

# Barts Health NHS Trust

# St Bartholomew's Hospital

## Quality report

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Date of inspection visit: 8 November 2013  
Date of publication: January 2014

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

## Overall summary

St Bartholomew's Hospital is in the City of London and provides a full range of local and specialist services, which include centres for the treatment of cancer, heart conditions, fertility problems, endocrinology and sexual health conditions. It is part of Barts Health NHS Trust, the largest NHS trust in England.

CQC has inspected St Bartholomew's Hospital once since it became part of Barts Health on 1 April 2012. Our most recent inspection was in February 2013 when we looked at cancer care patients undergoing surgical procedures. We found that the trust was meeting all of the 16 national standards of quality and safety. As part of this inspection, we were assessing whether the trust had addressed the shortfalls in other locations, as well as taking a broader look at the quality of care and treatment in a number of departments to see if the hospital was safe, effective, caring, responsive to people's needs and well-led.

Our inspection team included CQC inspectors and analysts, doctors, nurses, allied health professionals, patient 'experts by experience' and senior NHS managers. We spent one day visiting St Bartholomew's Hospital. We spoke with patients and their relatives, carers and friends and staff. We observed care and inspected the hospital environment and equipment. Prior to the inspection, we also spoke with local bodies, such as clinical commissioning groups, local councils and Healthwatch.

We found the wards and departments we visited were clean and infection rates were low. Patients were treated with dignity and respect and were involved in decisions about their treatment and care. The majority of people were satisfied with the service they had received and were complimentary about the care and compassion shown by staff.

Staff were committed to providing good standards of care in all circumstances. Staff morale was low in some areas, mainly due to the implementation of a staffing review. Best practice professional guidelines were used. Most staff had received training to undertake their role and the trust had focused on ensuring staff completed mandatory training.

Services were well-led and staff used quality and performance information to improve. There was evidence that the clinical academic group CAG management structures and leadership were effective.

However, we found there were a number of areas for improvement in some of the services we inspected.

There were not enough staff on some medical wards to meet minimum staffing levels to ensure patients received care and attention in a timely manner. In surgery there were concerns the dependency of patients was not taken into account when staffing levels were set. Across all

# Summary of findings

## Overall summary (continued)

services, patients and staff raised concerns about the quality and quantity of the food served to patients.

There were systems in place to report incidents, but some

staff reported that they did not have access to the IT system to do so. There were also problems with the speed and functionality of the IT system.

## The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

### **Are services safe?**

Patients were protected from the risk of infection and the hospital was clean. There was a focus on safety and quality and this was embedded through the clinical academic group (CAG) structures in the clinical areas visited. However, we found staffing in some medical wards did not meet the minimum staffing levels at the time of the inspection and patient needs may not be met in a timely manner. There were also concerns that patient needs may not be met due to the reliance on bank (overtime) and agency staff in some areas.

### **Are services effective?**

National guidelines and best practice was followed. Care was effective and patients' needs were met.

### **Are services caring?**

Patients told us staff were caring and compassionate and they were treated with dignity and respect. We observed staff were polite, kind and caring in their interactions with patients, visitors and colleagues. However, we had concerns about the standard of the meals provided by the hospital which patients described as "inedible".

### **Are services responsive to people's needs?**

Patients told us that the hospital services had responded to their needs. We found discharge arrangements were coordinated through multidisciplinary teams and patients were aware of their expected date of discharge. Patients' wishes were taken into account in the planning and delivery of care.

### **Are services well-led?**

There was effective leadership and governance at all levels of the clinical academic groups. Staff were clear about their responsibilities and were supportive of each other.

# Summary of findings

## What we found about each of the main services in the hospital

### Accident and emergency

There were no emergency services provided at the hospital. There is a minor injuries unit (MIU) providing a service to people working in local offices and businesses. Patients were seen and treated within acceptable time limits. Nurse practitioners provided the service and patient treatment was provided in accordance with agreed protocols.

### Medical care (including older people's care)

Staff had appropriate skills and training. Some of the areas we visited were short of staff. However, the staff were caring, compassionate and the majority of people we spoke with told us that they were happy with the care. The areas were well-led at the point of service delivery, although some staff told us that there was a disconnect between the executive team and the wards. Patients were admitted either directly to the wards via the outpatient department, day units or from other hospitals within the trust as well as from other external providers.

### Surgery

Patients were treated in accordance with national guidance, for example, cardiac and thoracic surgery. Risk management processes were in place and staff were aware of how to report incidents. Staff were not, however, aware of learning from incidents to improve patient safety.

Staffing levels were in line with professional guidance. However, there were some concerns that the staffing levels did not take into account the dependency of patients on surgical wards at night and weekends, and the impact of using high levels of agency staff. Patients were not discharged over the weekend on one ward which could lead to an extended length of stay for the patients.

### Intensive/critical care

Patients received appropriate care and treatment in accordance with national guidelines. There were sufficient numbers of staff on duty to provide 24-hour care. Systems were in place to monitor the quality and safety of patient care provided. Staff were aware of the incident reporting system and received feedback. They told us they were encouraged by senior staff to report incidents and raise awareness of patient safety issues.

# Summary of findings

## What people who use the hospital say

The NHS Family and Friends test scores showed the trust average score was above the national figure. Cancer patients rated the trust in the bottom 20% of all

trusts nationally. The NHS Choices website showed St Bartholomew's Hospital had a star rating of 4.5 out of 5.

## Areas for improvement

### Action the hospital MUST take to improve

- Ensure there are sufficient staff with an appropriate skills mix on all wards to enable them to deliver care and treatment safely in a timely manner.
- Ensure patients receive nutritious food in sufficient quantities to meet their needs.

### Other areas where the hospital could improve

- Improve the visibility of senior leaders in the trust.
- Address concerns about the implementation of the review of nursing posts and the effects of this on the skills mix of nursing staff.
- Improve the dissemination of 'lessons learned' from serious incident investigations across all CAGs.
- Improve staff access to suitable IT to ensure timely incident reporting by all staff.

## Good practice

Our inspection team highlighted the following areas of good practice:

- The majority of patients were complimentary about the care and compassion of staff.

# St Bartholomew's Hospital

## Detailed findings

**Services we looked at:** Accident and Emergency; Medical care; Surgery, Intensive/Critical care

### Our inspection team

**Our inspection team for Barts Health NHS Trust was led by:**

**Chair:** Dr Andy Mitchell, Medical Director (London Region), NHS England

**Team Leader:** Michele Golden, Care Quality Commission

**Our inspection team at St Bartholomew's Hospital was led by:**

**Team Leader:** Sue Walker, Care Quality Commission

Our inspection team included CQC inspectors and analysts, doctors, nurses, student nurses, allied health professionals, patient 'experts by experience' and senior NHS managers.

### Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. The inspection took place on 8 November 2013 we are testing the new approach in 18 NHS trusts. We chose these trusts because they represented the variation in hospital care in England, according to our new 'intelligent monitoring' system – which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations. Using this model, Barts Health NHS Trust was considered to be a high-risk service.

# Detailed findings

## How we carried out this inspection

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

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

The inspection team inspected the following services at this inspection:

- Accident and emergency (A&E)
- Medical care
- Surgery
- Intensive/critical care

Before visiting, we looked information we held about the trust and also asked other organisations to share what they knew. The information was used to guide the work of the inspection team during the announced inspection on 8 November 2013.

During the announced inspection we:

- Held four focus groups with different staff members as well as representatives of people who used the hospital.
- Held one drop-in session for staff.
- Looked at medical records.
- Observed how staff cared for people.
- Spoke with patients, family members and carers.
- Spoke with staff at all levels from ward to board level.
- Reviewed information provided by and requested from the trust.

The team would like to thank everyone who spoke with us and attended the focus groups and drop-in sessions. We found everyone to be open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the hospital.

# Are services safe?

## Summary of findings

Patients were protected from the risk of infection and the hospital was clean. There was a focus on safety and quality and this was embedded through the clinical academic group (CAG) structures in the clinical areas visited. However, we found staffing in some medical wards did not meet the minimum staffing levels at the time of the inspection and patient needs may not be met in a timely manner. There were also concerns that patient needs may not be met due to the reliance on bank (overtime) and agency staff in some areas.

## Our findings

### Patient safety

Patients told us they felt safe in the hospital and the majority had experienced good care. Comments included, "Staff are always visible and never rush even though I know they are short-staffed and busy". Another person said, "We always have our call bells to hand and staff usually responded promptly".

There was a focus on safety. Staff reported incidents and were encouraged to do so by their managers. Staff also confirmed that they received feedback and incidents were analysed and used to improve the quality and safety of services. Staff were not aware of learning from incidents that had occurred in other parts of the trust which suggests systems to share learning were not effective.

Serious safety issues and avoidable harm were reported to the National Reporting and Learning Service. The number of reported serious incidents for St Bartholomew's Hospital was 12 and a third of those related to grade 3 and 4 pressure ulcers.

### Staffing

Staff reported they were often "stretched" and under pressure at busy times, particularly in the nursing workforce. We were told there were adequate numbers of doctors. Junior medical staff and student nurses told us they were usually well supported by senior staff. There were systems in place to order additional nursing staff to cover vacant posts and short-term absence. However, we saw on several wards that the minimum staffing levels

and skills mix necessary to meet patients' needs were not achieved.

### Cleanliness and hospital infections

Patients were protected from the risks of infection. The trust infection rates for *Clostridium difficile* (*C.difficile*) and methicillin-resistant staphylococcus aureus (MRSA) were within an acceptable range taking account of the trust size and national infection levels. The wards visited displayed information regarding their individual infection rates for staff and patients to see.

All the wards we visited were clean, with schedules followed by cleaning staff. Patients and visitors were provided with information on how to prevent infections. There was hand hygiene gel at the entrance of every ward and by every patient bed for staff, patients and visitors to use. Staff were seen wearing personal protective equipment (gloves and aprons) and washing their hands in between attending to patients. Patients were screened prior to admission. Patients with a spreadable infection were treated in isolation in side rooms. We also saw that patients vulnerable to infections were nursed in isolation for their protection.

### Managing risks

The hospital was managing patient safety risks. There were safety measures in place to monitor patient falls, development of pressure ulcers, blood clots and catheter urinary tract infections. There was ongoing monitoring to improve safety and ward-based quality monitoring and performance results were displayed on ward notice boards for staff and patients to see.

### Patient records

Patient records contained information regarding patients' wishes with regard to end of life care and, where appropriate, 'do not attempt resuscitation' decisions were documented and discussed with patients.

### Medical equipment

Equipment seen in the hospital was clean and had been serviced and maintained. Emergency equipment was available in all areas and records showed daily checks were carried out.

# Are services effective?

(for example, treatment is effective)

## Summary of findings

National guidelines and best practice was followed.  
Care was effective and patients' needs were met.

## Our findings

### Clinical management and guidelines

Patients received care according to national guidance. The trust used National Institute for Health and Care Excellence (NICE) and professional guidelines. The trust participated in national audits and there were staff in place to ensure these were implemented and monitored. We observed good multidisciplinary team working in the services visited.

### Staff skills

Staff did have appropriate skills and training. The trust supported staff to have the appropriate skills, knowledge and training. Staff attendance at mandatory training was monitored and reminders sent when an update was due. Records seen showed mandatory training rates had increased from August 2013.



# Are services caring?

## Summary of findings

Patients told us staff were caring and compassionate and they were treated with dignity and respect. We observed staff were polite, kind and caring in their interactions with patients, visitors and colleagues. However, we had concerns about the standard of the meals provided by the hospital which patients described as “inedible”.

## Our findings

### Patients’ feedback

Patients we spoke with told us, without exception, that staff were kind, caring and treated them with dignity and respect. They told us the care they received was “excellent” and the staff were “fantastic”. Comments included: “Staff always give me the time I need, they never rush me even though they are busy and short-staffed most of the time”; and “I’m lucky to have had such wonderful care”.

Information on the NHS Choices website included a number of positive and negative comments. Most of the comments were positive and highlighted excellent care and that staff were kind and caring. The negative comments highlighted the poor conduct and attitudes of some staff and poor environmental standards.

### Patient treatment

Patients were supported to ensure their care needs were met. We saw patients had food and drink when they needed it. They were supported with their personal care and to manage their pain. Staff were observed to be kind, compassionate and caring. They were also honest about when the quality of care did not meet their standards due to a lack of staff.

### Staffing levels

Nursing staff told us there were frequent occasions when patients were not attended to in a timely manner due to a shortage of staff or because patient dependency was higher than anticipated particularly during evenings and weekends. We saw staff worked very hard to meet the needs of patients and were caring and compassionate towards patients.

The trust had undertaken a review of nursing establishments and posts. Staff across all disciplines expressed concerns that the numbers of experienced staff were reducing and the quality of care provided would be affected.

### Patient privacy and rights

Staff respected patients’ privacy and dignity and their right to be involved in decisions and make choices about the care and treatment. We observed communication between staff and patients that was polite, professional and respectful.

### Food and drink

Patients were provided with a choice of food and drink. We were concerned, however, that the majority of patients we spoke with told us the food served was “unacceptable” and “tasteless”. Comments included, “The food is terrible, the portions are small and the food isn’t always hot”. Other patients told us the food was “horrible, burnt” and “shrivelled”, and often “inedible”.

Staff attending some of our focus groups and drop-in session confirmed patients’ comments. We raised the concerns directly with the responsible deputy director to take action to address our concerns that patients were not receiving adequate amounts of nutritious food.

# Are services responsive to people's needs?

(for example, to feedback)

## Summary of findings

Patients told us that the hospital services had responded to their needs. We found discharge arrangements were coordinated through multidisciplinary teams and patients were aware of their expected date of discharge. Patients' wishes were taken into account in the planning and delivery of care.

## Our findings

### Patients' feedback

Patients told us they were happy with the responsiveness, care and attention they had received from the services in the hospital.

Information on NHS Choices website included a number of positive and negative comments. Positive comments highlighted prompt attention in minor injuries unit (MIU) and excellent care and attention for inpatient wards. The negative comments related to lengthy processes to book and waiting times in the outpatients department.

The trust used the NHS Family and Friends test to gather patient feedback and results were displayed in most areas. The information published on the NHS Choices website showed the vast majority of people using the hospital would "be extremely likely" to recommend the hospital to people they knew.

### Discharge of patients

Most patients were discharged appropriately and were coordinated by the multidisciplinary teams. Patients told us they were aware of the plans for their discharge. Records showed discharge planning commenced at the pre-admission stage of the patient pathway. However, we were told staff could not discharge patients over a weekend on Vicary Ward and patients waited until the Monday to be discharged reducing the effectiveness of the service and extending the patient's length of stay.

### Accessible information

Information was available in various formats and was made available by staff. The hospital had a translation and advocacy service for people whose first language was not English.

# Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

## Summary of findings

There was effective leadership and governance at all levels of the clinical academic groups. Staff were clear about their responsibilities and were supportive of each other.

## Our findings

### Leadership

Staff told us they had access to good management and leadership. They said they felt supported and valued by their colleagues and direct line managers. There had been a recent staffing review and a re-grading process was ongoing which had affected staff morale.

There was a clear management structure in place and there was evidence of effective systems and communication at all levels of the CAG. Ward managers and senior clinicians had a good understanding of the performance of their wards and departments. Staff told us the chief nurse and senior nurses in the trust undertook 'clinical Fridays' and spent time on the wards. This allowed senior staff to see the quality of care and gather first-hand feedback from patients and staff. Staff were less aware of other senior managers in the trust and reported that they did not recall seeing them in the clinical areas.

### Managing quality and performance

The trust Board had established the CAGs and devolved the management for performance, quality and governance to the CAG leadership board. There was evidence that quality and performance monitoring data was reported on at the CAG leadership meetings and senior managers in the hospital reported they attended.

We observed safety and quality of care was monitored and action taken in response to concerns at ward level. Staff demonstrated a good understanding of the clinical governance framework, how risks were managed, controlled and mitigated against. Communication of performance, quality and governance information was apparent from 'ward to board'.

# Accident and emergency

## Information about the service

There were no emergency services provided at the hospital. There is a minor injuries unit (MIU) which is staffed from the London Hospital emergency department (ED) and is open from 8am to 4pm Monday to Friday, providing a service to people working in local offices and businesses.

We spoke with staff but were unable to speak with patients as none were in the department at the time of our visit.

## Summary of findings

Patients were seen and treated within acceptable time limits. Nurse practitioners provide the service and work to agreed protocols.

### Are accident and emergency services safe?

Services in the minor injuries unit were safe.

#### Patient safety

The MIU was staffed with two senior staff members that were trained in dealing with minor injuries and minor ailments. Staff told us that there was always two staff present in the unit to ensure patient and staff safety was maintained.

Staff told us that all incidents were reported electronically via the computer system and they demonstrated a good understanding of the type of incidents to report. There was, however, no information regarding incidents available in the unit and staff were unsure of how many incidents had been reported.

#### Managing risks

The risks to patients were managed and monitored on a daily basis. We observed that individual patients were discussed at handover and information recorded on a board which identified issues such as pressure ulcers or falls. Staff told us they were able to access suitable equipment such as pressure relieving mattresses when needed and that equipment was cleaned and maintained.

However, on the outpatient area staff told us that one of the blood centrifuge machines was only checked annually and it was felt that this may be insufficient.

All the areas we visited had resuscitation equipment in place which had been checked regularly, although, due to time constraints, we did not check the emergency checks had been completed in the MIU.

#### Cleanliness and hospital infections

Staff had a good understanding of how to protect patients from the risk of infections. The MIU was clean and there were adequate sinks, paper towels and hand hygiene gel available. Information about the prevention of infections was available for patients and visitors. Hand-washing audits were completed and the majority of the results showed 100% compliance.

### Are accident and emergency services effective?

Services in the minor injuries unit are effective.

#### Clinical management and guidance

Patients were seen, assessed and treated by experienced nurse practitioners who worked to agreed clinical protocols. The department used the same protocols and procedures as other units across the trust, which the staff stated were informative and provided clear guidance.

Staff told us that the x-ray department is not co-located to the MIU and does cause some delay for patients to walk between departments. All x-rays are viewed on the computer system and the staff can ask for opinions from specialist teams if they need to.

#### Staff skills

The MIU staff were employed to work in the emergency department at the Royal London Hospital and had the appropriate qualifications such as advanced life support (ALS) to deal with unforeseen emergencies.

Staff told us they worked in the MIU from 8am to 4pm and then, as all staff work long days, they return to the Royal London ED to finish the shift. We were told the journey on public transport can take up to one hour and staff felt this was not an effective use of their time.

# Accident and emergency

## Are accident and emergency services caring?

Services at the minor injuries unit are caring.

### Patient feedback

There was no information regarding the NHS Family and Friends test available in the waiting room. Staff were unsure how patient feedback was collected and reported on for this part of the service. We could not determine whether the information was collated as part of the Royal London Hospital ED surveys or specific to the MIU. We were unable to ask people about their experiences as the unit was very quiet on the day of our inspection.

We saw that patient feedback on the NHS Choices website was positive and noted that staff were professional, caring and compassionate.

## Are accident and emergency services responsive to people's needs?

Services at the minor injuries unit are responsive to the needs of patients.

### Environment

The MIU comprised a waiting area that was able to accommodate approximately 20 or more patients, there were three treatment areas and a separate resuscitation bay. We were told that, if a patient needed urgent transfer to an A&E, staff called the emergency services via a 999 call which meant that the response was quick and the patient received immediate care.

### Accessible support and information

Staff told us the trust had reversed a decision to reduce the opening hours of the MIU following requests from local businesses.

There were a variety of information leaflets available in English to advise patients on minor injuries and care.

## Are accident and emergency services well-led?

The minor injuries unit is well-led.

### Leadership

The MIU is managed from the Royal London Hospital ED and comes under the clinical academic group (CAG) of Emergency Care and Acute Medicine (ECAM).

Staff told us they are able to access the necessary mandatory training and specialist qualifications and they received supervision and debriefing regarding any difficult situations encountered as part of their work in the department. The records for this were not held at the MIU.

Staff told us there had been no communication from the trust management team regarding the removal of hospital transport for staff to be taken back to the Royal London Hospital ED. They commented told us that they now have to use public transport to get back to the ED at The Royal London Hospital which does not seem to be an effective use of their time while on duty.

# Medical care (including older people's care)

## Information about the service

### General information

We inspected three wards and an outpatient department. The wards and outpatient specialities included haemato-oncology and endocrinology providing services for patients with cancer.

We talked with 10 patients, two relatives and 13 members of staff which included doctors, nurses, support staff, administrative staff and allied health professionals such as physiotherapists. We observed care and looked at care records.

## Summary of findings

Staff had appropriate skills and training. Some of the areas we visited were short of staff. However, the staff were caring, compassionate and the majority of people we spoke with told us that they were happy with the care. The areas were well-led at the point of service delivery, although some staff told us that there was a disconnect between the executive team and the wards. Patients were admitted either directly to the wards via the outpatient department, day units or from other hospitals within the trust as well as from other external providers.

### Are medical care services safe?

Improvements are needed in the medical units for care to be safe. Some of the wards we visited did not have enough staff on duty.

### Patient safety

There were systems in place to report incidents electronically. Staff told us they reported incidents and most felt they were encouraged and able to do so. However, some students working on the wards told us they did not have access to the system and relied on the ward staff to report issues on their behalf. Most staff said that they received an acknowledgement and feedback if they had reported an incident. The wards had display boards which identified any incidents that had been reported and the results of infection control audits that had been completed.

### Patient feedback

Patients told us they felt safe and comments included, "Staff are always visible and never rush even though I know they are short-staffed and busy". Another person said, "We always have our call bells to hand and staff usually responded promptly". The majority of patients felt the care delivered by the doctors and nurses was excellent. Although some patients told us they had experienced problems with outpatient appointment letters and had been sent to the wrong hospital to have tests carried out which had caused delays, as appointments needed to be rearranged in some cases.

At our listening event, people expressed concern about the central appointments system. They gave examples of being sent to the incorrect department and hospital for tests and outpatient appointments. People told us that staff were always apologetic and the clinic staff were very helpful. One person said, "The appointment system is a shambles you can never get through to check things, but the care in hospital is fantastic".

### Patient treatment

Patients' medical needs were assessed appropriately in all the areas we visited to reduce the risk of unsafe or inappropriate care. Patients who attended the day unit for chemotherapy were assessed to ensure they were well enough to continue being treated or admitted to the appropriate ward if necessary. Records were fully completed and risks identified. This included falls, skin integrity and risk of infection which was recorded within their care plans. Staff told us that people were occasionally moved within the ward from a four-bed bay into a side room to reduce the risk of infection if their condition required.

### Patient records and end of life decisions

Patient records contained information regarding patients' wishes with regard to end of life care and, where appropriate, 'do not attempt resuscitation' decisions were documented and discussed with patients.

### Staffing

The majority of areas we visited were short of nursing staff. The treatment provided was very specialised and we were told there were adequate numbers of doctors. Junior doctors and student nurses told us they usually felt supported by senior staff. Some doctors told us that low levels of permanent nurses and the high use of bank (overtime) and agency staff was impacting on patient



# Medical care (including older people's care)

care. Some of the wards we visited had a 33% vacancy factor and staff told us that there was also a high sickness rate. Staff told us they were able to get approval for bank or agency staff to cover shortages. We were told that the process was lengthy and sometimes delays in getting approval meant that shifts remained unfilled. Staff told us it was difficult to achieve the appropriate staff skills mix required to ensure the safe delivery of the complex treatment patients received. Staff told us that delays in treatment due to staff shortages were reported as incidents.

The majority of staff were able to access mandatory training and senior staff covered the wards to enable training to go ahead. Nurses' competency in giving chemotherapy drugs was reviewed annually to ensure safe practice. We were told that junior nurses all take a medication calculation test at interview and were not able to give chemotherapy until they had completed the appropriate competency framework for their speciality. This ensured that staff maintained safe practice.

## Are medical care services effective?

Services in the medical unit are effective.

### Clinical management and guidelines

Patients received care according to national guidelines and the appropriate drug therapy regimes were followed in line with pharmacy instructions. The trust participated in national audits, for example, the trust's urinary tract infection (UTI) rates are consistently above the national average and venous thromboembolism (VTE) rates had fluctuated either side of the national average. One of the ward areas had identified UTIs and catheter care as topics for the trust's Safety Cross system to highlight to staff the appropriate clinical management and care.

### Staff skills

Staff had the appropriate skills and their competency was regularly monitored. On each of the areas we visited we saw that staff were professional and competent in their interactions with patients. Staff told us that they were able to access mandatory training. We were told that senior nursing staff provided individual training or

training days to cover specialist topics. Staff said that study days occasionally had to be cancelled due to staff shortages but senior staff tried to cover to enable the training to go ahead. Staff told us that they received computer training at induction. However, it was reported across all areas that the computers were slow and crash regularly in all areas we visited.

## Are medical care services caring?

The staff on the medical wards are caring but people told us the food was inedible.

### Patient feedback

Most patients told us they were happy with the care they received. People told us the care is excellent and staff were fantastic. One person said, "Staff always give me the time I need, they never rush me even though they are busy and short-staffed most of the time" and "I'm lucky to have had such wonderful care". Patients were asked to complete the NHS Family and Friends test. We saw the scores for Garrod Ward had improved for two out of the previous three months. Patients we spoke with told us the main problem they had related to the quality of food provided.

### Patient treatment, privacy and dignity

Staff told us that patients that attended for chemotherapy on Ward 4B had a choice of being able to receive their treatment in bays with other people or in single rooms. Staff told us that, where possible, they tried to accommodate people's wishes. We saw that staff treated patients with dignity and respect.

Some patients and staff felt there was insufficient privacy in curtained areas for sensitive conversations to be held. However, staff tried to maintain confidentiality but it was difficult due to the lack of space. Staff reported they were able to facilitate 'fast track' discharges for patients wishing to receive end of life care in their own home. Staff told us that charitable agencies such as the Macmillan nursing team and the community nursing services provided enormous support to families and enabled staff to facilitate rapid discharges for end of life care.

# Medical care (including older people's care)

Children under the age of 12 were not allowed onto the main ward. However, staff told us they made arrangements so that patients with young children could meet in single rooms.

The wards had processes in place for reviewing care plans and risk assessments. Staff told us that patient care and treatments were reviewed by the multidisciplinary teams on a weekly basis and more frequently if a patient became unwell.

## Food and drink

Patients were provided with food and hydration. The majority of patients reported that the food was unacceptable and tasteless. One patient said, "The food is terrible, the portions are small and the food isn't always hot". Patients told us that, when they had complained about the food, in some cases the chef had provided an alternative meal. Staff told us the menus catered for medical conditions such as diabetes, gluten intolerance as well vegetarians and religious needs. Some wards had house-keepers who did milkshake and snack rounds and people felt this helped to support an adequate diet and stopped them feeling hungry.

## Are medical care services responsive to people's needs?

Services on the medical wards at St Bartholomew's Hospital are responsive to people's needs.

## Patient feedback

Patients told us that they felt cared for and that staff responded to their needs and requests in a timely manner. For example, if people became very unwell or had reduced immunity, staff would transfer people into side rooms. We were told that staff could admit people fairly quickly if they became unwell during chemotherapy sessions and were not fit enough to go home.

## Ward environment

The ward environment was appropriate for patients. All the wards had single-sex bays and side rooms with en suite facilities. The side rooms were used to accommodate patients needing either end of life care or isolation to protect them from the risk of infection or vice versa. One ward had a dedicated clinical treatment area for patients to have minor procedures carried out to enable staff to complete the task more quickly.

## Patient records and end of life decisions

Patient records contained information regarding patients' wishes with regard to end of life care and where appropriate 'do not attempt resuscitation' decisions were documented and discussed with patients. Information regarding conditions and treatments were available in all the areas in English but could be requested in other languages.

## Are medical care services well-led?

Medical care was well-led.

## Leadership

Senior doctors told us that they were involved in the performance of their individual clinical academic groups (CAGs) and that the teams were starting to work well together. Information regarding the NHS Family and Friends test was regularly distributed to all the ward and outpatient areas.

Some staff told us that senior managers visited the wards on a regular basis and they were aware of the initiative 'clinical Fridays'. This is where the senior nurses in the trust worked in the clinical settings. Other staff told us they were familiar with the matrons and heads of nursing but had never met anyone above that designation. Ward managers told us that regular updates and information was distributed by the CAG management team.

Staff told us the consultation process relating to the review of grading of some of the clinical staff had been communicated through the CAG. Staff confirmed they had received the information but felt there had been little recognition of the impact this had on staff morale and the impact of staff resigning as a result of management's decision. Some staff felt there was a 'disconnection' between the wards and the trust Board and the impact the consultation was having on care.



# Surgery

## Information about the service

We visited surgical care services on Vicary Ward (cardio thoracic), Ward 5b (surgical oncology) and the theatre suite in the George V block.

We spoke with a number of patients, staff working in the surgical areas including doctors, senior managers, nurses and support staff. We observed care and treatment and looked at care records.

## Summary of findings

Patients were treated in accordance with national guidance, for example, for cardiac and thoracic surgery. Risk management processes were in place and staff were aware of how to report incidents. Staff were not aware of learning from incidents to improve patient safety.

Staffing levels were in line with professional guidance. However, there were some concerns that the staffing levels did not take into account the dependency of patients on surgical wards at night and weekends, and the impact of using high levels of bank (overtime) and agency staff. Patients were not discharged over the weekend on one ward which could lead to an extended length of stay for the patients.

## Are surgery services safe?

There are improvements needed to ensure there is sufficient equipment in good condition available and enough staff on duty to provide a safe level of care.

### Patient safety

There was a system in place to record serious incidents that occurred. This was through the use of a computerised logging system. The ward managers of all the areas we visited were familiar with the system and told us they used it. Other staff we spoke with on Ward 5b, including staff nurses and student nurses, were unaware of the system. The last entry to the system from Ward 5b was three weeks prior to the day we inspected and was associated with a fall. However, staff told us they had been short of staff for the previous two shifts (night duty and morning shift) which they said was the type of incident that should be reported as patient safety was compromised. On Vicary Ward, doctors and nurses were aware of the system but

said that access to a computer was unlikely to be available because there were problems with both the number of available computers and slow running of the IT systems.

Staff we spoke with were unaware of any learning from incidents that had occurred throughout the trust. This meant that the systems in place were not effective and opportunities for lessons to be learned to improve standards may be missed.

### Medical equipment

Resuscitation trolleys in all areas visited had been checked daily and were complete and in date. Records of the checks were available and showed consecutive entries. Staff told us equipment such as pressure-relieving mattresses was available with minimal delay.

The theatre in the George V block did not have a blood gas machine in the unit and staff were required to obtain one from the intensive therapy unit (ITU) if needed. We also noted there was no overnight 'O negative' emergency blood stored in the theatre and staff told us they had to obtain this from another building if it was needed. The delay in availability of emergency blood may compromise the safety of patients.

### Staffing

At the time of our inspection, staffing levels were safe and met national guidance. However, staff on Vicary Ward told us that staffing levels on an evening and at a weekend reduced to one qualified nurse to nine patients without any indication as to how the changing needs of the patient or dependency levels were taken into account. This may compromise patient safety. The duty rotas we looked at confirmed these staffing levels.

We found the staffing levels on Ward 5b met national guidance, but staff told us this did not take into account the dependency needs of the patients. This ward also used a high percentage of agency nurses to cover short-notice absence.

Staffing levels in the theatres in George V block were adequate during the day. However, there was no on-call rota for theatre staff and a second on-call emergency team from the Royal London Hospital would attend if required.

The staff in all areas we visited had a cohesive team and a positive attitude towards the provision of care. Staff had completed mandatory training but reported that access to developmental training was limited.

# Surgery

## Cleanliness and hospital infection

Patients were protected from the risk of infection. Areas we visited were clean and the patients we spoke with confirmed this. Hand hygiene gel was available in the ward areas and at the foot of each patient's bed. Staffs wore personal protective equipment such as gloves and were observed to wash their hands between caring for each patient. It was observed that one of the hand gel dispensers at the entrance to Ward 5b was empty.

## Transfer of patients

If a patient's condition deteriorated on Ward 5b, transfer to the high dependency unit (HDU) in the Queen Elizabeth unit a separate building would require a qualified nurse to accompany the patient. Staff we spoke with and the duty rotas confirmed that this may impact on the safety of patients on the ward if a nurse was required to leave the ward to transfer a patient.

## Are surgery services effective?

Services in the surgical ward are effective.

## Clinical management

Patients felt their care and treatment had been effective at each stage from consultation to successful surgery and discharge. Staff were enthusiastic to ensure that patients had successful outcomes. The care records we looked at were complete and included risk assessments and effective discharge planning which commenced pre-admission.

## National guidelines

Patients received care in line with national guidelines. Integrated pathways of care were used for patients undergoing cardiac or thoracic surgery. Multidisciplinary wards rounds were carried out on a daily basis during the week. Although the consultant surgeon was not present, staff told us this did not compromise the care the patient received. However, staff told us that, on Vicary Ward, they were unable to discharge patients at weekends and patients waited until Monday to be discharged, reducing the effectiveness of the service and lengthening the patient's hospital stay.

## Staff skills

Staff had completed mandatory training and records seen confirmed this. Staff spoken with confirmed they received annual appraisal.

## Are surgery services caring?

Although staff are caring on the surgical ward patient's complained that the food offered is boring and inedible.

## Patients' feedback

We saw, and patients told us, that staff treated patients with kindness and respect. Patients were pleased with the care they received and, on Vicary Ward, the ward manager was particularly complemented for her care and compassion.

The wards and theatres we visited were very busy and the care needs of the patients were complex.

We were told by staff that they used the NHS Family and Friends test to obtain feedback from patients about their experience. On Ward 5b, a monthly report was received from the Patient Advice and Liaison Service (PALS) who analysed the feedback. The ward manager told us there had not been any adverse reporting.

## Privacy and dignity

Patients' privacy and dignity were maintained. Some wards were mixed-sex with segregated male and female bays. There was adequate signage for male and female toilet and bathroom areas. We observed screen curtains were used by staff to maintain dignity and patient communication was carried out in private.

## Food and drink

We were told by patients and staff that the quality of the food served was poor. Patients described the food as "horrible, burnt" and "shrivelled", and often "inedible". Meal times were flexible and the food trolleys on each ward meant that the food could be served warm. We raised the concerns with the deputy director responsible for catering.

# Surgery

## Are surgery services responsive to people's needs?

Services are responsive on the surgical wards.

### Patient treatment

We observed, and the care records we looked at confirmed, that staff responded appropriately to the changing needs of patients. Patients were regularly monitored and their observations recorded. The elective admission system was planned and coordinated from the consultation through to a successful discharge.

### Discharge planning

The care records we looked at included a discharge plan which had commenced at the pre-admission stage and was updated during the patient's stay. There was information in the plan to indicate the tentative discharge date and the support that was required on discharge. Patients we spoke with confirmed that they were informed of the planned arrangements for discharge.

### Accessible information

St Bartholomew's Hospital had a high percentage of patients for whom English was not their first language. Staff we spoke with explained the arrangements in place for obtaining translation services through the use of Language Line phone service and interpreters. Information booklets were available in a range of languages for patients. However, they were not on display. Staff we spoke with knew where to access the information booklets.

## Are surgery services well-led?

Services in surgery were well-led.

### Leadership

Senior managers had a good understanding of the performance of their department. There was cohesiveness in surgical teams, although patients reported not seeing their consultant cardio-thoracic surgeon from the initial consultation prior to admission until following discharge. There was a management structure in place and there was evidence of effective systems and communication at all levels of the CAG.

### Managing quality and performance

Overall, patients said they were very pleased with the care they had received and felt the service was well run. They were complimentary about how hard the staff worked in the wards. Safety and quality of care was monitored and action taken in response to concerns. Risk registers were maintained for the CAG and fed into the overall trust risk register. Risks were mitigated against.

# Intensive/critical care

## Information about the service

The intensive therapy unit (ITU) and high dependency unit (HDU) cared primarily for patients who had cardiac or thoracic surgery post-operatively. At the time of the inspection, there was only one patient in ITU. Further patients were expected later that day, following surgery.

## Summary of findings

Patients received appropriate care and treatment in accordance with national guidelines. There were sufficient numbers of staff on duty to provide 24-hour care. Systems were in place to monitor the quality and safety of patient care provided. Staff were aware of the incident reporting system and received feedback. They told us they were encouraged by senior staff to report incidents and raise awareness of patient safety issues.

### Are intensive/critical care services safe?

Intensive care services were safe.

#### Patient safety

The unit had in place a range of systems and processes to ensure the safety of patients. Relevant patient safety data was collected and submitted to the Intensive Care National Audit & Research Centre (ICNARC).

#### Staffing

Nursing staff worked on a one-to-one ratio for patients in ITU at level 3 and one-to-two ratio for patients in HDU.

#### Hospital Infections

The building was old but was clean, and all the equipment we observed was clean. Hand hygiene gel was available and staff were observed to use it. Hand wash basins with soap and disposable towels were available. Infection control information was available for patients and visitors. The unit had not reported any incidents of hospital-acquired infections in the past 12 months.

#### Transfers

Transfer of patients in and out of the unit was mostly planned.

### Are intensive/critical care services effective?

Services in the intensive care unit are effective.

#### Clinical management

Patients received care and treatment in line with national guidelines. Staff working in the unit had received appropriate training.

#### Patient mortality

A national independent survey by ICNARC highlighted that there were no unplanned readmissions to the unit. The comparative figures showed that 25% of patients being discharged from the St Bartholomew's unit experienced a delayed discharge, 1% of these occurred after 10pm. The unit is about average for hospital mortality however, the total number of admissions is very low.

### Are intensive/critical care services caring?

Services are caring in the ITU.

#### Patient privacy and dignity

Staff were observed to be respectful and maintained the privacy and dignity of the sole patient in ITU. Staff were seen to be polite and spoke in a respectful way. Staff told us there was a system in place for obtaining patient feedback.

### Are intensive/critical care services responsive to people's needs?

Services in ITU are responsive to people's needs.

#### Patient care

The unit provided a service 24 hours a day, seven days a week. The trust had in place networks and arrangements with other NHS trust regional centres should a patient require transfer to another unit outside of the trust.

We saw the patient was monitored closely in the unit and staff were observed to respond quickly to any changing needs. The records we looked at supported the monitoring we observed.

# Intensive/critical care

## **Translation services**

St Bartholomew's Hospital had a high percentage of patients whose first language was not English. Staff we spoke with explained they had access to Language Line and interpreters when required.

## **Are intensive/critical care services well-led?**

Services in ITU are well-led.

## **Leadership**

There was a management structure in place and staff said they felt well supported by their line managers in the unit.

## **Monitoring quality and performance**

The ITU carried out a range of audits. Information was provided to ICNARC which helped to ensure services are delivered in line with good practice. Regular meetings ensured that staff openly discussed concerns about the service and critical care.

# Good practice and areas for improvement

## Areas of good practice

Our inspection team highlighted the following areas of good practice:



- The majority of patients were complimentary about the care and compassion of staff.

## Areas for improvement

### Action the trust MUST take to improve



- Ensure there are sufficient staff with an appropriate skills mix on all wards to enable them to deliver care and treatment safely in a timely manner.
- Ensure patients receive nutritious food in sufficient quantities to meet their needs

### Other areas where the trust could improve

- Improve the visibility of senior leaders in the trust.
- Address concerns about the implementation of the review of nursing posts and the effects of this on the skills mix of nursing staff.
- Improve the dissemination of 'lessons learned' from serious incident investigations across all CAGs.
- Improve staff access to suitable IT to ensure timely incident reporting by all staff.

This section is primarily information for the provider.

## Compliance actions

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder and injury	<p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing.</p> <p>The registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.</p> <p>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing</p>

Regulated activity	Regulation
Treatment of disease, disorder and injury	<p>Regulation 14(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs.</p> <p>The registered person must ensure that patients are protected from the risks of inadequate nutrition and dehydration, by means of the provision of a choice of suitable and nutritious food and hydration in sufficient quantities to meet patients' needs.</p> <p>Regulation 14(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs.</p>