctors and nursing staff	4	4	100.0%	95%	Yes
Other Qualified Scientific, Therapeutic and Technical Staff	1	1	100.0%	95%	Yes
Qualified Healthcare Scientists	1	1	100.0%	95%	Yes
Qualified nursing and health visiting staff	53	46	86.8%	95%	No
Support to Scientific, Therapeutic and Technical Staff	5	4	80.0%	95%	No
Total	69	61	88.4%	95%	No

(Source: Trust Provider Information Request – Appraisal tab)

Staff survey results for 2017 showed that 95% of respondents of the children's directorate thought that appraisals/performance review identified training, learning or development needs and 100% felt that training helped them do their job more effectively.

All new staff, including agency staff underwent a local induction and orientation before starting their roles. We were shown evidence of induction documentation for staff during our inspection. New staff were supernumerary and did not work out of hours during the first four weeks. They were given competency books and were assigned a mentor and a buddy for additional support.

A practice development nurse was available for staff to support them in achieving competencies or training goals. Staff we spoke with said they had good access to their practice development nurse and felt supported. The practice development nurse was supported by a band 6 neonatal pathway educator.

The service also delivered regular skills and simulation training for medical and nursing staff.

The lactation nurses provided training for staff to be competent in the use of breast milk pumps.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

A multidisciplinary ward round took place once a week. It was usually attended by the neonatal consultant, neonatal junior doctor, nurses, pharmacist, dietitian, speech and language therapist, lactation nurse, neonatal outreach team and integrated family delivery of care (IFDC) project coordinator. Parents were encouraged to be present and participate in the multidisciplinary ward round. We observed an MDT ward round and found it to be comprehensive and inclusive with a professionally friendly atmosphere.

Both neonatal teams cross-site, including nurses in charge and a microbiologist liaised weekly via video conference to discuss patients.

A microbiology ward round took place weekly with microbiology consultant advice being available over seven days.

A cardiologist specialised in congenital heart disease visited the neonatal unit weekly for consultations or referrals.

There were weekly radiology meetings where the team reviewed images.

Seven-day services

The neonatal unit provided seven-day services.

The service provided 24-hour neonatal consultant cover on site for seven days a week.

From Monday to Friday, two consultants were on duty during daytime to cover the special care unit and the neonatal intensive care unit each, supported by two registrars and three senior house officers (SHO). One consultant was on duty during the night, supported by one registrar and two SHOs. On weekends, one consultant looked after the neonatal unit, supported by two registrars and three SHOs.

The neonatal outreach team was available Monday to Saturday 8.30am to 4.30pm.

Dietitians were available from Monday to Friday 8.30am to 4.30pm.

Radiology services were available 24 hours, seven days a week.

Pharmacy services were available from Monday to Friday between 9am to 7pm. At weekends, pharmacy services were available for five hours each day. Outside of these hours an on-call pharmacist was available for clinical advice and urgent supplies of medicines.

Health promotion

Health promotion was available on the neonatal unit.

There was information material and leaflets available for parents on the unit. Lactation nurses provided advice for mothers which included healthy lifestyle topics and nutrition. The hospital kitchen provided fresh cooked meals for breastfeeding mothers and all menus were designed to meet recommended salt-reduction targets, based on the Live Well guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to obtain consent. However, there was no guidance if there were concerns regarding parental capacity.

Staff obtained consent from parents before procedures verbally or written. During inspection we looked at five sets of patient records and they contained documentation of verbal consent and a copy of written consent forms, for example consent for vaccinations. The sets of notes we reviewed confirmed that consent forms were signed, dated and legible. They included the risks and benefits of the procedure the patient was undergoing.

Staff were unaware of any arrangements or guidance if there were concerns regarding parental capacity to provide consent for their babies. The trust did not provide any evidence of guidance for staff regarding this. Staff did not routinely receive training on mental capacity assessment or about the Mental Capacity Act.

Is the service caring?

Compassionate care

Staff cared for patients with compassion and showed sensitivity towards parents.

Staff provided care in a very caring and compassionate manner. Staff talked to babies as individuals, addressing them by their name and handling them with care. We saw doctors, nurses and support staff introducing themselves to parents. Throughout the inspection, we saw staff treat babies and their parents with dignity and respect. Crying or uncomfortable looking babies were not left but immediately attended to. Screens were used where parents had requested a period of privacy or where mothers wished to feed their baby. The noise level within the unit was kept at a minimum and we saw incubators being covered with sheets to protect babies from bright lights and create a more comforting atmosphere.

All parents we spoke with found staff kind, supportive and caring. All felt their babies were in safe hands when they left the unit. Comments from parents included: "The staff are amazing.", "Everyone is lovely." or "The care given to my baby was exceptional".

Staff told us they would provide parents with London travel cards through one of the charities if they identified a need for this.

The friends and family test (FFT) asked parents how likely they were to recommend the hospital to friends and family if they needed similar care or treatment. The answers showed an average of 100% from October 2018 to January 2019. However, the trust did not provide the number of responses or response rates.

We saw thank you cards and positive comments displayed in the unit. This meant that parents had taken the time to thank staff in writing. There were numerous photo collages of former patients on display as well as a handprint tree in the corridor with names of children.

Emotional support

Staff provided far-reaching emotional support to patients and parents to minimise their distress. Staff were aware of the emotional strain on all involved and thus endeavoured to relieve their stress as much as possible with the help of professionals and peers.

We saw families being reassured by nursing and medical staff to reduce anxiety. All staff we spoke with had deep understanding of the emotional distress parents and relatives go through during the stay at the neonatal unit. Staff were aware of possible triggers of stress or anxiety to babies and kept incubators covered and noise at a minimum.

Clinical psychologists were part of the neonatal team. They offered individual face to face sessions to parents whose baby was admitted to the unit and led weekly inpatient parent support groups. The team further organised an outpatient group for neonatal families after discharge.

The service had developed the integrated family delivery of care (IFDC) project. The project aimed to include parents in all aspects of neonatal care and thereby reduce stress among parents, improve their overall experience and enable babies to leave the unit sooner. It focussed on the relationship between parents and their child and gave parents confidence to look after their baby. One parent commented: "we soon stopped feeling helpless and instead felt really empowered". Weekly meditation and lullaby music sessions for parents were part of the IFDC support programme. Veteran parents were invited to attend parent support meetings to share their experience and support other parents.

All parents of newly admitted babies to the unit received a welcome pack which included a pair of mother and baby comforters used as a bonding aid. One comforter stayed with the mother and one with the baby, then the comforters were swapped carrying mother's scent to the baby to help calming them. The unit also used octopus comforters for premature babies, as the tentacles mimicked the umbilical cord in the womb. This had shown to have calming effects on babies and reduced the risk of babies pulling on tubes or lines. The use of any small toys or symbolic items was limited within the neonatal unit to help protect babies from harm and staff followed small toys on the neonatal unit guidelines, which contained information about safety or infection control requirements of toys.

Bereaved families were offered bereavement follow-up and support. Parents who had lost their baby were invited to meet with a neonatal consultant and psychologist to help them understand the cause of death and facilitate the grieving process. A standard operating procedure for palliative care had been developed jointly by neonatal and maternity services. The neonatal unit worked closely with the palliative care teams of a London children's hospital and local hospices. Bereavement training was available for all junior doctors. The ward clerk of the neonatal unit had completed bereavement training out of personal interest and empathy to be able to offer support to grieving families.

To support staff there were reflective practice sessions, debrief sessions following challenging situations, psychologists support and individual face to face sessions and monthly meditation sessions. Bereavement training was offered with the support of the psychologists.

Understanding and involvement of patients and those close to them

The service was focussed on involvement of parents in all aspects of their baby's care and treatment. Staff endeavoured to make parents feel empowered to care for their babies and to be part of the neonatal team.

The service had improved involvement of parents in the care of their babies since the last inspection. Parent involvement was part of the integrated family delivery of care (IFDC) project, seeing parents as an integral part of the neonatal team. Parents were encouraged and trained to provide most of neonatal care with nurses' help and support, including feeding, changing and monitoring their baby. Competencies were assessed and recorded in a passport, which parents

could take to other units if the baby was transferred to show they were able to perform different tasks, for example tube feeding. One staff member told us they aimed for parents to feel they were caring for their babies instead of visiting them.

Research had shown that better developmental outcomes could be observed in babies with strong bonding with their parents. Educating and engaging parents with the care of their baby could reduce anxiety, improve experience and bonding. Parent education was a significant part of the IFDC project, providing regular teaching sessions for parents as part of a rolling education programme and offering educational material on the project's interactive smartphone application with diary functions. There was a weekly consultant questions and answers (Q&A) session, where parents could ask a neonatal consultant questions in a relaxed atmosphere. Staff told us that this was usually well attended. Weekly parent craft sessions provided practical teaching, for example for tube feeding or milk preparation. Parents were encouraged to present their babies during ward rounds to the team and participate in the discussion. A template had been developed to help parents prepare and have the relevant information ready and IFDC coordinators were available for support.

We observed a multidisciplinary ward round take place on the neonatal unit; mothers presented their baby before the multidisciplinary team and participated in the discussion. The mothers presenting demonstrated sound knowledge and understanding of physiological processes regarding their babies' past and current health issues.

Previously, parents were often excluded from care or discussions, especially during ward rounds for confidentiality reasons in rooms with more than one cot. To avoid this, the service introduced noise isolating headphones for parents to wear during ward rounds so they could remain with their child.

Consultants spent time speaking with the parents throughout the day and provided many opportunities for them to ask questions about the care and treatment plans for their babies. Parents we spoke with felt they were regularly updated by medical and nursing staff and they could phone the unit at any time.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned services in a way that met the needs of local people.

The neonatal unit at QCCH had eight cots in the special care unit and 16 cots in the neonatal intensive care unit for level two and level three care.

The unit worked closely with the neonatal unit at St Mary's Hospital and there were daily cross-site phone conferences to discuss activity on the units, staffing or clinical issues. The service at QCCH was a medical neonatal unit. Neonatal patients undergoing surgery were transferred to St Mary's Hospital and complex cardiac patients were transferred to a tertiary cardiac centre in London.

There were close links with the foetal medicine unit and clinical genetics at one of the other hospitals within the trust and foetal medicine specialists worked closely with neonatologists around and after delivery if required.

Meeting people's individual needs

The service took account of patients' and parents' individual needs.

There were nine parent accommodation rooms which were located directly adjacent to the unit. Each room was furnished to a high standard and had an en-suite bathroom. The rooms allowed parents to be close to their baby and was especially helpful for those parents who had been transferred from hospitals located outside London. One of the accommodation rooms was designed wheelchair friendly with an ensuite bathroom with wheelchair access. There was an additional family room with comfortable seating and a television as well as a kitchen for parents with a fridge and microwave. Staff told us that additional on-site hospital accommodation would be available for parents in case the rooms on the unit were all occupied.

There was a separate bereavement room adjacent to the neonatal intensive care unit with a cot, comfortable seating and en-suite bathroom. The room was decorated with wallpaper and pictures to create a pleasing atmosphere. It allowed parents to spend time with their baby in privacy away from the clinical area.

The neonatal unit operated open visiting times to allow for families to see their baby. Staff encouraged parents to spend time with their baby as much as possible.

Parents received welcome packs to help them adapt to the neonatal environment. It contained information about unit procedures and rules, such as handwashing policy, a pair of mother and baby comforters, cool packs and bag for transporting milk and a book about the importance of talking to their baby.

The service offered weekly "Orientation to the neonatal intensive care" courses as part of the IFDC programme. This helped parents understand procedures and equipment in the unit.

Information boards were visible on the neonatal unit and in the family room, providing a range of information, for example about feeding, development or parental support.

Translation services were available for families for who did not speak English as their first language and staff knew how to access them.

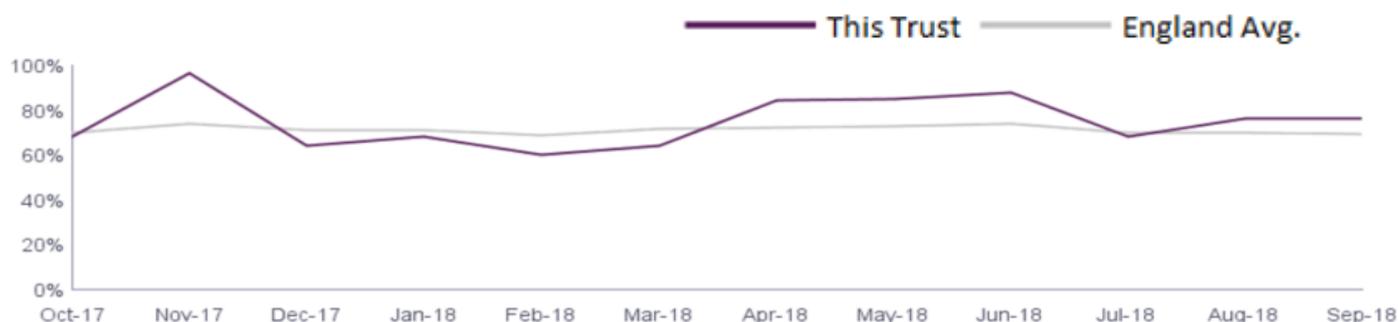
The hospital kitchen provided a variety of menu options, for example halal or vegetarian.

Staff and visitors had access to a multi-faith room within the hospital as well as a multi-faith chaplaincy service.

Access and flow

Patients could access the service when they needed it.

From October 2017 to September 2018, the trust had seen neonatal bed occupancy higher than the England average for six months of the 12-month period.



Note: Data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Between January and December 2018, the neonatal unit at QCCH admitted 522 babies.

Cot occupancy rates from January to December 2018 were an average of 86% for the neonatal intensive care unit and 76% for the special care unit. This was comparable to national figures.

Babies were admitted from the hospital's maternity unit or via referral from another hospital. The neonatal unit at QCCH treated extremely pre-term babies (less than 27 weeks gestation) and babies with complex medical needs. There was a standard operating procedure for referrals to maternity and neonatal services within the trust containing indications and exclusion criteria.

The neonatal outreach team was comprised of one Band 7 lead nurse, two Band 6 specialist nurses and two Band 6 lactation specialist nurses. The team provided a range of services including; supporting complex discharges and supporting parents at home, education and teaching for parents and families. Parents were provided with a booklet containing checklists for different stages of parents' and babies' journey through the neonatal unit from birth to discharge home. The outreach team assisted in completing the booklet and were available for information and advice.

As part of the discharge process, parents were provided with medication to take home, the discharge letter with clinical information and a follow-up appointment in the outpatient department. The documents included phone numbers to call in case of problems or questions.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

From November 2017 to October 2018, there were two complaints about neonatal services at Queen Charlotte's and Chelsea Hospital. One complaint related to clinical treatment and the other complaint was about privacy, dignity and wellbeing.

The trust took 41.5 working days to investigate and close these complaints. This was not in line with their complaints policy, which stated complaints should be completed within 40 working days.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Complaints and learning were on the agenda of divisional quality and safety meetings and the outcome of each investigation was shared with the staff involved. Complaints and learning were also discussed at weekly consultant meetings or monthly team meetings. One of the complaints was about breastfeeding advice given by a junior doctor. The advice was considered as not in line with good practice. As consequence, all junior doctors and midwives undertook breastfeeding training as part of their induction and training.

Patient advice and liaison services leaflets and posters were visible on the unit, informing patients how to raise a concern or make a complaint. Parents we spoke with were aware of how to make a complaint.

Staff told us that, where possible, they would resolve any issues informally, prior to a formal complaint being made. Any concerns raised by parents on the unit would be addressed immediately by the member of staff or escalated to the nurse in charge or matron.

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. However, staff survey results showed signs of disconnection with senior management.

The neonatal unit was part of the children's directorate of the women's, children's and clinical support (WCCS) division. The divisional general manager, divisional director and divisional director of nursing formed the clinical directorate leadership team for the service. The divisional director was part of the trust's executive team and reported to the chief executive. The divisional director of nursing reported to the director of nursing. Local leadership for the neonatal unit at QCCH was formed by the neonatal clinical lead and the neonatal matron. The matron was supported by band 7 nurses and a supernumerary nurse in charge. Staff informed us they had good access to the matron, as she was very visible and had her office within the neonatal unit. The clinical lead was an experienced neonatal consultant who was aware of past and current issues in the unit and had clear strategies how to address them, for example *Pseudomonas* in water systems.

Staff spoke highly of the support and leadership managers provided. Staff of all levels told us they felt valued as team members and felt listened to.

The NHS staff survey 2017 demonstrated that 67% of participants of the WCCS division felt that immediate manager took a positive interest in their health and well-being. The majority (88%) knew who their senior managers were, however, only 35% thought that senior managers tried to involve staff in important decisions.

Survey results for the children's directorate showed that only 25% of participants thought that communication between senior management and staff was effective and only 13% felt that senior managers acted on staff feedback. Both results were worse than organisational average. Actions taken in response were global emails to be used to share changes and ask for comments and additional monthly staff team meetings with a band 7 nurse.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The service's vision and strategy were based on the trust values to be kind, collaborative, expert and aspirational.

The unit continued to develop as an expert provider of neonatal care in collaborative working with local maternity services and the London Operational Delivery Network to ensure an integrated approach to the delivery of care involving parents (IFDC) and collaborating closely with specialist and paediatric services. The service aimed to continue training committed, innovative and enthusiastic neonatal workforce for the future and to build a world class neonatal service, based on expertise in research, increase opportunities for neonates to be involved in clinical trials, ensure that babies received the best possible care and develop a programme of quality improvement initiatives.

Another goal was to improve the environment by developing refurbishment plans with the trust to create a modern and welcoming place for staff to work, and children and families to receive health care.

Senior staff we spoke with were aware of the unit's vision and strategy.

Culture

Managers were successfully promoting a positive culture that supported and valued staff.

During inspection, we found an inclusive and constructive working culture within the service. Staff we spoke with felt that QCCH was a good place to work. Nurses and doctors reported approachable and supportive colleagues and described good teamwork and supportive managers. Consultants we spoke with praised the supportive and close working relationship with their colleagues. Staff we spoke with felt encouraged to develop and improve their skills. For example, they felt supported by the trust to undertake training courses. Staff told us that morale had improved since vacancy rates had been successfully reduced.

The NHS staff survey 2017 showed that only 34% of participants of the WCCS division felt able to meet conflicting demands on their time at work and 55% did not work any additional paid hours per week for the organisation, over and above contracted hours. One of the actions following the staff survey was to remind staff to follow the standard operating procedure for safe staffing for escalation of concerns so they were aware support was available.

Most survey participants of the children's directorate (92%) would feel secure raising concerns about unsafe clinical practice and 72% would feel confident that the organisation would address such concerns. These results were better than organisational average.

The trust had a whistleblowing policy in place and freedom to speak up guardians were available for all staff to voice concerns.

Staff we spoke with were aware of the requirements of duty of candour and we found that it was embedded into practice in the service. We saw one example of duty of candour being correctly applied.

Governance

The trust used a systematic approach to continually improve the quality of its services and safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

There was a solid governance framework in place to support the delivery of the strategy and good quality care.

Monthly divisional quality and safety meetings were chaired by the divisional director and reviewed risks, incidents, outcomes, complaints, patient feedback and audits. Senior staff disseminated learning and information in local meetings. Divisional governance days were organised six-monthly with training sessions for staff and audit updates.

The trust shared feedback from serious incidents to all staff in a newsletter, which included shared learning and any resulting changes to policies and procedures. The service displayed a neonatal unit dashboard, which was updated monthly and gave an overview of compliance with MRSA infections, hand hygiene and cleaning audits.

Nurse establishment reviews containing key initiatives to help ensure safe staffing were undertaken by the directorates and were presented to the board twice yearly.

The neonatal unit held monthly team meetings to disseminate updates, learning and information. Staff told us that besides monthly meetings, the daily team brief would be used to share updates, new incidents or feedback. Neonatal consultants attended weekly meetings and monthly mortality and morbidity meetings.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Risk management was highlighted as an area of concern during last inspection. Since then, the service had recruited a risk and audit nurse to support the neonatal unit. Her role included managing clinical risks, overseeing management of incidents and audits. Risks for neonatal service were included in the children's directorate risk register. The risk register was reviewed regularly and contained a description of the risk, ratings, any controls in place with record of progress and review dates. Managers and senior staff were aware of the directorate risks affecting all areas, for example nurse staffing, and risks specific to the neonatal unit. Various meeting minutes evidenced that risk registers were regularly reviewed, discussed and updated. Risks on the divisional risk register were reviewed at monthly divisional quality and safety meetings and fed into the corporate risk register.

The service had implemented a winter visiting guideline, which limited visitors to the neonatal unit to parents only during winter months. The purpose was to reduce the risk of infection.

There was a missing child policy in case of a suspected infant abduction within the service. It contained clear guidance how to respond including action cards for different members of staff.

The service had an annual audit programme with local and national clinical audits in relation to this core service to improve performance and support safety. Audits were reviewed regularly at local and divisional levels.

Information management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Staff used the trust's computer systems to access trust policies and resource material. Each member of staff had their personal login information to access the systems. Information governance was part of the mandatory training programme.

During inspection we saw staff logging off before leaving computers and we did not see unlocked computer screens. This prevented unauthorised access to data.

Staff had access to electronic patient records on the trust's computer systems. Any paper documents were scanned into the electronic system by staff in medical records and then destroyed.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

The NHS staff survey 2017 was conducted between September and November 2017 with 1207 surveys being sent out to a random selection of Imperial NHS staff by an independent external survey company. A total of 495 staff completed the survey (41% response rate), of whom 105 were from the WCCS division and 38.7% of randomised selected WCCS participants responded and shared their views. This was an improvement on the response rate from the previous year. The divisional final engagement score was 3.75 against a national average of 3.79 and an organisational average of 3.84.

Survey results of the children's directorate demonstrated that 87% felt they were able to provide the care they aspired to and that 85% would be happy with the standard of care provided by the organisation if a friend or relative needed treatment. Both results were better than the organisational average.

The General Medical Council national training survey addressed all doctors in training and asked them about different aspects of their current training hospital. Results from 2018 showed an overall satisfaction rate of 83% for the trust's neonatal service. This was better than results from previous years.

The service sought regular feedback from parents through comment cards or the friends and family test. The feedback we saw from parents about the service was generally positive.

Learning, continuous improvement and innovation

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The neonatal team had developed the Integrated Family Delivery of Care (IFDC) programme as a quality improvement project. The aim was to provide high quality, family centred, caring and compassionate care to babies and their families. Goals for improvement were parent experience and parent-infant bonding, parental mental health and infant health outcomes. The IFDC project was based on international evidence around family integrated care models, in line with the BAPM clinical strategy and developmental care ethos of the trust's neonatal service. The team developed staff education material and parent education and competency material together with veteran parents, nursing, allied health and medical staff. Parents presented their babies on ward rounds with support from IFDC coordinators and structured presentation material. An IFDC smart phone application was launched containing a wide range of information for parents as well as developmental timeline and a diary function. The IFDC project had been commended by the London Operational Delivery Network and had won the trust's Chairman's award. The project team had published articles in neonatal and paediatric care journals.

The service conducted and participated in a multitude of clinical multicentre research studies, for example Generic Imaging in Neonatal Encephalopathy (GENIE), Cooling in Mild Encephalopathy, Magnetic Resonance Biomarkers in Neonatal Encephalopathy (MARBLE).