King's College Hospital NHS Foundation Trust

King's College Hospital Denmark Hill Site

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	Good
Medical care	Good
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

King's College Hospital Denmark Hill Site is part of King's College Hospital NHS Foundation Trust. The trust provides local services primarily for people living in the London boroughs of Lambeth, Southwark, Bromley and Lewisham. King's College Hospital Denmark Hill Site provides acute services to an inner city population of 700,000 in the London boroughs of Southwark and Lambeth, but also serves as a tertiary referral centre in certain specialties to millions of people in southern England.

King's College Hospital NHS Foundation Trust employs around 11,723 whole time equivalent (WTE) members of staff with approximately 8,785 staff working at King's College Hospital Denmark Hill Site.

We carried out an announced inspection of King's College Hospital Denmark Hill Site between 13 and 17 April 2015. We also undertook unannounced visits to the hospital on 25 and 28 April 2015.

Overall, this hospital requires improvement. We found that urgent and emergency care, medical care, services for children and young people and outpatients and diagnostic services were good. However surgery, critical care, maternity and gynaecology services and end of life care required improvement.

The effectiveness of care, care of patients and the leadership at this hospital were good overall. However, the hospital required improvement in order to provide a safe and responsive service towards patients and their carers.

Our key findings were as follows:

Safe

- There was an open and transparent approach to the investigation of incidents. Staff were encouraged to report incidents when they occurred.
- There were largely adequate medical and nursing staff on duty to provide safe care to patients apart from medical care, maternity and neonatal intensive care services.
- There were effective arrangements in place to minimise risks of infection to patients and staff.
- Medicines were stored, recorded and administered safely to protect patients.
- The support provided by the iMobile team for deteriorating patients was excellent.
- The critical care service did not meet basic safety standards in some areas, particularly on the high dependency units.

Effective

- Staff followed accepted national and local guidelines for clinical practice.
- There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals.
- Some newly qualified midwifery staff had not received appropriate training to enable them to carry out their roles effectively.
- Patients were given timely pain relief and pain scoring tools were consistently used.
- The nutritional needs of patients had been assessed and patients were supported to eat and drink according to their needs.
- Understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was variable and some groups of staff needed to improve their knowledge in these areas.

Caring

- Patients were cared for by staff who were kind, caring and compassionate in their approach. Patients were supported, treated with dignity and respect and were involved as partners in their care.
- Patients felt that they were listened to by health professionals, and were involved in their treatment and care.

Summary of findings

- Staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

Responsive

- Services were planned to meet the needs of the local population.
- The emergency department (ED) was often overcrowded. Patient flow required improvement and waiting times were above the national average, due to capacity constraints and the trust's arrangements for making decisions to admit patients.
- Referral-to-treatment times were not being met in a number of surgical and outpatient specialties. Surgical procedures were cancelled and not always rescheduled and undertaken within 28 days.
- There was a lack of critical care beds, which affected patients' length of stay and delayed discharges.
- Outpatient services were not organised in a manner that responded promptly to ensure that patients' needs were met.

Well-led

- The leadership, governance and culture of the hospital promoted the delivery of high quality, person-centred care.
- Robust governance arrangements were in place to monitor, evaluate and report back to staff and upwards to the trust board.
- Most staff were proud of working for the department and staff worked well together as a team.

We saw several areas of outstanding practice, including:

- Trauma nurse coordinators tracked pathways and the progress of trauma patients by visiting them daily on the wards. This role also included networking with other trusts and coordinating repatriation in advance.
- The ED had an established youth worker drop in scheme operated by a London-based organisation, which was effective in supporting vulnerable young people. Staff could refer young people to the service, although engagement was voluntary. The service also supported young people to access specialist services, such as housing support and access to social workers.
- The iMobile outreach service was innovative and there was evidence that it was producing positive outcomes both for patients and the critical care service as a whole.
- The pioneering work being done by neurosciences, liver and haematology specialist services.
- The surgical directorate had set up the first national training for a trauma skills course in the country.
- There were well-established pathways for pregnant women, which provided appropriate antenatal care, including access to specialist clinics for women with medical needs.
- The foetal medicine unit provided interventions, such as foetal blood transfusions, fetoscopic insertions of endotracheal balloons and laser separation procedures of placental circulations for complicated monochorionic twin pregnancies.
- The enhanced scanning programme included combined screening for chromosomal abnormalities at 12 weeks, with women being given the results on the same day.
- The gynaecology and urogynaecology services offered a one-stop service with diagnostics carried out by a specialist doctor. The hospital was a regional training unit for this service and the unit was recognised as a gold standard unit by The British Society of Urogynaecologists.
- For children with complex liver conditions and those who required surgery as neonates, staff developed and advocated the use of innovative and pioneering approaches to care.

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

Importantly, the trust must:

- Review its facilities within critical care so that it meets both patient needs, and complies with building regulations. This includes bed spacing and storage facilities, particularly for IV fluids and blood gas machines.

Summary of findings

- Ensure that the 'Five steps to safer surgery' checklist was always fully completed for each surgical patient.
- Re-configure the Liver outpatient clinic in order to avoid overcrowding.
- Ensure patients referral to treatment times do not exceed national targets.
- Improve patient waiting times in all outpatients' clinics.
- Review the capacity of the maternity unit so that women and their babies are receiving appropriate care at the right place at the right time.
- Implement a permanent solution to the periodic flooding following heavy rain of the renal dialysis unit and endoscopy suite areas.
- Ensure that current trust policy around syringe drivers affords optimum protection for patients against the risk of adverse incidents.
- Ensure the cover for the concealment trolley for deceased patients is in good repair and not an infection control risk.

In addition, the trust should:

- Fully complete controlled drug registers in the ED.
- Complete safeguarding flowcharts for children attending the ED.
- Improve the number of senior ED medical staff trained in safeguarding children training at level 3 to meet Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings recommendations.
- Identify and mitigate risks to patients attending the ED, such as the development of pressure sores, falls and poor nutrition.
- Improve the uptake of training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards for staff working in the ED, medical care, surgery and services for children and young people.
- Review staff understanding of the Mental Capacity Act 2005 in critical care and end of life care, to ensure their practice and documentation reflects the legislation.
- Develop guidelines for admission to the children's clinical decision unit (CDU).
- Review the area used for the children's CDU to ensure the environment fulfils the criteria for a ward area.
- Review the practice of undertaking adult consultations in the children's ED.
- Improve patient flow and waiting times in the ED, including their arrangements for making decisions to admit patients.
- Take action to improve the percentage of ED patients seen, treated and discharged within four hours.
- Consider ways of improving the documentation of patient safety checks.
- Improve attendance at mandatory training.
- Improve theatre utilisation and a reduction in cancellations.
- Improve the referral to treatment times.
- Improve patient flow through the surgical pathway.
- Consider ways of improving the discharge process by engaging with external agencies.
- Consider how staff can be made aware of the broader strategy for the surgical division.
- Review the systems for checking equipment to ensure that they are in date, in working order and stock is effectively rotated.
- Ensure it continues to review its critical care bed capacity so that it can meet its expected admissions.
- Review its patient record documentation to ensure it is fully completed and information between wards is seamless.
- Review its use of the Waterlow assessment to ensure those patients that need pressure-relieving support, receive it.
- Review the nursing, consultant and junior doctor levels on the neonatal intensive care unit.
- Review the space between cot spaces on the neonatal intensive care unit as they were sometimes restricted or limited.
- Provide clear and up-to-date information on outpatient clinic waiting times.
- Monitor the availability of case notes/medical records for outpatients and act to resolve issues in a timely fashion.
- Review medical cover for gynaecology and obstetrics.

Summary of findings

- Stop overbooking outpatient clinics including the liver outpatients department clinic.
- Share outpatients and diagnostic imaging performance data with clinical staff.
- Make sure the preferred place of care/preferred place of death, or the wishes and preferences of patients and their families is documented.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	Staff demonstrated an open and transparent culture about incident reporting and patient safety. Staff understood their roles and responsibilities and were empowered to raise concerns and to report incidents and near misses actively to promote learning and improvement. There were adequate medical and nursing staff on duty to provide safe care to patients. Medicines were stored, recorded administered safely to protect patients from the risk of medicine misuse. Patients were safeguarded from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children, although some improvements were required in documentation relating to safeguarding and staff training. Staff followed accepted national and local guidelines for clinical practice. The department had developed a number of pathways to ensure that patients received treatment focused on their medical needs. The trust participated in national College of Emergency Medicine audits so that they could benchmark their practice and performance against best practice and other emergency departments. There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals. Patients were given timely pain relief and pain scoring tools were consistently used. Patients in the ED were supported, treated with dignity and respect and were involved as partners in their care. Patients felt that they were listened to by health professionals, and were involved in their treatment and care. Staff treated patients with respect. Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. Staff respected patients' choices and preferences and were supportive of their cultures, faith and background. The emergency department was often overcrowded. Patient flow required improvement and waiting times were above the national average due to capacity constraints and the trust's

Summary of findings

arrangements for making decisions to admit patients (DTA). This meant patients were not transferred to areas treating their speciality, but were accommodated in the ED for longer than necessary. There were no trust guidelines for admission to the children's CDU, which did not fulfil the criteria for a ward area. It was not clear why children were admitted to the CDU rather than the short stay paediatric unit. Admission to the CDU avoided breaches relating to length of stay in the department.

The leadership, governance and culture of the ED promoted the delivery of high quality person-centred care. Clear governance structures were in place and were designed to enhance patient outcomes. Staff were proud of working for the department and staff worked well together as a team. There was an effective and comprehensive process in place to manage risks.

Medical care

Good

Patients received care based on the best available evidence and national guidance. The hospital scored highly in most of the patient outcome measures which indicated good adherence to evidence-based measures, which improved outcomes for patients. Patients gave their consent for care and treatment and were involved in decision making. There was an effective multidisciplinary approach to care and good team working.

Patients were cared for by staff, who were kind, caring and compassionate in their approach. Patients praised the staff, for their attitude and approach, using adjectives, such as "wonderful," and "absolutely fabulous". Patients were involved in decisions about their care and treatment. The service was planned to meet the needs of the people it served and care was responsive to people's individual needs and wishes. Systems were in place to manage and learn from complaints. There was strong and passionate leadership and a culture of openness, with an enthusiasm to further develop and improve services for the future.

Regarding safety, there were many aspects of good practice, including the reporting and management of incidents and infection prevention and control. The iMobile critical care outreach service provided

Summary of findings

			excellent support to wards, but, in some areas, the identification and escalation of deteriorating patients was inconsistent. In addition, nurse staffing in some wards and the environment within the renal dialysis unit needed improvement. There was no formal approach to identifying the possibility of sepsis or implementation of Sepsis Six in the medical assessment centre or acute medical unit.
Surgery	**Requires improvement**		Referral-to-treatment times were not being met in a number of surgical specialties. Surgical procedures were cancelled and not always rescheduled and undertaken within 28 days. Theatre utilisation was not always maximised and there were cancelled procedures and delays in arranging surgery within expected timeframes. Patient flow through the surgical services was limited by availability of beds linked, at times, to delayed discharges. Staff had not been able to complete all the required mandatory training, which supported the delivery of safe patient treatment and care. There was a lack of understanding regarding Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The recording of required safety checks for surgical patients was not always completed to a consistent standard. There were good arrangements in place for reporting adverse events and for learning from these. Staffing arrangements in surgical areas were managed to ensure sufficient numbers of skilled and knowledgeable staff were on duty during day and night hours. Consent was sought from patients prior to treatment and care delivery. Consultants led on patient care and there was access to specialist staff for advice and guidance. Procedures were in place to continuously monitor patient safety and surgical practices and patient care reflected professional guidance. Surgical outcomes were generally good and results were communicated through the governance arrangements to the trust board. Patient experiences were positive with regard to the treatment and care by doctors, nurses and other staff.

Summary of findings

Surgical staff spoke positively about their departmental leadership and felt respected and valued. Staff were generally aware of the trust's values, but had not been made aware of the strategic plans. Staff reported the surgical directorate as being a good place to develop their skills and expertise.
The governance arrangements supported effective communication between staff and the trust board. Risks were continuously reviewed and discussed. The trust board was informed and updated with regard to service delivery and performance. The views of the patients and staff were sought in respect to improving and developing services.

Critical care **Requires improvement** 

Although the critical care service at the hospital had positive patient feedback, produced better than average outcomes for patients, were involved in innovative practice and treated highly complex patients, due to its transplant and trauma services, there were fundamental areas of the service that required improvement.
Although there was work in place to build a new set of critical care units, current facilities were not adequate, with a lack of bed and storage space. There was a lack of bed capacity and a lack of infection control facilities. The HDU did not always meet patient to nurse ratio standards.
Medicines management was not appropriate in a number of areas, particularly storage. There was a high, but improving rate of pressure ulcers. Patient records were haphazard, although there were also plans to improve this via a new electronic system. Mental Capacity Act 2005 awareness and recording was not always in place. There was multidisciplinary working, but it was not taking place across all the staff groups. Governance arrangements were fragmented.
There was an innovative iMobile service (who provided the outreach service), patient outcomes were better than peer services, incident reporting and learning was in place, patient harms (other than pressure ulcers), were well managed, public engagement was proactive, and staff development was positive.

Summary of findings

Maternity and gynaecology

Requires improvement

Maternity inpatient care and treatment was not always received in the right place and/or at the right time at times of peak demand. These issues were long standing, and had not been resolved at the time of our inspection, in spite of action to deal with the flow of women through inpatient areas. Midwifery, support and medical staff worked hard to keep women safe, but sickness levels among midwives had risen. Consultant leave was not covered, and this caused additional pressures on medical staff.

It was recognised that medical cover at night, which was provided across gynaecology and maternity inpatient services, was insufficient to guarantee prompt review and treatment of patients.

There were a number of innovative and ground-breaking services in maternity and gynaecology. Care and treatment was evidenced-based and the audit programme monitored adherence to guidelines and good practice standards. Actions were identified following audits and these were re-audited.

There were robust care pathways for pregnant women to access appropriate services.

Gynaecology services were responsive to women's needs.

The safety of maternity and gynaecology services was enhanced because reporting of, and learning from, incidents was promoted. There was systematic, multidisciplinary review of incidents. Risks were recorded and plans put in place to address, or mitigate these risks. The risk register was used to respond reactively to issues that had been recorded, and not to anticipate risks that might arise.

Senior management in women's services had succeeded in establishing integrated clinical governance structures, including risk management, across the newly merged trust, which now included Princess Royal University Hospital.

There were clear reporting routes to the trust-wide committees and the board. There had been changes to the delivery of gynaecology services at the Denmark Hill site as a result of the merger, and senior management in maternity services had spent time supporting and developing maternity services

Summary of findings

at Princess Royal University Hospital. Following the structural reorganisation, the aim of the women's service was to achieve stability and the delivery of high quality care.

Services for children and young people

Good

Nursing staff levels were seen to be in line with national standards in the majority of clinical areas, except for the neonatal intensive care unit where nursing levels were such that one-to-one care could not always be provided in line with national standards.

Continued increased capacity within the neonatal intensive care unit meant that the number of consultants and junior doctors employed was not sufficient to meet the needs of the unit. The existing model of medical cover was not sustainable in the long term, as there was a reliance on the good will of a small number of doctors to work additional hours.

The environment in which children and neonates were cared for was, in the main, appropriate. However, the increased capacity of the neonatal intensive care unit meant that space between cot spaces was sometimes cramped, which meant that access to cots was sometimes restricted or limited.

The uptake of mandatory training in some professions was far below the trust standard. Staff demonstrated an open and transparent culture about incident reporting. A culture of optimising patient safety was apparent amongst nursing and medical staff alike. Staff understood their roles and responsibilities in reporting incidents and described how they learnt from incidents.

Patients were safeguarded from the risk of abuse. Staff were well versed in the trust's local safeguarding policies and could describe national best practice guidance. Staff adopted a truly holistic approach to assessing, planning and delivering care. Staff developed and advocated the use of innovative and pioneering approaches to care, especially for those children with complex liver conditions and those who required surgery as neonates. Additionally, the service hosted national specialist multidisciplinary bariatric services for children with obesity issues.

Clinical teams were committed to working collaboratively to enhance the provision of care to

children. The service led on a range of national medical and surgical initiatives and worked in conjunction with a range of third party peers to drive forward advancements in paediatric surgery and medicine. Paediatric mortality rates were seen to be in line, or better than peer averages across a range of specialties. The service participated in a range of local and national audits, including clinical audits and other monitoring activities, such as reviews of services, benchmarking, peer review and service accreditation. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff. Information from local and national audit programmes was used to improve care and treatment and people's outcomes, but some work was required regarding the management of patients with asthma and diabetes. When people were due to move between services their needs were assessed early, with the involvement of all necessary staff, teams and services. People's discharges or transition plans took account of their individual needs, circumstances, ongoing care arrangements and expected outcomes.

Staff acknowledged that the demands on the service were increasing year-on-year and that capacity had proven to be difficult to manage during peak times. This was especially pertinent to the neonatal intensive care unit (NICU), whose activity had been seen to be increasing annually. The organisation recognised the need to extend children's services over the coming years to ensure that it could continue to meet the needs of the population it served. Plans had commenced to build a new children's hospital on the Denmark Hill site and local initiatives had commenced, including the opening of a paediatric short stay unit to help alleviate capacity problems in the short term.

Staff were aware of the trust vision and values. Staff had been provided with information on trust developments that had been cascaded down from their line managers. The service had a child health specific strategy, which was aligned to the trust-wide strategy. The strategy was driven by quality and safety and took into account the requirement for the service to be fiscally responsible. There were governance arrangements

in place, for which a range of healthcare professionals assumed ownership. Further work was being undertaken to strengthen the governance relating to children who received care or treatment outside the auspices of child health services. There was evidence that risks were managed and escalated accordingly.
Nursing staff reported good management support from their line managers. Changes to the management team within the NICU was said to have a had a positive impact on the service.
Innovation and long-term sustainability were seen as key priorities for the leaders of the service.
Participation in national and international research was a driving motivation for clinical staff in order that the wellbeing and clinical outcomes of children could be enhanced.

End of life care — **Requires improvement**

Current trust policy around syringe drivers was inconsistent across the sites and did not protect patients from adverse incidents. The cover for the concealment trolley was in poor repair and was an infection control risk. We saw little evidence of the documentation of preferred place of care/preferred place of death or the wishes and preferences of patients and their families. Although there was a unified do not attempt cardio-pulmonary resuscitation (DNA CPR) policy, orders were not consistently completed in accordance with the policy. There were also no standardised processes for completing mental capacity assessments.
Staff at King's College Hospital (the Denmark Hill site) provided compassionate end of life care to patients. The specialist palliative care team (SPCT) provided face-to-face support, seven days a week, with a palliative care consultant providing out-of-hours cover. There was strong clinical leadership of the SPCT and chaplaincy team resulting in well-developed, strong and motivated teams.
Bereavement support was available from the social workers, chaplaincy and bereavement office staff, who were able to provide support for carers and their families following the death of their relative.
The teams worked well together to ensure that end of life policies were based on individual need and

that all people were fully involved in every part of the end of life pathway. However, we did not see any evidence of a long-term vision around end of life care across the trust.
Relatives of patients receiving end of life care were provided with open visiting hours and were also offered 'keepsakes' from the deceased patient.
There was excellent spiritual/religious awareness by staff across the hospital and facilities were in place to support the different cultures and religions of the local population.
End of life care was embedded in all the clinical areas and staff we spoke with were passionate about end of life care and the need to ensure that the wishes and preferences of their patients and families were met as they entered the last stage of their life.
There was a multidisciplinary team approach to facilitate the rapid discharge of patients to their preferred place of care or preferred place of death.
Patients were cared for with dignity and respect and received compassionate care. Medicines were provided in line with guidelines for end of life care.

Outpatients and diagnostic imaging

Good

Patients received a caring service, as staff treated them with compassion, kindness and respect.
Positive feedback had been received by the trust from patients using the outpatients and diagnostic and imaging departments. The service was delivered by trained and competent staff who had been provided with an induction as well as mandatory and additional training specific for their roles.
The leadership, governance and culture with the outpatient and diagnostic imaging services promoted the delivery of person-centred care. Staff were supported by their local and divisional managers. Risks were identified and addressed at local level or escalated to divisional or board-level if necessary. The trust promoted a good working culture. However, some clinical staff we spoke with did not feel supported by their line managers.
Many patients complained about the waiting times in the outpatient clinics. They said they had little information about the waiting times and staff were not always open with them about it. There was no systematic template of clinic schedules for the

hospital. Different clinics used different templates and some templates allowed for the over booking of clinics and multiple bookings of appointments under one time slot.

Outpatient services were not organised in a manner that responded promptly to ensure patients' needs were met. Some patients experienced long delays in waiting times to their first outpatient appointment. The booking team were taking action to address waiting times and monitored patients who did not attend for appointments.

The liver clinic environment presented challenges for staff and patients, particularly in relation to the space required for patients to sit comfortably while waiting for their appointments. Seating areas were cramped and, throughout our inspection, we saw patients standing in areas of the clinic, who were unable to find a seat. Access for patients and visitors with mobility issues was challenging, due to tight spaces in corridors and seating areas in some areas of the clinic.

King's College Hospital Denmark Hill Site

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to King's College Hospital Denmark Hill Site

King's College Hospital Denmark Hill Site is one of three registered acute hospital locations of King's College Hospital NHS Foundation Trust, which we visited during this inspection. The other registered hospital locations that we visited were Princess Royal University Hospital and Orpington Hospital.

King's College Hospital Denmark Hill Site has 1001 beds. The hospital is in the London Borough of Lambeth, but the lead clinical commissioning group is Southwark, which co-ordinates the commissioning activities on behalf of the other local clinical commissioning groups such as Lambeth, Lewisham and Bromley. The hospital serves the population living in the South East of London.

Our inspection team

Our inspection team was led by:

Chair: Kathy Mclean, Medical Director, NHS Trust Development Authority

Head of Hospital Inspections: Alan Thorne, Care Quality Commission (CQC)

The hospital was visited by a team of 56 people, including: CQC inspectors, analysts and a variety of specialists. There were consultants in emergency medicine, medical care, surgery, haematology, cardiology and palliative care medicine, an anaesthetist and two junior doctors. The team also included midwives, as well as nurses with backgrounds in surgery, medicine, paediatrics, critical care and palliative care, board-level experience, a student nurse and two experts by experience.

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 always inspects the following core services at each inspection:

- Urgent and emergency services
- Medical care (including older people's care)

Detailed findings

- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, NHS Trust Development Authority, Health Education England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch. We also received information from the trust's council of governors.

We observed how patients were being cared for, spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospital, including doctors, nurses, allied health professionals, administration and other staff. We also interviewed senior members of staff at the hospital.

Facts and data about King's College Hospital Denmark Hill Site

Context

- King's College Hospital Denmark Hill Site is based in South East London and serves an inner city population of 700,000 in the London boroughs of Southwark and Lambeth, but also serves as a tertiary referral centre for certain specialties to millions of people in southern England.
- The hospital offers a range of local services, including: a 24-hour emergency department, medicine, surgery, paediatrics, maternity and outpatient clinics. Specialist services are available to patients, which provide nationally and internationally recognised work in liver disease and transplantation, neurosciences, haemato-oncology and foetal medicine.
- In the 2011 census the proportion of residents who classed themselves as white British was 40.1% in Southwark and 39.6% in Lambeth.
- Lambeth ranks 29th out of 326 local authorities for deprivation (with the first being the most deprived). Southwark ranks 41st.
- Life expectancy for women in Southwark (83.1) is slightly higher (better) than the England average (83). However, life expectancy for men in Southwark (78) is slightly lower (worse) than the England average (79.2).
- Life expectancy for women in Lambeth (83) is the same as the England average (83). However, life expectancy for men in Lambeth (78.2) is slightly lower (worse) than the England average (79.2).
- In Southwark, rates of obese children, acute sexually transmitted infections, smoking-related deaths and the incidence of tuberculosis are worse than the England average.
- In Lambeth, rates of obese children, acute sexually transmitted infections, smoking-related deaths, infant mortality and incidence of tuberculosis are worse than the England average.

Activity

- The hospital has approximately 836 beds; 633 general and acute beds, 100 critical care beds and 103 maternity beds.
- The hospital employs 8,785 staff. The workforce was supported by 6% bank/agency staff and locum medical staff between March 2014 to April 2015.
- There are approximately 70,781 inpatient admissions, including day case activity per annum.
- There are approximately 671,544 outpatient appointments per annum.
- There are approximately 168,413 urgent and emergency care attendances per annum.
- There were 3,983 births in the first three quarters of 2014/15.
- There were 805 deaths at the hospital between April and December 2014.

Detailed findings

Key intelligence indicators

Safety

- There were five Never Events between February 2014 and January 2015. (Never Events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.)
- The Strategic Executive Information System (STEIS) recorded 114 serious untoward incidents between February 2014 and January 2015.
- Overall, there were six cases of Methicillin-resistant staphylococcus aureus (MRSA) (against a target of zero) from April 2014 to March 2015.
- Overall, there were 6.4 cases of C. difficile from April 2014 to March 2015 (against a target of 4.8).

Effective

- The Hospital Standardised Mortality Ratio (HSMR) indicator was produced at trust level only. The ratio was 87.65, which is lower (better) than the national average of 100 from 1 July 2013 to 30 June 2014. There was no evidence of risk.
- The Summary Hospital-level Mortality Indicator (SHMI) was produced at trust level only. The SHMI was 0.91, which is lower (better) than the national average of 1. 1 from July 2013 to 30 June 2014. There was no evidence of risk.

Caring

- The NHS Friends and Family Test for urgent and emergency care (for January 2015) showed the percentage of respondents who would recommend the emergency department was 83%, which was worse than the national average of 88%. The response rate was 22%, which was better than the national average of 20%.
- The NHS Friends and Family Test for inpatients (January 2015) showed the percentage of respondents who would recommend the inpatient wards was 97%, which was better than the national average of 94%. The response rate was 37%, which was better than the national average of 36%.
- The NHS Friends and Family Test for maternity (January 2015) showed the percentage of respondents who would recommend the antenatal service was 100%, which was better than the national average of 95%. Response rate figures were not available. The percentage of respondents who would recommend giving birth at the hospital was 98%, which was better than the national average of 97%. The response rate was 16.8%, which was worse than the national average of 22.9%. The percentage of respondents who would recommend the postnatal service was 80%, which was worse than the national average of 93%. Response rate figures were not available.
- The Cancer Patient Experience Survey 2012/13 showed the trust as a whole was amongst the bottom 20% of trusts for the majority of the questions in the survey. The trust as a whole had an 83% rating for 'Patients' rating of care' as being 'excellent' or 'very good' in the survey. This was lower than the 92% rating for the top 20% of trusts.
- The CQC Adult Inpatient Survey for 2013/14 showed the trust performed about the same as other trusts for all indicators in the survey.

Responsive

- The cancer two-week wait standard for April 2014 to March 2015 was met by the hospital. The two-week standard was met for 97.7% of patients, against a target of 93%.
- The breast symptom two-week wait for April 2014 to March 2015 was met by the hospital. The two-week standard was met for 98.7% of patients, against a target of 93%.
- The 31-day first treatment for tumours for April 2014 to March 2015 was met by the hospital. The 31-day standard was met for 98.4% of patients, against a target of 96%.
- The 31-day subsequent treatment (treatment group) drug treatments was met by the hospital. This 31-day standard was met for 100% of patients, against a target of 98%.
- The 31-day subsequent treatment (treatment group) radiotherapy treatments for April 2014 to March 2015 was met by the hospital. The hospital met this 31-day standard for 99.6% of patients against a target of 94%.
- The 31-day subsequent treatment (treatment group) for surgery for April 2014 to March 2015 was met by the hospital. The hospital met this 31-day standard for 97.7% of patients, against a target of 94%.
- The 62-day standard cancer plan for tumours for April 2014 to March 2015 was met by the hospital. The hospital met this 62-day standard for 85% of patients, against a target of 85%.

Detailed findings

- CRS The 62-day screening standard for tumours for April 2014 to March 2015 was met by the hospital. The hospital met this 62-day standard for 95.5% of patients, against a target of 90%.
- The emergency department, four-hour waiting time target of 95% was not met by the hospital between April 2014 and March 2015. Eighty-nine point five per cent of patients were seen, treated, admitted or discharged in under four hours.
- The referral-to-treatment times were as follows: 80.4% of patients who were admitted were seen within the 18-week target. Of the patients who were not admitted, 96.1% were seen within the 18-week target. Of the patients whose pathways were incomplete, 92.6% were seen within the 18-week target.

Well-led

- The overall engagement score for the Department of Health NHS Staff Survey for 2014 (for the trust as a whole) was 3.79, which was slightly better than the England average of 3.75.
- The results of the 2014 Department of Health NHS Staff Survey demonstrated that for the King's College Hospital NHS Foundation Trust most scores were within expectations, in line the national average over the 29 key areas covered in the survey. These included the facts that the trust scores were:
  - Within expectations in 13 key areas.
  - Better than average in five key areas.
  - Worse than average in 11 key areas.
- The response rate for the staff survey was 30%, which was lower than the national average of 42%.

Inspection history

This is the first comprehensive inspection of King's College Hospital Denmark Hill Site.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Urgent and emergency services

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

Information about the service

The accident and emergency department is also known as the emergency department (ED). It is a designated Major trauma centre and provides a 24 hour a day, seven-day a week service to the local area.

There were 165, 422 attendances in the ED at King's College Hospital, Denmark Hill site between January and December 2014. Around 22% of patients were aged between zero and 16 years old.

Patients presented into the department by walking into the reception area, or arriving by ambulance into a separate entrance. Patients arriving on foot were initially seen by a nurse, who would then direct them to the appropriate area, where they were booked in by reception staff before being seen by a triage nurse. (Triage is the process of determining the priority of patients' treatments based on the severity of their condition). If the patient arrived by ambulance, they were then initially assessed by a senior nurse in an assessment area before being taken to the most appropriate area in the department to receive their care and treatment.

The ED was divided into areas depending on the acuity of patients. The resuscitation area had 10 trolley spaces, including one designated bay for paediatrics and a cubicle with a door.

There were 15 cubicles/rooms in the Majors 'A' areas and five cubicles/rooms in the Majors 'B' areas. Several cubicles had doors for extra privacy. Three cubicles in minor injuries (Minors) and a cubicle in the children's area were used by general practitioners (GPs) in the integrated Urgent Care Centre (UCC). There were four trolley cubicles and three chair spaces in the 'Minors' area and additional chairs provided an ambulatory decision unit (ADU) where patients could wait comfortably pending the results of investigations. The clinical decision unit (CDU) had eight male and eight female beds in gender specific areas.

Children up to 16 years of age attending the ED were streamed as they arrived and directed to the children's area of the ED, where they received their care and treatment by appropriately trained staff. The children's ED had four cubicles and four bays, which could accommodate trolleys as well as two seated cubicles. Two cubicles in the children's department were assigned to a paediatric CDU. There were two cubicles adjacent to the reception for the assessment and triage of non-ambulance patients.

We visited the ED over three weekdays during our announced inspection and one evening during an unannounced inspection. We observed care and treatment and looked at 31 sets of patient records. We spoke with 49 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We also spoke with 18 patients and relatives who were using the service at the time of our inspection. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also used information provided by the organisation and information we requested.

Urgent and emergency services

Summary of findings

Staff demonstrated an open and transparent culture about incident reporting and patient safety. Staff understood their roles and responsibilities and were empowered to raise concerns and to report incidents and near misses actively to promote learning and improvement.

There were adequate medical and nursing staff on duty to provide safe care to patients. Medicines were stored, recorded administered safely to protect patients from the risk of medicine misuse. Patients were safeguarded from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children, although some improvements were required in documentation relating to safeguarding and staff training.

Staff followed accepted national and local guidelines for clinical practice. The department had developed a number of pathways to ensure that patients received treatment focused on their medical needs. The trust participated in national College of Emergency Medicine audits so that they could benchmark their practice and performance against best practice and other emergency departments.

There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals. Patients were given timely pain relief and pain scoring tools were consistently used.

Patients in the ED were supported, treated with dignity and respect and were involved as partners in their care. Patients felt that they were listened to by health professionals, and were involved in their treatment and care. Staff treated patients with respect. Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. Staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

The emergency department was often overcrowded. Patient flow required improvement and waiting times were above the national average due to capacity constraints and the trust's arrangements for making decisions to admit patients (DTA). This meant patients were not transferred to areas treating their speciality, but were accommodated in the ED for longer than necessary. There were no trust guidelines for admission to the children's CDU, which did not fulfil the criteria for a ward area. It was not clear why children were admitted to the CDU rather than the short stay paediatric unit. Admission to the CDU avoided breaches relating to length of stay in the department.

The leadership, governance and culture of the ED promoted the delivery of high quality person-centred care. Clear governance structures were in place and were designed to enhance patient outcomes. Staff were proud of working for the department and staff worked well together as a team. There was an effective and comprehensive process in place to manage risks.

Urgent and emergency services

Are urgent and emergency services safe?

Good

Staff demonstrated an open and transparent culture about incident reporting and patient safety. Staff understood their roles and responsibilities and were empowered to raise concerns and to report incidents and near misses actively to promote learning and improvement.

There were adequate medical and nursing staff on duty to provide safe care to patients. Medicines were stored, recorded and administered safely to protect patients from the risk of medicine misuse.

Patients were safeguarded from abuse. Staff spoken with were aware of their responsibilities to protect vulnerable adults and children, although some improvements were required in documentation related to safeguarding and staff training.

Incidents

- All incidents were reported through a trust wide electronic reporting system called Datix. This allowed for management overview of incident reporting and an ability to analyse any emerging themes or trends.
- We spoke with medical, nursing and allied health professionals who told us they knew how to report incidents and 'near misses' using the Datix system.
- There was evidence of learning from incidents, not just from within the ED, but also trust wide. Trends or lessons learned from incident reporting were shared effectively during staff 'handovers or 'huddles' and also through newsletters and staff meetings. We saw documented evidence of action taken in relation to incidents in the department's patient safety report (April 2015).
- All the staff we spoke with said they were supported and encouraged to raise any concerns with the clinical and nursing leads on the department.
- Information provided by the trust showed 624 adverse incidents (AI) were reported by staff in the ED between 1 September and 31 December 2014. Information provided included action taken in response to AI. Incidents were graded by severity. Of the 624 incidents reported, 168 were investigated at departmental level, 15 were investigated at divisional level and three were treated as Serious Incidents.
- The Serious Incidents related to medication, clinical assessment/diagnosis and the deterioration of a patient during transfer home. Following investigation, action plans were implemented to reduce the likelihood of similar events occurring in the future.
- Summaries of actions taken by the trust included sending 'Duty of Candour' letters to tell the relevant person that a notifiable safety incident has occurred and provide support to them in relation to the incident. Training records provided by the trust showed that none of the ED staff had attended training sessions in Duty of Candour. However, the trust told us ED consultants and registrars had received ED specific duty of candour training from the Head of Risk so did not attended the generic central training sessions.
- There were no Never Events in the ED in the 12 months prior to the inspection. (Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented).
- We looked at minutes of meetings of the mortality monitoring committee (MMC), which demonstrated a multidisciplinary review of the care of patients who had had complications, or an unexpected outcome, to share learning and inform future practice.
- In the 2014 NHS staff survey, the trust scored higher than other trusts nationally for the percentage of staff reporting errors, near misses or incidents and about the same as other trusts nationally for the fairness and effectiveness of procedures for reporting errors, near misses and incidents.

Cleanliness, infection control and hygiene

- A labelling system was in use to indicate that an item had been cleaned and was ready for use. The equipment we looked at was clean.
- The treatment areas had adequate hand-washing facilities. We observed staff washing their hands between seeing each patient and using hand-sanitising gel. The 'bare below the elbows' policy was observed by all staff.
- We observed that staff complied with the trust policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- Side rooms were available for patients presenting with a possible cross-infection risk.

- The department was clean and tidy. We saw support staff cleaning the department throughout the day and doing this in a methodical and unobtrusive way.
- Sixty-four per cent of nursing and 68% of medical staff working in trauma, emergency and acute medicine at the Denmark Hill site had received training in infection control against the trust's own target of 80%.
- We looked at the ED infection control scorecards for three months between December 2015 and February 2015, which recorded the results of audits. Environmental cleanliness audits for the nurse responsible, as well as the contracted cleaning service, did not meet the trust's target. Hand hygiene audits did not meet the trust's target and care of intravenous line audits did not meet the trust's target for two of the three months.
- We noted that the trust policy was followed for the management of a patient presenting with a risk of viral haemorrhagic fever.

Environment and equipment

- There was sufficient seating in the waiting room and reception staff had a direct line of sight of the area. There was a dedicated area to accommodate trolleys for the handover of patients arriving by ambulance. There was a streaming desk and two triage cubicles near the reception area.
- The resuscitation area had 10 cubicles, including one designated for the resuscitation of children. This contained a wide range of equipment so that patients of all ages could be immediately resuscitated.
- Equipment was clean and ready for use. We found that equipment checklists for the resuscitation area were checked and signed for sporadically. There were gaps each week where checks were not documented.
- The department had two 'Majors' areas. Majors A had 15 cubicles. This area was used 24 hours a day. Majors B had five cubicles. Between 10am and 6pm, this area was used as a rapid assessment and treatment (RAT) processing area. Outside of these hours, Majors B was used to increase the capacity of the ED.
- There was a separate children's ED with a separate waiting room for children inside the department where staff at the workstation were able to monitor the area.
- A room was available for private and quiet discussions with relatives and an adjoining room was available where relatives could spend time with their loved one in the event of their death.
- Electronic locks maintained a secure environment. There was a facility to 'lock down' the department in the event of an untoward incident.
- Each bed space within the resuscitation area were designed and configured in exactly the same way. This allowed staff working within that area to be familiar with the bed space, which ultimately led to improved working during trauma and resuscitation events.
- A room with two exits was designated for interviewing patients presenting with mental health needs.
- The X-ray department and computerised tomography (CT) scanning facilities were adjacent to the ED and was easily accessible.

Medicines

- We saw that locks were installed on all storerooms and most cupboards and fridges containing medicines and intravenous fluids. Keys were held by nursing staff. In some areas of the department, such as the resuscitation area, cupboards and fridges were left open to facilitate access to medicines in emergencies, for example, rapid sequence intubation (RSI). Risk assessments were undertaken for these.
- We found controlled drugs were checked daily by staff working in the department. We audited the contents of the controlled drug cupboard in the resuscitation area and Majors areas against the controlled drug registers and found they were correct.
- We noted that the controlled drug register required entries for the amounts of medicine supplied, administered and destroyed. Although there were always two signatures, we saw gaps in recording. Nursing staff told us it was sometimes difficult to get medical staff to confirm how much of a controlled drug was administered to a patient in an emergency.
- The patient allergy status was recorded on each of the 31 records we looked at.
- Eighty-two per cent of medical staff working in trauma, emergency and acute medicine at the Denmark Hill site have had mandatory medicines management training against the trust target of 80%.
- Nursing staff told us it was mandatory for them to complete medicine training and have their knowledge and competency checked before they were allowed to administer medicines.
- Competency was certified as level 1 (nursing staff can administer oral (non-controlled) medication to adults on their own without a second registered nurse/midwife

being present); level 2 (administration of oral medicines under the supervision of a second registered nurse/ midwife) and level 3 (nurses do not administer medicines and are required to attend a study day before resitting the drug administration assessment).

Records

- A paper record was generated by reception staff registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- An electronic patient system ran alongside paper records and allowed staff to track patients' movements through the department and to highlight any delays.
- A risk of inappropriate treatment arising from the existence of clinical information in multiple places (both paper and electronic) was identified as a high risk in the EDs risk register. The hospital was managing the risk of information in multiple places safely.
- Specific pathway documentation was available for patients presenting with specific conditions. For example, a fractured neck of femur. The documents were clear and easy to follow. There was space to record appropriate assessment, including assessment of risks, investigations, observations, advice and treatment and a discharge plan.
- Eighty-six per cent of nursing staff and 76% of medical staff working in trauma, emergency and acute medicine at the Denmark Hill site have had mandatory 'Health Record Keeping' training against the trust's target of 80%.
- Seventy-three per cent of administrative staff and 80% of nursing staff in the ED at Denmark Hill had completed information governance training against a trust target of 80%.

Safeguarding

- There were appropriate systems and processes in place for safeguarding patients from abuse. Staff spoken with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- Staff had access to patients' previous attendance history and to the child risk register. Electronic flags identified 'at risk' children when they were booked in and notifications of ED attendance were made to local authority social services for children with a child protection plan. We noted that although staff obtained consent verbally to undertake background checks, this was not documented. However, the trust told us that the paper flowchart was no longer in use as the safeguarding questions were mandatory fields on the nursing triage in the symphony computer system for all children. One of the fields in the electronic safeguarding assessment record was a verbal consent to information sharing taken by the triage nurse.
- ED staff were represented at a weekly multidisciplinary child safeguarding meeting. The ED had a nominated lead consultant and nurse who were responsible for safeguarding children's notes were reviewed by a health visitor to screen for children at risk of harm.
- Eighty-two per cent of nursing and 44% medical staff working in trauma, emergency and acute medicine at the (Denmark Hill site) had received training in safeguarding vulnerable adults against the trust's own target of 80%.
- Eighty-three per cent of nursing and 63% medical staff working in trauma, emergency and acute medicine at the Denmark Hill site had received training in safeguarding children at level 2 against the trust's own target of 80%.Eighty-three per cent of nursing staff had received training in safeguarding children at level 3.
- Twenty per cent of senior ED doctors (ST4 or equivalent and above) of senior ED medical staff (specialty registrar and above) had undertaken training in safeguarding children training at level 3. This meant the trust could not demonstrate they met the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings recommendations. These recommendations were in accordance with the Royal College of Paediatrics and Child Health's publication 'Facing the Future: Standards for Acute General Paediatric Services: "All children and young people [must] have access to a paediatrician with child protection experience and skills (of at least safeguarding level 3 training)".
- Over several days, we observed that GPs operating an urgent care service from a cubicle in the children's area brought adult patients for consultation in between seeing paediatric patients. This compromised the safety of children attending the department.

Mandatory training

- Compliance with statutory and mandatory training was generally good. For example, 79.6% of staff working in

trauma, emergency and medicine (which includes ED) had completed fire training, 91% had completed health and safety training and 73% had completed moving and handling training against a trust target of 80%.

- Seventy-six per cent of paediatric nurses and 6% adult nurses had undertaken paediatric life support training. The trust told us PILS was identified as a high risk area at both sites and training dates were established.
- Sixty-eight per cent of nursing staff and 53% of medical staff working in trauma, emergency and acute medicine at the Denmark Hill site had completed resuscitation training against the trust's own target of 80%.

Assessing and responding to patient risk

- Patients presented at the department by walking into the reception area or arriving by ambulance into a separate entrance.
- Data for meeting the standard for initial assessment of patients within 15 minutes was not collected. Patients arriving at the ED were seen immediately by a healthcare professional.
- Patients arriving by ambulance as a priority (blue light) call were transferred immediately through to the resuscitation area, or to an allocated cubicle space. Such calls were phoned through in advance, so that an appropriate team could be alerted and prepared for their arrival.
- Other patients arriving by ambulance were assessed by a nurse assigned to ambulance triage, who took a 'handover' from the ambulance crew. Based on the information received, a decision was made regarding which part of the department the patient should be treated in.
- If a patient arrived on foot, they were initially seen by a nurse who would then direct them to the appropriate area where they were registered by reception staff before being seen by a triage nurse. This meant patients had a clinical assessment as soon as they arrived, rather than waiting in a queue for registration. The trust told us they operated this system because "patients can wait up to 15 minutes for registration, especially at busy times, and we want to ensure that all patients in ED have an immediate clinical review regardless of departmental pressures/waits".
- Data provided by the trust for January 2015 showed that ambulance patients were triaged before registration. Triage was undertaken in accordance with the Manchester Triage System. This is a tool used widely in emergency departments to detect those patients who require critical care or who are ill on arriving at the department. Trained triage nurses followed a pathway, or algorithm and assigned a colour coding to the patient following initial assessment. Red being the label assigned to those patients who needed to be seen immediately, then orange (very urgent), yellow (urgent), green (standard) through to blue (non-urgent).
- There were two adult triage cubicles adjacent to the main reception area and waiting room. Having been triaged, patients were then prioritised for treatment and clinical intervention in the most appropriate area within the department for their ongoing management.
- Children attending the ED were streamed at the main reception and while this was not undertaken by a paediatric nurse, children were directed to the dedicated children's ED, where triage was undertaken by a paediatric nurse consistently, within 15 minutes.
- The department utilised Physiological Observation Track and Trigger System (POTTS) system to detect deterioration in adult patients. However, the children's department did not have a scoring system in use to monitor deterioration, but depended on the clinical judgement of the staff.
- We saw evidence of rapid assessment and treatment of adult patients by a designated team of staff in the Majors B area of the department between 10am and 6pm daily.
- The triage cubicles and the bays in Majors B being used for rapid assessment and treatment, were also used to commence investigations that would assist with diagnosis and treatment. For example, blood was taken, electrocardiograms (ECG) carried out, analgesia administered and x-rays ordered.
- Trust-wide, the median time to treatment for patients was between 55 and 72 minutes. This meant that, at times, the trust exceeded national guidelines of 60 minutes time to treatment in the year up to November 2014.
- In the 12 months up to February 2015, there were 144 occasions when an ambulance waited over 30 minutes to hand over a patient to the ED at Denmark Hill, but this was still significantly better than some trusts nationally during the same period.
- The ED was a major trauma centre and part of the South East London, Kent and Medway Trauma Network. Any expected ambulance admissions to the department

were announced via the tannoy system indicating their colour status and anticipated time to arrival. This enabled the relevant and appropriate staff to be ready and waiting.
- A risk assessment booklet was available with tools to assess patient risks associated with falls, manual handling, developing pressure sores and poor nutrition. Risk assessments were not completed in six of the eight patient records we reviewed in the CDU.

Nursing staffing

- There were sufficient numbers and a skills mix of nurses on duty in the ED over each 24-hour period to care for patients safely given the acuity of patients and the geographical layout of the department.
- We interviewed the deputy head of nursing (HoN) for the ED who told us there were 137 adult nurses, 53 paediatric nurses, 12 emergency nurse practitioners (ENPs) and 11 technicians for the department.
- The trust considered Royal College of Nursing Baseline Emergency Staffing Tool (BEST) recommendations and National Institute for Health and Care Excellence (NICE) draft guidance in reviewing nurse staffing establishment for the ED in March 2015. The usual staff complement for the ED was 26 registered nurses (RN) during the day and 24 RNs at night. Generally, the department was staffed with the planned numbers.
- The department utilised a staffing algorithm, which produced a Red/Amber/Green (RAG) rated risk assessment for the number of staff on duty. On the days of our inspection, the actual numbers of registered and unregistered nurses on duty did fall below the planned number of RNs. However, the skills mix and flexibility of staff on duty was such that they were able to deploy themselves as demand and workload dictated so there was no obvious detriment to the standard of care being delivered and the RAG rating was 'green'.
- The nursing vacancy rate was 25.1% at the Denmark Hill site at the time of our inspection. The deputy HoN told us there were 20 vacant posts, although five appointments were being processed at the time of our inspection. Nursing staff told us it was difficult to recruit band 7 staff.
- Six point eight per cent (6.8%) of the total adult nurse staffing and 2.5% of paediatric nurse staffing was provided by bank or agency staff between January and December 2014. We saw evidence of an induction process for agency staff.

Medical staffing

- There were emergency medicine consultants on duty in the department between 8am and midnight on a daily basis, with 'on-call' cover outside of these hours seven days a week. The trust met the College of Emergency Medicine (CEM) recommendation that an ED should provide emergency cover 16 hours a day, seven days a week.
- The 24 hours a day, seven days a week trauma rota was staffed by a pool of 30 trauma consultants who worked at least 12 shifts per year to maintain their competencies.
- We examined the medical staffing rota and spoke with consultants, as well as middle grade and junior doctors. The department employed:
  - Seventeen point seven whole time equivalent (WTE) emergency consultants in post, which exceeded the establishment of 16.7 WTE. This included three locums, two covering maternity leave and one covering the PGME (Post Graduate Medical Education).
  - Seven WTE specialist registrars in post against an establishment of nine.
  - Seven point eight WTE senior clinical fellow posts against an establishment of 10.
  - Three point eight WTE specialist trainees in post against an establishment of two.
  - Sixteen point five WTE junior clinical fellows in post against an establishment of 17.5.
  - The numbers of other grades of medical staff were up to establishment; FY1: 2 WTE, FY2: 13 WTE, Staff Grade one WTE, ST3 Paediatric EM: one WTE.
- There was a GP rota, which provided three GPs between 8am and 8pm daily to staff the urgent care area of the department.
- The medical vacancy rate was zero at the Denmark Hill site.
- Locum usage in the ED was 7.5 to 12.1% between 1 September and 31 December 2014 at the Denmark Hill site.

Major incident awareness and training

- The trust had a major incident plan, which was last reviewed in May 2014. This was available for all staff on the trust's intranet pages.
- Staff that we spoke with had an understanding of their roles and responsibilities with regard to any major incidents.

Urgent and emergency services

- Decontamination equipment was available to deal with casualties contaminated with chemical, biological or radiological material, hazardous materials or items (HAZMAT). Forty-seven of 160 (29%) nursing staff, 10 of the 18 consultants and 11 of the 27 customer care officers in post held current HAZMAT certificates.
- An isolation unit was available in the department for patients presenting with infection risks. It was in use for a patient with suspected viral haemorrhagic fever at the time of our inspection.
- The trust employed 21 security staff at the Denmark Hill site against a proposed establishment of 28. Security staff held Security Industry Authority (SIA) licences for 'manned guarding', 'door supervision' or 'security guard' (SIA is the organisation responsible for regulating the private security industry in the UK). Seventy-six per cent of security staff had received training in control and restraint and 81% had completed conflict resolution training. They also had additional training provided by the trust for the patient groups they worked with. For example, 71.5% security staff had completed dementia awareness training.
- Sixty-two per cent of staff working in the trust's trauma, emergency and medicine division (which included the ED) had completed conflict resolution training against the trust's target of 80%.
- The department had good links with local police, who had a presence in the ED from 9am to 5pm, Monday to Friday.
- CCTV was in use in some of the publicly accessible and high risk areas in the department, such as corridors and waiting rooms. Patient areas were not subject to surveillance.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Staff followed accepted national and local guidelines for clinical practice. The department had developed a number of pathways to ensure that patients received treatment focused on their medical needs.

The trust participated in national College of Emergency Medicine audits so that they could benchmark their practice and performance against best practice and other emergency departments.

There was a multidisciplinary, collaborative approach to care and treatment that involved a range of health and social care professionals.

Patients were given timely pain relief and pain scoring tools were consistently used.

There was a low rate of appraisal for nursing staff.

Evidence-based care and treatment

- Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies, such as the College of Emergency Medicine (CEM), the National Institute for Health and Care Excellence (NICE) and the Resuscitation Council (UK).
- Guidelines were easily accessible on the trust intranet page and were up to date. Junior doctors were able to demonstrate ease of access and found them clear and easy to use.
- Clinical guidelines were accessible electronically. We saw an example of a printed copy in the case notes of a patient presenting with an overdose of mirtazapine.
- Adherence with guidelines was encouraged through the development of illness specific proformas to prompt use of best practice guidelines. For example, we saw evidence of use of the fracture neck of femur guidelines and sepsis guidelines.
- We saw guidelines for admitting patients to the CDU. Comprehensive antimicrobial guidelines were also available.
- The trust had no audits in place for patients with learning disabilities.

Pain relief

- The trust performed about the same as other trusts in the 2014 CQC ED survey responses to effective pain management.
- We observed that an assessment of pain was undertaken on a patient's arrival in the department. All of the patients we spoke with told us that they were offered, and/or provided with, appropriate pain relief. Patients' records confirmed this.

- Age appropriate pain scoring tools were used in the department. A score was recorded in all of the records we looked at.
- We did not see any patient displaying verbal or non-verbal signs of pain during our inspection that were not being addressed by the staff.

Nutrition and hydration

- We observed staff providing drinks and snacks to patients during our inspection. We were told that 'Grab boxes' of food were available for patients outside of set meal times.
- The integrated patient care documentation booklet provided staff with a prompt to carry out a nutritional risk assessment using the malnutrition universal screening tool (MUST).
- Following the assessment of a patient, intravenous fluids were prescribed and recorded, as appropriate.

Patient outcomes

- The ED at Denmark Hill had mixed results in the College of Emergency Medicine (CEM) audit for fractured neck of femur audit published in 2013. The ED performed above the national average for analgesia provided within 60 minutes of arrival, analgesia provided in accordance with need and time to imaging. Areas identified for improvement included re-evaluation of analgesia, time to admission and time from arrival to surgery.
- The ED at Denmark Hill performed above the national average for the majority of standards audited in the CEM audit for the treatment of renal colic published in 2013.
- In the CEM audit for pain management in children published in May 2012, the ED at Denmark Hill performed above the national average for time after arrival in the ED that analgesia was provided, recording of pain scores, patients accepting analgesia and length of time after arrival that a patient was taken to x-ray. Areas for improvement included improving the process for documenting the re-evaluation of pain scores, revising the paediatric analgesia guideline and training and reviewing the patient process in paediatric emergency.
- In the CEM audit for severe sepsis and septic shock published in 2014, the ED at Denmark Hill performed above the national average for the majority of criteria audited. However, performance was the same as, or below, the previous for the majority of criteria that were re-audited.
- In 2014/15 the attendances resulting in admission (18.9%) were less than the national average (21.9%).
- The Trauma Audit and Research Network (TARN) data published in 2014 demonstrated mixed results for the ED at Denmark Hill against the major trauma dashboard criteria compared to the national average. Areas for improvement included the proportion of patients:
  - Transferred to the major trauma centre (MTC) within two days of a referral request.
  - With a Glasgow Coma Scale (GCS) score of nine (a head injury is usually classed as being moderate if someone has a GCS score of 9-12), with definitive airway management within 30 minutes of arrival in ED.
  - Directly admitted patients receiving a CT scan within 30 minutes of arrival at the MTC.
  - With an injury severity score (ISS) of more than eight that have a rehabilitation prescription completed.
- The trust's monthly trauma performance meeting and trauma board review TARN data review areas of below average performance, monitor performance against actions set for the trust and co-ordinate a joint action plan to ensure successful data submission across both trust sites.
- The TARN clinical report III for the South East London, Kent and Medway Trauma Network (published in November 2014) recorded that the 'Most senior doctor seeing patients in the emergency department' had a 79.8% ratio for all patients directly admitted (for all specialties) at the trust as a whole. These patients were also seen by a consultant between April 2014 and September 2014, compared to the mean 31.6% for the South East London, Kent and Medway Trauma Network.
- The TARN clinical report III for the South East London, Kent and Medway Trauma Network published in November 2014 documented the median time to giving a patient a CT scan. All direct admissions, excluding patients taken directly to theatre, took 0.6hrs between April 2014 and September 2014, which was the best performance in the South East London, Kent and Medway Trauma Network.

Competent staff

- The department complied with nursing and clinical staffing guidance published by The Intercollegiate Standards for Children and Young People in Emergency Care Settings. Nurses working in the children's ED had a minimum level of knowledge, skills and competence in

both emergency nursing skills for the care of children and young people. Clinical staff working in the children's ED had a minimum level of knowledge, skills and competence in caring for children and young people, for example, recognition of serious illness, basic life support, pain assessment and identification of vulnerable patients.
- There were four (2.6 WTE) practice development nurses (PDNs) in post at the Denmark Hill site.
- We saw evidence of development programmes for nurses at varying grades. The department also supported a number of nurses to develop their skills and competencies as emergency and advanced nurse practitioners.
- Information provided by the trust showed that 8% of nursing staff in the ED at the Denmark Hill site had an appraisal between April and December 2014. In 2013/14, 11% nursing staff had an appraisal and in 2012/13 it was 4%.
- Junior doctors told us they were well supported and had weekly training sessions.

Multidisciplinary working

- GPs were included on the clinical rota to support the effectively integrated urgent care service within the ED.
- Medical and nursing staff worked across the ED with other specialists and therapy staff to provide multidisciplinary care. We observed team working between medical and nursing staff throughout our inspection. There were examples of multidisciplinary working both within the ED and within the wider hospital. For example, the advanced nurse practitioners worked alongside the medical staff and were included on their duty rota.
- Timely assessment and support was generally available for people presenting with mental health issues as mental health practitioners were based on site. Staff had access to the mental health crisis team to assess and treat patients with acute mental health needs, 24 hours a day.
- The Intercollegiate Standards for Children and Young People in Emergency Care Settings recommend departments seeing more than 16,000 children per year employ play specialists at peak times or have access to a play specialist service. The children's ED did not have a dedicated play worker, but had access to a play worker from the children's short stay unit.

Seven-day services

- The trust was committed to the vision of seven-day services with consistent quality of care, optimal patient flow and consistent access to high quality emergency care at all times of the day and week.
- Seven/seven (7/7) initiatives were in place at Denmark Hill to support a 24 hours a day, seven day a week working strategy, which included: a weekend rota for the matron and acute medicine consultant, ward-based social workers and acute medicine service manager and 7/7 pharmacy, phlebotomy, enhanced bed management, enhanced therapy cover across the Trauma, Emergency and Acute Medicine division, clinical administration and 24 hours a day, seven day a week laboratory services.

Access to information

- The department had a computer system that showed how long patients had been waiting, their location in the department and what treatment they had received.
- A paper record, referred to by departmental staff as a Central Alerting System (CAS) card, was generated by reception staff registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- Staff could access records, including test results on the trust's computerised system.
- Electronic Patient Records (EPR) were in use for patients admitted to the hospital, including the CDU.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained in a way that they could understand before they were carried out.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity to consent to their care and treatment.
- Seventy-nine point eight per cent of staff working in the trauma emergency and medicine division, which included the ED, had completed consent training against a trust target of 80%.

Urgent and emergency services

- Forty-six per cent of nursing and 19% medical staff working in trauma, emergency and acute medicine at the Denmark Hill site have received training on Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 against the trust's own target of 80%.
- There were no Deprivation of Liberty Safeguards applications made through ED in 2013/14 or the year to date.

Are urgent and emergency services caring?

Good

Patients in the ED were supported, treated with dignity and respect and were involved as partners in their care.

Patients felt that they were listened to by healthcare professionals, and were involved in their treatment and care. Staff treated patients with respect. Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. Staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

Compassionate care

- The NHS Friends and Family Test results for the trust for the 12 months up to November 2014 showed between 82% and 87.5% people were 'extremely likely' or 'likely' to recommend the ED compared to an England average of between 86.5 and 88.5%.
- Throughout our inspection of the ED, we observed staff treating patients with compassion, dignity and respect. Patients' privacy was respected by curtains being drawn when personal care was given. Staff lowered their voices to prevent personal information being overheard by other patients.
- Patients responding to the CQC ED survey 2014 said they were treated with respect and dignity while they were in the ED, which was about the same as other trusts nationally.
- The patients and relatives we spoke with during our inspection were positive about the way staff treated them. Their comments included: "I'm happy with the care. It was good and it was fast," and, "Everyone made sure I understood what was happening; that made it less frightening."

Understanding and involvement of patients and those close to them

- Patients responding to the CQC A&E survey 2014 said they were given information about their condition or treatment and they felt involved in decisions about their care, which was about the same as other trusts nationally. However, the trust performed worse than other trusts nationally when asked about relatives being given an opportunity to talk to a doctor if they wanted to.
- Patients and relatives we spoke with told us their care and treatment options were explained to them in way they could understand.
- We observed staff responding quickly when relatives of critically ill patients arrived, which meant relatives were not left waiting for information about patients' progress and were offered comfort from staff.

Emotional support

- We spoke with staff about caring for the relatives or others close to them when patients died in the department. They said family members were taken to the relatives' room to be informed of the death in private. Where possible, relatives were given the opportunity to spend time with the deceased person if they wished to.
- We observed staff giving emotional support to patients and their families. Staff made use of the designated relatives' room so that people had privacy when they were receiving upsetting news about their relatives' condition.
- Staff had access to the hospital's chaplaincy service and could request support when needed.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement

The ED was often overcrowded. Patient flow required improvement and waiting times were above the national average, due to capacity constraints and the trust's arrangements for making decisions to admit patients (DTA). This meant patients were not transferred to areas treating their specialty, but were accommodated in the ED for longer than necessary.

Urgent and emergency services

There were no trust guidelines for admission to the children's CDU, which did not fulfil the criteria for a ward area. It was not clear why children were admitted to the CDU rather than the short stay paediatric unit. Admission to the CDU avoided breaches relating to length of stay. Children admitted to the CDU were seen by the relevant specialists.

Service planning and delivery to meet the needs of local people

- The ED at Denmark Hill serves an inner city population of 700,000 in the London boroughs of Southwark and Lambeth.
- The trust introduced streaming of all patients at reception to include screening for patients with suspected viral haemorrhagic fever. The ED had good facilities for isolating these patients, which we saw in use during our inspection.
- The department had an established youth worker drop in scheme operated by a London-based organisation, which was effective in supporting vulnerable young people. Staff could refer young people to the service, although engagement was voluntary. The service also supported young people to access specialist services such as housing support and social workers.
- Patient information and advice leaflets were available in English, but were not available in any other language or format. Telephone translation services were available for patients for whom English was not their first language and some staff spoke more than one language.

Meeting people's individual needs

- There were 3,105 people with dementia admitted to the trust during the year 2014/15. On average, there were approximately 78 inpatients with dementia at any one time. The trust did not have an electronic flagging system for people with dementia.
- There were three dedicated dementia and delirium specialist nurses on the Denmark Hill site and a registered mental nurse as a part of the Older Person's Liaison Team within medicine to support the care of older patients admitted with mental health problems. All patients aged over 75 years admitted as emergencies to the trust were screened for dementia and delirium. The team received a list of these patients electronically and, in addition, electronic referrals could be made using Electronic Patient Records (EPR) to the Dementia and Delirium (DAD) team, who worked closely with the psychiatric liaison team.
- In the National Audit of Dementia Care in General Hospitals 2012/13, the Denmark Hill site performed in line with, or above, the national average for 80% of the applicable criteria audited across six domains. An action plan was in place to improve patient management further. This included the development of a care pathway and guidelines for patients with delirium and dementia, an improved discharge planning process and improved training on the assessment and documentation of delirium and dementia. Dementia was a 2013/14 quality priority at the Denmark Hill site.
- There were 538 patients with a learning disability admitted to the trust last year. On average, there were approximately seven or eight inpatients with a learning disability at any one time.
- There was no universal flagging system in place for patients with a learning disability. However, the trust had a well-established learning disability service at the Denmark Hill site and all patients presenting in the ED with a learning disability had a 'Special Case' notification on Symphony (The electronic system for monitoring the progress of patients through the ED).
- The trust employed one learning disability nurse at the Denmark Hill site. Clinical staff sent an alert whenever an adult with a learning disability was admitted or attended the ED. Referrals were sent either as a safeguarding concern with the safeguarding adults team or as a routine notification of a learning disability admission.
- Adjustments for patients with learning disabilities varied, but could include: increased visiting hours, extended ward rounds or specific multidisciplinary team meetings in addition to the usual clinical discussion, use of a Health Passport to aid handover from carers to clinical teams and joint working with community learning disability teams.
- There was a CDU in the children's ED. This comprised two cubicles in the middle of the children's ED, adjacent to the nurse's station. The cubicles did not have en-suite facilities and did not fulfil the criteria for a ward area. There were no trust guidelines for admission to the children's CDU. It was not clear why children were

admitted to the CDU rather than the short stay paediatric unit. Admission to the CDU avoided breaches relating to length of stay. Children admitted to the CDU were seen by the relevant specialists.

- Trauma nurse coordinators tracked pathways and progress of trauma patients by visiting them daily on the wards. This role also included networking with other trusts and coordinating repatriation in advance.
- Staff had access to the mental health crisis team to assess and treat patients with acute mental health needs, 24 hours a day. A Child and Adolescent Mental Health Services (CAMHS) worker was available between 9am and 5pm, however, there were problems getting assessments for children 'out of hours', which caused long waits for these children in the ED.
- A social worker, occupational therapist and physiotherapist were based in the CDU to support people's needs.

Access and flow

- Capacity and waiting times were an ongoing problem in the ED. The issue of overcrowding had been presented as an issue at the patient safety committee. Nursing staff told us that, although infrequent, there were occasions when patients were 'doubled up' in cubicles. Screens were used to mitigate risks to privacy and dignity, but staff recognised it was not ideal.
- The ED Quality Indicators Scorecard showed 782 patients waited in the ED (trust wide) for 12 hours or more after a decision was made to admit (DTA) between January and December 2014. These 12-hour breaches were measured from the time of DTA. However, we found that a DTA was often delayed so there were many more patients spending excess time in the ED. It was trust policy for DTA to be made by speciality teams and not by emergency medicine consultants. This further delayed patients' pathway through the hospital. We looked at the nurse in charge handover sheet for 28 March 2015 which recorded 28 unvalidated breaches.
- On the morning of one of our inspection days, there were 23 patients with a DTA waiting for a bed on a ward. On a different inspection day, a 92 year old patient arrived at 10.27pm , DTA was 5.17am the following day. The patient was still in the ED in the afternoon of our visit.
- At 6pm during our unannounced inspection visit on 28 April, 10 of the 35 patients in Majors and the resuscitation area had waited more than six hours. Six of these patients had been referred to specialty and a DTA had been made for two patients. It was trust policy to escalate to the clinical site manger (CSM) for all patients awaiting beds at four hours from the DTA.
- The specialties with longer lengths of stay in the ED were medicine (top), mental health and paediatrics, often because a bed on a ward was not available.
- Nursing staff took action to mitigate risks associated with long stays in the ED. For example, patients were transferred from trolleys onto beds and pressure-relieving mattresses were available.
- There were 165,422 attendances at the Denmark Hill site between January and December 2014. Around 22% of these patients were aged between zero and 16 years old.
- The ED at the Denmark Hill site consistently failed to meet the target to see, treat and discharge 95% patients within four hours between January and December 2014. The 95% target was reached in only eight out of the 52 weeks in this period. The weekly performance ranged between 88% and 96%. The average for the period was 93.3%.
- The total time in the ED (average per patient) for the trust was consistently significantly higher than the national average. In the 12 months up to September 2014, patients spent an average of 150 and 180 minutes in the department .The national average for the same period was less than 140 minutes.
- In the 12 months up to September 2014, the unplanned re-attendance rate to the ED within seven days was 4.35%, which was below the England average (between 7% and 7.5%) and the CEM standard (5%).
- The percentage of patients who left the department before being seen was recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait. Between 1.97% and 3.08% of patients left the trust without being seen compared to between 0.2% and 3% nationally.

Learning from complaints and concerns

- Information about how to complain was displayed in the department. Information leaflets were available to all patients. They contained information about how to access the Patient Advice and Liaison Service and how to make a complaint. The department followed the trust's complaints policy.

- Informal complaints could be received by any member of the team. These were dealt with by the most appropriate person. Staff were aware that if they could not resolve an issue they should advise the patient/ relative as to how to use the formal complaints policy.
- Information received from the trust showed 66 complaints were received by the ED in the last 12 months. The top areas of complaint were diagnosis (11), care (9), attitude (7) and communication (6).
- The trust's 'Review of Complaints at King's College Hospital NHS Foundation Trust' (Update Briefing February 2015) showed that 43% of complaints in 2013/ 14 were responded to within 25 working days on the Denmark Hill site.
- A survey of complainants from at the Denmark hill site between April and October 2013 showed that only one third of respondents were satisfied with the time taken to investigate their complaint and only half of respondents were confident that their complaint had been taken seriously. Less than half of respondents felt that their complaint response was open and honest and only one third felt that their response addressed their concerns or resulted in learning.
- The ED complaint rate for 2012/13 and 2013/14 was 0.6 per 1,000 ED attendances and 0.5 per 1,000 in 2011/12.
- There was a 20% increase in complaints at the Denmark Hill site in 2013/14 compared to the previous year and an overall organisational increase of 52%.
- Two per cent of Denmark Hill complaints were referred by complainants to the Parliamentary and Health Service Ombudsman.
- Patient experience data, including complaints, was reported to the trust board monthly, and more detailed trend information and analysis was reported on a quarterly basis through the board quality and governance committee (which had full board membership) and subsequently to the board of directors. A patient story or complaint formed the first item on each agenda. There was a quarterly patient experience report to the board.
- A monthly trust patient experience report collated information about complaints with patient feedback from Patient Advice and Liaison Service, the 'How Are We Doing' survey, patient comments and NHS Friends and Family Test results. This was reported through the patient issues committee and widely through the organisation.
- Complaints, issues and performance were reviewed at monthly performance meetings with divisions chaired by the chief operating officer, and attended by the medical and nursing directors. Complaints were also reviewed at the governors patient issues and safety committee.
- At divisional level, patient complaints were reported six monthly at governance meetings, with trends and themes highlighted.
- Following the Francis Report (the Mid Staffordshire NHS Foundation Trust Public Inquiry), the trust established a serious complaints committee in February 2014 chaired by a non-executive director also appointed as the non-executive director (NED) Patient Experience Champion. The membership included many of the executive team, senior consultant staff and senior nurses. The committee's purpose was to champion improvements in complaints handling, provide a degree of independent challenge and to improve organisational learning from complaints.

Are urgent and emergency services well-led?

Good

The leadership, governance and culture of the ED promoted the delivery of high quality, person-centred care.

Clear governance structures were in place designed to enhance patient outcomes. Staff were proud of working for the department and staff worked well together as a team

There was an effective and comprehensive process in place to manage risk.

Vision and strategy for this service

- The 'King's Values' were developed and defined by staff and stakeholders in 2009. They were: 'Understanding you, inspiring confidence in our care, working together, always aiming higher and making a difference in our community'. The ED did not have an individual departmental vision or values, but staff we spoke with during the course of our inspection were aware of the trust values.

Urgent and emergency services

Governance, risk management and quality measurement

- The trust maintained a system of scorecards for monitoring targets; for example, national performance targets, patient experience and clinical quality. These were accessible for staff reference.
- We looked at the governance structure for trauma and emergency medicine division. The schedule of clinical governance and risk meetings included trauma, ED and therapists to ensure comprehensive clinical and operational oversight at divisional and departmental level. We looked at minutes of governance meetings for three months before the inspection and attended an ED core group meeting, which provided further assurance of robust governance.
- An ED patient safety report was produced monthly and included moderate and high risks identified on the department's risk register. Highest risks were identified as overcrowding, absconding patients, inappropriate treatment because both paper and electronic systems were in place for recording clinical information and the fact that an outdated version of the Manchester Triage System was being used on Symphony. The risk register reflected key concerns for the service.
- There was consistency between what frontline staff and senior staff said were the key challenges faced by the service. Staff were clear on the risks and areas in the department that needed improvements.

Leadership of service

- The ED was included in the trust's trauma, emergency and medicine (TEAM) division. The service had a clear management structure both at divisional and departmental level. The structure of the department included a clinical lead (an emergency care consultant), head of nursing and an operational manage .
- There was positive feedback from trainee doctors who had been on placement in the department. They said they had been made to feel part of the team and staff ensured that they were fully involved in all aspects of patient care and treatment.
- Staff within the department spoke positively about the care they provided for patients. Quality and patient experience were seen as everyone's responsibility.

Culture within the service

- King's College Hospital (Denmark Hill site) is located in one of the most diverse areas in London. Forty-five per cent of trust staff were from Black and Minority Ethnic (BME) backgrounds. Information in the trust's annual report 2013/14 stated there were three staff-led diversity groups active in taking forward the trust's work on the national Equality Delivery System and they participated in King's Hospital Staff Engagement Group. These were the Cultural Diversity Network, Disability Inclusivity Network and the Lesbian, Gay, Bisexual and Transgender Forum. The trust had worked closely with external partners, such as Stonewall. Over 1,000 staff had been trained in Stonewall's 'Train the Trainer' scheme.
- The trust was accredited as a nationally recognised Positive About Disabled People 'Two Ticks' employer.
- Equality and diversity training was mandatory for all new staff and training records showed 88.8% of staff working in trauma, emergency and medicine division had completed equality and diversity training.
- Staff had 24 hours a day, seven day a week access to two support services. The first was the Dignity at Work Partnership helpline, which supported staff in relation to bullying and harassment, and workplace options, which offered telephone, online and web-based advice on a range of matters, including: legal matters, financial management, and general counselling. The second was Kingsflex, King's College Hospital's working scheme, which helped staff balance family and work commitments.
- The sickness rate was 3.9% among nursing staff at the Denmark Hill site for the 12 months up to December 2014.
- There was a sickness rate of 0.8% among medical staff at the Denmark Hill site for the 12 months up to December 2014.
- The turnover rate was 23.1% among nursing staff at the Denmark Hill site between April and December 2014. There was a year on year upward trend in turnover among nursing staff. In 2012/13 it was 11.8% and in 2013/14 it was 18.
- There was turnover rate of 58.5% among medical staff at the Denmark Hill site between April and December 2014.

Public and staff engagement

- The 2014 response rate to King's College Hospital's participation in the national NHS staff survey was 30%, which was worse than the previous year (42%) and the

national average (42%). Overall, the trust performed better than other trusts nationally for five survey responses (out of 31) and worse than other trusts nationally for 12 responses (out of 31).

- The response rate from the NHS Friends and Family Test in the ED was 82.5% and 84.5% between April and November 2014, which was worse than the England average of 87% to 88% for the same period.
- In the 2014 ED survey, 63% of staff agreed that feedback from patients was used to make informed decisions in their directorate/department, which was significantly better than 56% nationally.
- We saw a quality board displayed in the CDU to show staff, patients and visitors how the department was performing and to celebrate their achievements.

Innovation, improvement and sustainability

- Helicopter ambulances landed in the local Ruskin Park (which is a Civil Aviation Authority recognised landing site) in order to take emergency patients to the ED for treatment. This involved disruption to the park and required the presence of the police to secure the site. The London Ambulance Service also provided the ambulances to transfer patients. The trust's planning proposal for a helipad on top of the Ruskin Wing was approved and we saw construction in progress during the inspection. The helipad will facilitate landings of helicopters and the transferring of patients to the Denmark Hill site, by shortening transfer times from the existing landing zone.
- Although ED redevelopment plans (such as the plan to create a dedicated area for mental health patients) existed, the implementation of this had been delayed.

Medical care (including older people's care)

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

Information about the service

Medical services provided at the King's College Hospital Denmark Hill Site included specialist renal, liver, haematology, cardiology and stroke services, as well as other medicine and care of the elderly services.

We visited 16 medical wards/units, the cardiac catheter laboratory and a surgical and a gynaecology ward to review medical outliers. Wards/units visited were, the medical assessment centre, Davidson Ward (haematology), Annie Zunz Ward (general medicine), endoscopy unit, coronary care unit (CCU) and Sam Oram Ward (cardiology), Oliver Ward (acute medical unit), Cotton Ward (cardiovascular), RD Lawrence Ward (acute medical unit), Byron Ward (health and ageing unit), Mary Ray Ward (health and ageing unit), Fisk Ward (renal), Cheere Ward (renal), and Twining Ward (general medicine, diabetes and endocrine).

There were 68,542 admissions to medical services between July 2013 and June 2014.

We spoke with 64 staff in addition to attending a meeting with twelve managers and consultants from medical services. We also spoke with 30 patients and three relatives. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. We reviewed care records and attended handovers. We reviewed other documentation from stakeholders and performance information from the trust.

Summary of findings

Patients received care based on the best available evidence and national guidance. The hospital scored highly in most of the patient outcome measures which indicated good adherence to evidence-based measures, which improved outcomes for patients. Patients gave their consent for care and treatment and were involved in decision making. There was an effective multidisciplinary approach to care and good team working.

Patients were cared for by staff, who were kind, caring and compassionate in their approach. Patients praised the staff, for their attitude and approach, using adjectives, such as "wonderful," and "absolutely fabulous". Patients were involved in decisions about their care and treatment. The service was planned to meet the needs of the people it served and care was responsive to people's individual needs and wishes. Systems were in place to manage and learn from complaints. There was strong and passionate leadership and a culture of openness, with an enthusiasm to further develop and improve services for the future.

Regarding safety, there were many aspects of good practice, including the reporting and management of incidents and infection prevention and control. The iMobile critical care outreach service provided excellent support to wards, but, in some areas, the identification

Medical care (including older people's care)

and escalation of deteriorating patients was inconsistent. In addition, nurse staffing in some wards and the environment within the renal dialysis unit needed improvement.

There was no formal approach to identifying the possibility of sepsis or implementation of Sepsis Six in the medical assessment centre or acute medical unit.

Are medical care services safe?

Requires improvement

There was a high nursing vacancy rate and, while this did not directly impact on the safety of care in most wards, we had concerns that the high vacancy rate combined with inexperienced staff on Cotton Ward could compromise the safety of care provided.

Improvements were also needed in the identification of deteriorating patients in some areas, although the support provided by the iMobile team for deteriorating patients was excellent. We found the layout of the renal wards was cramped with little storage room and there was a risk that this would have an impact on the safety of patients.

There was an open and transparent approach to the investigation of incidents. Staff were encouraged to report incidents when they occurred. Learning from incidents was given a high priority.

Infection control scorecards enabled the performance of each ward to be monitored against infection prevention and control priorities. Generally, the wards appeared to be clean and patients told us cleaning was regular and thorough.

Incidents

- There were no "Never Events" reported in medical service between February 2014 and January 2015. Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken.
- An online computer incident reporting system was used to report incidents and staff told us it was easy to report incidents when they occurred. Staff were encouraged to report incidents and they felt there was a good culture of reporting. One person said that during training they were told they were "not to keep quiet if you witness an incident", but to escalate and report it. We checked whether a fall which had occurred the previous day had been reported and saw that it was recorded on the incident reporting system.
- Most staff we talked with said they received good feedback when they reported incidents and action was taken to reduce the risk of similar incidents occurring in the future. Staff gave us examples of incidents which

had been reported and the action taken to prevent recurrence. For example, a doctor told us of an incident in which a person had received the wrong dose of a drug. They described the steps taken to ensure the safety of the patient, the investigation process and the action put into place to prevent recurrence, including the provision of additional training and changes to the procedures for the administration of the drug. However, three nurses and a junior doctor said they had not received any feedback following incidents and no action was taken. One person said they had raised concerns to "all levels in the chain" and said, "They are always friendly, but they never do anything about it. It's like hitting your head against a brick wall."

- One hundred and thirty-five serious incidents were reported in the medical service between February 2014 and January 2015. Of these, 84 related to pressure ulcers and 27 related to slips, trips and falls. The nurses we spoke with were aware of the trust's focus on reducing pressure ulcers and falls and told us of some of the initiatives that had been introduced across the trust to reduce the incidence. However, wards did not have specific action plans to address the factors pertinent to their individual ward. We saw the prevalence of new pressure ulcers was variable, but it appeared to be reducing from October 2014 onwards.
- Safety goals had been set to reduce the number of pressure ulcers and falls, but we did not see evidence of numerical values being attached to these. There were clearer targets for the improvements in compliance with infection prevention and control performance indicators.
- A process was in place for the investigation and escalation of incidents. We saw examples of the investigations and root cause analysis (RCA) which had been carried out in relation to pressure ulcers. A range of relevant professional groups were included in the RCA. Staff told us incidents were discussed at monthly multidisciplinary governance and risk meetings and the grading of the incident agreed on.
- Staff were aware of the 'Duty of Candour' which ensures patients and/or their relatives are informed of incidents that have affected their care and treatment and they are given an apology. They told us of incidents that had occurred which they had discussed with patients.
- Medical staff told us there was a robust approach taken at meetings to review mortality and morbidity. We saw evidence of mortality review meetings for each division, which appeared to be comprehensive.

Safety Thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections. Safety Thermometer data had been collected from all the wards on a monthly basis and the results were made available to the ward managers. Safety Thermometer results were not displayed centrally on the wards, but some wards kept the results in the folder of information for the nurse in charge.
- When asked about the action taken to improve, we were told of steps taken to increase the nurse presence in patient bays to provide better monitoring of patients at risk of falls.

Cleanliness, infection control and hygiene

- All the wards we visited were visibly clean. Cleaning schedules were in place and the housekeeping staff were conversant with the requirements of cleaning their area.
- Patients told us they felt the wards were very clean and we received positive comments from patients such as, "There is lots of cleaning, which is thorough and regular," and, "Immaculate, bed tables are cleaned and de-cluttered daily,." Another person said, "Yes, it is very clean. They've cleaned under my bed, including the rails, the floor and the locker top." There was one adverse comment on cleanliness from a patient on the renal dialysis unit. They said, "The only thing that is not right is the toilets. When I come here at 4pm they are usually filthy, all over the floor and the bowl." We checked the toilets and found the female toilet had an odour of stale urine, the toilet was un-flushed and there was no hand soap in the dispenser. A member of housekeeping was informed and 10 minutes later the soap had been replenished but the toilet remained un-flushed.

Medical care (including older people's care)

- Adequate hand washing facilities and hand gel were available for use at the entrance to the wards/clinical areas and within the wards. There was prominent signage reminding people of the importance of hand washing.
- We saw staff using the appropriate personal protective equipment (PPE) and following "bare below the elbows" guidance in the clinical areas. Clear signs were in place at the entrance to side rooms which were being used for patients with infections, giving information on the precautions to be taken when entering the room.
- There was an outbreak of norovirus (winter vomiting virus) on the medical wards at the time of the inspection. One ward was closed to all new admissions and several other wards had bays closed to new admissions to reduce the spread of infection. Appropriate steps were being taken contain the outbreak and the situation was reviewed on a daily basis. The Infection Prevention and Control Team were visible in the affected areas, providing advice and ensuring adherence to control measures. We visited one ward where there was only one bay in which patients were not symptomatic. We saw nurses were allocated to either an affected or unaffected bay, but we found that when patients required more than one nurse to move them in the unaffected bay, they had to use staff from an affected bay to provide care. This increased the risk of the spread of the virus to the unaffected bay.
- Staff on one ward told us they ran out of supplies of red alginate bags (used for contaminated linen) and disposable washbowls on a regular basis. There did not appear to be appropriate contingency plans in place for this and staff said they used disposable bed pans when they ran out of washbowls.
- Most of the equipment we examined was visibly clean and labelled to indicate it had been cleaned. There was a visual guide to indicate which group of staff was responsible for cleaning which equipment. We saw this displayed on some of the wards.
- The trust had an infection control score card giving performance against a range of infection control indicators, including hand hygiene compliance and adherence to the high impact interventions known to reduce infections and cleanliness audits. The wards had large display boards with key infection prevention and control messages and the performance score card for their ward.

Environment and equipment

- There was sufficient equipment available to meet the needs of the patients receiving care. There was a central equipment library and staff told us equipment not available on the ward was provided in a timely manner.
- Resuscitation equipment was stored on resuscitation trolleys on each ward. According to the trust policy, the resuscitation trolleys should be checked daily. We found the checks were carried out inconsistently on seven of the twelve wards where we reviewed the records of checks. On two wards either the security tag was broken or not in place, meaning that the contents could be tampered with.
- Fisk Ward and Cheere Ward were renal wards and cared for high dependency patients and those requiring dialysis. We identified a number of concerns with the environment when taking into account the mix of patients on the wards. The layout of the wards was cramped without a separate room for the cleaning of equipment. There was a lack of storage areas on the wards and the narrow main corridor was cluttered, with a range of equipment and patient information boards for the high dependency patients. The two toilets on the acute ward were away from the bays and accessed via a narrow corridor. This meant it was difficult to monitor patients in the toilets and if an emergency occurred and equipment was required to assist the patient, there would have been considerable difficulties in manoeuvring it into place. The room that was used for storing intravenous fluids was glass fronted and subject to large fluctuations in temperature. We did not see evidence of the temperature of the room being monitored and on one day when we visited, the room felt very hot. This may have impacted on the shelf life of the fluids. In addition, the room was not locked and inspectors entered the room unobserved and unchallenged on one occasion.
- The renal dialysis unit and endoscopy suite areas were prone to flooding following heavy rain. The ward area in the dialysis unit was also prone to flooding with sewage following heavy rain, or inappropriate material being flushed in the ward above. This happened on the day of the inspection and we were told this was the second time it had happened this year. There was a contingency plan in place to deal with it and the risk was recorded on the trust risk register. Patients were accommodated elsewhere when necessary, but they found it unsettling and disorientating.

- Systems were in place for the segregation, storage and labelling of waste and we saw the appropriate disposal facilities in place in the clinical areas.

Medicines

- Medicines were stored in locked cupboards or medicines trolleys. However, we found intravenous fluids were stored in rooms that were unlocked at the time of the inspection on Byron Ward and the renal wards.
- We observed medicines rounds in progress and saw staff checked the identity of patients prior to administering their medicines. We observed them talking to patients about how they liked to take their medicines during administration.
- An electronic prescribing and administration system was in place. This facilitated communication between the pharmacy and ward staff, which improved patient flow. We were told it had brought benefits in relation to patient safety, but there were some limitations in its ability to accommodate some requirements. For example, while warfarin was prescribed on the electronic system, staff identified issues in relation to their prescriptions when they needed to be changed on a daily basis and the visibility of these on the electronic system. We were told there had been two incidents in relation to warfarin in a month.
- To reduce the possibility of doses being missed a 'warfarin reminder' (which prompts review of the patient's INR and the need to review warfarin doses) was prescribed and appeared on the worklist manager.
- Pharmacists checked that the 'warfarin reminder' had been prescribed and add it if it had not. Changes were also made to the timing of blood tests for patients on warfarin to enable results to be available earlier.
- Pharmacist support to the medical wards was good and pharmacists completed the medicines reconciliation process. Pharmacists played a proactive role in checking the prescriptions charts and identifying issues.
- Nurses completed a training and competency assessment prior to administering medicines without supervision. However, the increased use of temporary staff and a high percentage of newly qualified nurses, limited the number of staff able to administer medicines on some shifts on some wards and this created pressure on the staff that were competent to administer medicines.
- We spoke with the clinical nurse specialists and they told us of the problems they encountered with being able to use their prescribing qualification. This was a source of frustration as it inhibited their practice and impacted on the care they could offer patients.
- There was a medicines safety committee within the clinical governance structure and when medicines safety issues were identified, communication was sent to the relevant areas in the form of alerts, emails, or posters to raise awareness and ensure key messages were received.

Records

- An electronic patient record (EPR) was in use and each profession involved in the care of the patient recorded information in chronological order in the clinical notes section. This section included the medical plan for the patient. The clinical notes provided a good description of the patient's progress.
- Nurses used paper documentation to record a standard range of risk assessments and care plans. We were told the documentation for this had been introduced two weeks prior to the inspection and had been piloted at the Princess Royal University Hospital prior to this. We found the completion of this documentation was variable and was particularly poor in the medical assessment unit and the acute medical unit (Oliver Ward). We reviewed six risk assessments in these units and five were only partially completed, despite the patients having been in the unit for more than six hours. We found care plans had not been initiated for three patients and had only been partially completed for the other three. As a result, it would have been difficult to identify the nursing care the patient required from the care record. For example, a patient who was a diabetic was receiving sliding scale insulin. There was a comprehensive chart to provide details of their insulin requirements in relation to the blood glucose results, but the nutritional care plan was not completed and there was no flag on the nutritional assessment to indicate the person was a diabetic. The risk assessments on the other medical wards were generally appropriately completed and reviewed. However, we found a bed rails assessment had been undertaken for one person, which indicated in the body of the assessment that bed rails should not be put in place, but the final recommendation was to use bed rails. There was no explanation for this.

- Staff had been involved in the development of the EPR and were very positive about its benefits. Mechanisms were in place to improve compliance with protocols and reduce risk. Staff said they found it helpful to see the input of all professionals at a glance. The mix of electronic and paper records increased the risk of omissions and duplication, but staff told us the documentation was continually being reviewed to reduce this.
- The electronic patient record required password access to ensure security. Patients' previous medical notes (hard copies) were stored in trolleys on the wards. Entries in the patient records were legible, dated and signed. However, some entries were not timed, particularly the nursing risk assessments.

Safeguarding

- Staff had access to an adult safeguarding policy and an adult safeguarding team were available to provide advice and guidance, when required. Safeguarding training was mandatory for staff and different levels of training were provided according to the job role. The training records indicated at least 72% of staff had attended safeguarding training on each of the medical wards. The target for the trust was 80%.
- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral. We were given examples of concerns they had identified and referrals made. Staff said they did not usually receive any feedback on the outcome of referrals. The adult safeguarding lead nurse for the trust said obtaining feedback from social care on the outcomes of referrals was difficult when it did not have an impact on the person's discharge and this therefore impacted on their ability to provide feedback to staff who had initiated the referral.

Mandatory training

- Mandatory training records were available on the intranet. Training records were graded red (training required), amber (training due and booked), or green (training undertaken). We reviewed the training records on several wards and saw there were a number of red training blocks. We were told there was a delay in attendance being added to the training database and compliance was slightly higher than the database suggested.
- Mandatory training covered a range of topics, including: health and safety, fire record keeping, infection control, information governance, moving and handling safe guarding adults and safeguarding children. There was a target for 80% of staff to have attended training. Compliance with mandatory training for blood transfusion, conflict resolution and fire were low (below 60%) on medical wards but the other topics were amber or green. On Cotton Ward only 50% of staff had attended resuscitation training. However, following a serious incident on the ward, there was an action plan for staff to attend resuscitation and ILS training and the ward manager took us through each of the staff who were showing on the database as requiring training, indicating the planned dates for their attendance.

Assessing and responding to patient risk

- An Early Warning Score (EWS) was in use to aid identification of deterioration in a patient's condition**.** When the vital sign observations were recorded in the EPR, the EWS was automatically generated. The staff we spoke with were fully conversant with the procedure for escalation when the score increased.
- We identified an inconsistent approach to escalation on Byron Ward, where one patient had an EWS which moved from one to five and should have triggered escalation, but the patient was not reviewed until the following day. Another patient's score increased from one to four, however, the nursing notes stated that the observations were stable.
- There was no formal approach to identifying the possibility of sepsis or implementation of Sepsis Six in the medical assessment centre or acute medical unit. Staff we spoke with were aware of the signs of sepsis, but were not familiar with Sepsis Six and the importance of commencing antibiotics within an hour of admission. This meant there was the possibility of a suboptimal approach to the identification and management of sepsis.
- A team called iMobile provided critical care outreach services and were available 24 hours a day, seven days a week. The service provided by the team was outstanding. The team consisted of specialist registrars and nurses (with at least five years critical care experience). During office hours, a critical care consultant was also part of the team. In addition to responding when a patient's condition deteriorated, the team was also able to help when a patient required a

high level of respiratory support, such as non-invasive ventilation or continuous positive airway pressure (CPAP) for a short period. The team would set up the equipment and a nurse could provide one-to-one support for the patient for up to four hours. If the patient's condition did not improve in this timescale, the iMobile team would facilitate the patient's transfer to the intensive care unit. The team could also review the EWS for individual patients through the EPR.

- All staff we spoke with were extremely positive about the support the iMobile team provided. A ward manager said they felt the service was exceptional and that it was "one of the things that makes King's an excellent centre".

Nursing staffing

- A tool to assess the nurse staffing requirements (the Safer Nursing Care Tool) was in use in the trust and the nurse staffing levels had been reviewed using this tool in conjunction with professional judgement. As a consequence, the ward nurse staffing levels had been increased on some of the medical wards. There was an increase in band 6 nurse posts to provide four band 6 nurses on each ward in the last financial year and the complement of band 5 nurses had been increased with the aim of providing a 1:5 registered nurse to patient ratio. However, we were told recruitment to the posts had been challenging and, at the time of the inspection, there were vacancies on most of the wards. A recruitment campaign had been undertaken, but there was some concern voiced that the recruitment process was very lengthy and the turnover such that the recruitment campaign had had a limited impact.
- A RAG (Red/Amber/Green) rating approach was used daily to assess the safety of staffing levels and used to inform escalation to the duty matron.
- Although we saw that most wards had shifts when they were operating at less than optimum nurse staffing levels, there was no visible impact on the safety of care provided. However, in some wards the percentage of newly qualified nurses was high, which impacted on the skills mix. This, combined with a high vacancy factor, resulted in high levels of stress reported by nursing staff.
- Cotton Ward had 50 % of their posts vacant and six of the registered nurses on the ward were newly qualified within the past six months. The newly qualified nurses had not completed their preceptorship competencies and felt they had received a lack of support when they had reported their concerns about the expectations placed on them and their need for additional training. There had been three serious untoward incidents on the ward, which identified deficits in nursing care. We discussed these with the ward manager, who described the action plan in place to address the issues. These included the need for staff to complete resuscitation training and Intermediate Life Support (ILS), to increase the numbers of staff able to administer medicines and to reduce the high usage of temporary staff. Additional support had recently been provided to the ward manager, but we were not confident that the issues were being resolved in a timely way.
- The trust limited the responsibilities of agency nurses until they had completed competency assessments. For example, agency staff were required to undertake the same competency checks as permanent staff prior to administering medicines. This reduced the risk of medicines errors occurring, but placed additional pressure on permanent staff by limiting the number of people able to give medicines.
- A pool of healthcare assistants had been created to provide one to one care (specials) for people who required close observation. Guidance had been provided for staff on how to manage the risks and the circumstances when one to one care might be required. Staff told us, managers were responsive when they identified the need for an additional person to provide one to one care for a patient and the creation of this pool had enabled them to secure additional support when it was necessary.
- A structured, standardised approach to handover had been introduced on the acute medical wards called 'One Best Way' to ensure key issues were covered and ensure handovers were concise and focused. Staff we spoke with said the handovers provided the information they needed to progress the care of the patients they were responsible for.

Medical staffing

- There were enough junior doctors to fill the medical roster. Junior doctors felt they had good support from senior medical staff and other foundation doctors. They said staffing was good and there was good cover.
- The proportion of consultants was slightly less than the national average. However, the staff we interviewed felt consultant cover was adequate in medicine generally. There were three unfilled vacancies in acute medicine,

which the consultants felt resulted in a high workload and impacted on the continuity of care, but not on patient safety. Some consultants' job plans had not been reviewed for over two years.
- A consultant trained in general or acute internal medicine was on call at all times and was able to reach the unit within 30 minutes.
- There was on-site consultant cover for acute medicine between 8am and 9pm Monday – Friday and 8am – 8pm Saturday and Sunday. There was 24 hour on-call consultant support for medical patients.
- We observed the handover to the Hospital at Night team and found there was good attendance from junior doctors from each specialty and there was effective handover of necessary information. However, there were multiple evening handovers at different locations, giving a fragmented approach.
- We observed two board rounds and two ward rounds and found they were carried out efficiently and effectively, with the appropriate staff present.

Major incident awareness and training

- Staff were aware of the trust's major incident procedure and how to access it via the intranet. There were action cards giving guidance for ward areas, and the wards kept a copy of their action card in their "Nurse in Charge" folder.
- There was a bed management system to ensure patients were placed appropriately when there was an increased demand on beds. When beds were not available on medical wards, patients were placed on surgical wards. There were procedures in place to ensure these patients were reviewed regularly by a consultant.
- When bed capacity was critical, senior managers responded by providing support to wards in accelerating patient discharge by liaising with other departments to ensure investigations and other issues causing blockages were progressed. .

Are medical care services effective?

Good

Patients received care based on the best available evidence and national guidance. The hospital scored highly in most of the patient outcome measures including National Heart Failure Audit, National Diabetes Inpatient Audit, Sentinel Stroke National Audit Programme (SSNAP) and Chronic Obstructive Pulmonary Disease (COPD) audit programme. These results indicated good adherence to evidence-based measures, which improved outcomes for patients.

However, there was no formal approach to identifying the possibility of sepsis or implementation of Sepsis Six in the medical assessment centre or acute medical unit. Also, readmission rates were worse than the England average for elective cardiology and non-elective general medicine and stroke medicine.

Patients gave their consent for care and treatment and were involved in decision making. Understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was variable and needed to be improved for some groups of staff, but we saw some good discussions and decision making in multidisciplinary teams in relation to this. There was an effective multidisciplinary approach to care and treatment and good communication between teams.

Evidence-based care and treatment

- Staff were aware of National Institute for Health and Care Excellence (NICE) guidance in relation to their specialty and we saw there was good access to the guidance on the intranet. There was a good range of locally produced evidence-based guidelines on the intranet, which were updated regularly. These were based on NICE guidance, where relevant. Staff told us they found the guidelines easy to access, comprehensive and clear.
- From the minutes of clinical governance meetings we saw that adherence to NICE guidance was discussed and any changes in practice disseminated. For example, we saw care pathways based on best practice in use in cardiology in relation to congestive cardiac failure and balloon valvuloplasty (the widening of a stenotic aortic valve using a balloon catheter inside the valve). We were told the care pathway for myocardial infarction was currently being updated.
- The endoscopy department had been accredited by Joint Advisory Group (JAG) and in the last six months had been recognised as a training centre.

Pain relief

- The nursing risk assessment documentation in use included a pain assessment tool.

- Patients told us that they were always asked about pain during medication administration rounds. The patient prescriptions we reviewed indicated that as required medication was prescribed for pain, where appropriate.

Nutrition and hydration

- A nutritional assessment was included in the nursing risk assessment document. We found an assessment was completed for most patients whose care records we reviewed, with the exception of patients in the medical assessment unit. A visitor on Mary Ray Ward told us the assessment recorded for their relative had been completed incorrectly indicating their relative had a good appetite when this was not the case. They had pointed it out to staff and it had been changed. We saw the score had been changed on the documentation, but when we discussed it with the nurse in charge they were unaware and told us they would look into it.
- Most patients said the food was good, but two people said the portions were too large. One person said they had been told they could ask for a small portion, but when they did they were told: "This is how it comes." Another person said despite asking for a small portion there was too much on the plate and this was "off putting".
- A jug of water was provided for each patient and changed daily. Hot drinks were provided at intervals throughout the day. Fluid balance charts were generally completed well with the balance being recorded when fluids were recorded. However, we found the totals were not always documented on the cardiac ward (Sam Oram Ward), but patients were weighed daily when required.

Patient outcomes

- The hospital scored highly in the National Heart Failure Audit, scoring above the average for all but one of the measures.
- There was good performance in the National Diabetes Inpatient Audit. These results indicated good adherence to evidence-based measures, which improved outcomes for patients.
- The hyper acute stroke unit (HASU) at the hospital achieved the fourth highest overall score compared to all national peers in the Sentinel Stroke National Audit Programme (SSNAP).
- The hospital achieved the highest organisational score compared to 15 national and London peer trusts and ninth out of 198 units nationally in the national Chronic Obstructive Pulmonary Disease (COPD) audit programme.
- Performance in all national audits were analysed and actions to improve performance were identified for all audits in which the scores were at, or below, the national average. As a result, 45% of audits for trauma, emergency and acute medicine had action plans.
- Monthly mortality review meetings were undertaken within each division and the mortality data was broken down at ward/team level looking at deaths as a proportion of total discharges. Deteriorating patient incidents were also discussed at the meetings and the root cause analysis information examined.
- Readmission rates were worse than the England average for elective cardiology and non-elective general medicine and stroke medicine. The hospital episode statistics for 2013/14 on Standardised Relative Risk of Readmission indicated how services compared nationally in providing care that was effective, such that patients recover and do not require a return visit to hospital. We spoke with the senior medical staff about this and there appeared to be reasons relating to the management of patients and coding when they returned for further investigations, which may have accounted for the raised rates.

Competent staff

- Junior medical staff said weekly training sessions were provided and they were normally able to attend these. They said there was a good mix of practical versus classroom teaching. They received good support and met with their clinical supervisor regularly.
- The senior medical staff we spoke with were conversant with the requirements for revalidation and all had dates for this. They all had received an appraisal within the previous year.
- Newly qualified nurses underwent a twelve-month period of preceptorship and had assessments to check their competency in key areas of the staff nurse's role. All nursing staff were required to undertake medicines training and a competency assessment prior to administering medicines unsupervised.
- Specialist nurses were available to provide advice and guidance on the care of specific groups of patients, such as those with diabetes and tissue viability issues. A

specialist nurse was available to review all those over 75 years of age who were being cared for on a general medical or acute medical ward and facilitated their move to a care of the elderly ward when it would improve their management. An Acute Coronary Syndrome (ACS) nurse had been appointed and was able to provide specialist advice to patients with ACS on outlying wards

- Staff on the coronary care unit said there were plans to accept level 2 (high dependency) patients onto the unit. For example, those who had had a tracheostomy. The staff we spoke with said there had been good training and support in preparation for this.
- Staff were scheduled to have their annual appraisal within the forthcoming month.
- Practice development nurses (PDNs) provided training and support to staff on the medical wards. Staff were positive about their input, but there sometimes appeared to be some uncertainty as to the division of responsibility between the ward manager and the PDNs for some aspects of training and assessment.
- A clinical housekeeper said they had undertaken induction and mandatory training, including: safeguarding, manual handling and infection control. They said they had been able to become involved in hand hygiene audits, infection control and environmental audits to facilitate their development.

Multidisciplinary working

- Staff we spoke with said there was good multidisciplinary working and support. The multidisciplinary EPR ensured good communication about the input of each professional in the care of individual patients.
- We observed good communication between different professionals and a respect for each other's expertise and input. We observed multidisciplinary meetings taking place and these were well attended and everyone's contribution was valued. A pharmacist said, "There's a big emphasis on equality of all the team members."
- There was good pharmacist support on the medical wards.
- We saw regular consultant-led multidisciplinary rounds. Patients' care and treatment were reviewed daily in ward areas, with action being taken to progress care.
- Staff on Sam Oram Ward said there was a five-day wait for occupational therapy following a referral. This caused delays into the progress of some patients.
- Medical staff felt there were good transitional services from paediatric to adult services in haematology through the teams working together.
- A dedicated social worker provided support in acute medicine and this facilitated safe and timely discharge.
- There was a multidisciplinary team for the homeless consisting of a nurse, a doctor, a social worker, a volunteer, and a housing worker specifically funded and working across King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust to facilitate timely and appropriate discharge and prevent readmission.

Seven-day services

- Consultants provided a seven-day service across medicine. They carried out ward rounds seven days a week in acute medicine areas. Care of the elderly areas piloted the delivery of weekend ward rounds over the previous winter period.
- A general medicine consultant covered the acute medical unit seven days a week and a care of the elderly consultant was contactable by telephone when out of hours and at weekends, and could get to the hospital within half an hour.
- In the acute medical unit there was pharmacist, occupational therapist and physiotherapist cover seven days a week. Therapists were moving towards a full seven day service, but some services were reduced at the weekend.
- In cardiology, there was a three tier consultant rota. There was access to echocardiology on a Saturday and there was an on-call, out of hours service covered by the registrar. Consultants said they had never had a clinically necessary scan delayed, but routine scans would wait until the Monday.
- There were two CT scanners working full-time at the weekend and neuroradiology reporting at the weekend.
- We were told the stroke service had no weekend therapist cover, which had an impact on their ability to discharge patients at the weekend when there was uncertainty about whether the patient was safe to go home.

Access to information

- On our visits to the medical wards we saw there was good access to computer terminals for staff and past

medical records were stored in notes trolleys on the ward. We were told there was no access to hard copies of past medical notes at the weekend, but more recent admission information was on the electronic system.
- Staff were positive about the EPR and said that, overall, it worked well but at times the system was very slow and would occasionally crash. We found it was slow at times when we reviewed some records during the inspection.
- Access to clinical guidelines through the intranet was easy and logically organised.
- A proforma in the nursing documentation was used to ensure key information was provided when a patient was transferred between wards. We saw this had been completed for a patient who had moved from another ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was taken from patients appropriately. We observed consent for a procedure being taken by a consultant in endoscopy and found it was carried out in accordance with guidelines. We were told some nurses had been trained to take consent for minor procedures in endoscopy.
- We saw documents were in place for consent to diagnostic scans and interventions. These were completed appropriately to show that patients understood the procedure and relevant risks.
- We observed staff explaining what they were about to do and checking their wishes prior to providing care. Patients told us staff sought their consent prior to providing care and treatment.
- We asked staff on the wards about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff knowledge was variable and most of the nursing staff said the medical staff were responsible for mental capacity assessments. They did not appear to have considered the need for capacity assessments in relation to the provision of the care they provided. For example, a patient with a brain injury on a cardiac ward was provided with a one-to-one special to provide constant observation and the implications had not been recognised. Staff on the care of the elderly wards were more knowledgeable about the Mental Capacity Act 2005 and we observed some good discussion and decisions about capacity in multidisciplinary team meetings. We saw evidence of a Deprivation of Liberty Safeguards application and authorisation for one patient.
- The adult safeguarding lead for the trust told us they had introduced training for staff on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and had prioritised the care of the elderly wards for training.

Are medical care services caring?

Good

People were cared for by staff who were kind, caring and compassionate in their approach. All the patients we spoke with, praised staff for their attitude and approach, calling them "angels" and using adjectives such as "amazing", "absolutely fabulous" and "wonderful".

Patients felt involved in decisions about their care and treatment and told us staff explained everything to them. A proactive approach was being taken to assess the experience of carers of people living with dementia who were admitted to hospital. This identified areas where improvement was needed and an action plan was in place to bring about improvement.

Compassionate care

- Medical services had introduced a compassionate care initiative to promote compassionate care and recognise good practice in relation to this. Seventeen behaviours or actions to demonstrate compassion in practice were identified. Staff were recognised for promoting and delivering compassionate care through monthly staff awards.
- All wards asked patients to complete a 'How Are We Doing' patient survey prior to discharge to obtain feedback from patients on their experience. Each ward had the results of the surveys displayed within the ward. Wards also identified the actions they were taking to improve.
- The hospital achieved a 42.4% response rate in the NHS Friends and Family Test in comparison to a national response rate of 30.1% (December 2013 to November 2014). Only two medical wards had a lower response rate than the national average, these were Cotton Ward (21%) and Mary Ray Ward (20%). The scores for the NHS

Friends and Family Test for the medical wards ranged from 67 out of 100 (Adult Cystic Fibrosis Unit) to 97 (Annie Zunz Ward and The Friends Stroke Unit) in November 2014.

- All the patients we spoke with said the nursing staff were kind, caring and cheerful. One person said, "Staff are amazing, absolutely fabulous, brilliant," and, "They are so amazing and caring. Day shift, night shift, right down to the cleaners," and, "Staff tell you their name, it makes things more cheery and makes you happier. Even my husband said 'Wow' about the staff." Another patient said, "The nursing staff are angels. They will do anything for me."
- Patients were also complimentary about the medical staff. One person said, "The doctors have a wonderful bedside manner." Another person said, "The doctors are very friendly and quite open." However, one patient said their consultant was very arrogant and they did not feel able to ask questions.
- We observed staff interacting with patients with a warm and caring attitude and when one patient called out, a nurse attended to them immediately, trying to calm the person in a respectful manner. We also observed two doctors talking to the relative of a person who was seriously ill. They talked to the person with compassion, answered questions and addressed their concerns.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in the decisions about their care and staff explained everything to them in a way they could understand. One person said, "My named consultant talked through the procedure and treatment." They went on to say, "Continuity is important and it's important to know who is taking responsibility, for example, nurse, consultant, etc; They have been very helpful."
- However, one person said that although they had been provided with information about the plan for their care, the procedures hadn't happened in the timeframe planned. The patient said medical staff did not return following their procedure as they had indicated they would and nurses were left with insufficient information on the management plan and the doctors could not be contacted. Two other patients commented on being given information as to when investigations and treatments would happen but there were delays and things did not happen as planned. They did not appear to have been given any reason for this.
- Patients requiring renal dialysis were shown a video of someone undergoing dialysis and then invited to the ward to see someone undergoing dialysis. They were given the opportunity to talk to current patients. This enabled them to gain an idea of what to expect.
- The endoscopy waiting room had had a display providing information on the waiting times.
- Each ward had a range of information leaflets available. This included generic trust information on topics such as infection control, bereavement support, chaplaincy, Patient Advice and Liaison Service (PALS), complaints and VTE, plus some relevant diagnosis/condition specific information, such as the sickle cell service, asthma and chronic obstructive pulmonary disease (COPD).
- The trust was taking a proactive approach to improving the experience and support offered to carers of people living with dementia. A Dementia Carers Audit was carried out in each quarter of 2014/15 to assess progress and obtain the views of the carers of people with dementia on the information provided and the opportunities offered to them to be involved in the person's care. The results from quarter three (October to December 2014) indicated that 93% of carers felt involved in the care of the person with dementia while in hospital 'sometimes' or 'always', but only 57% felt fully involved in the person's care. Less than 40% of carers were offered information on carer support or on a carer's assessment and less than 10% were given the King's College Hospital dementia leaflet. Further actions had been identified to improve.

Emotional support

- Staff on a haematology ward (Davidson Ward) told us they had access to a psychosocial worker, who provided support and counselling as needed. They would see patients, relatives and nursing staff either individually or as a group. The staff said they knew the patients well as they attended over a long period and it was helpful to have the opportunity to debrief, particularly when there was a bereavement.

Medical care (including older people's care)

- The chaplaincy also provided emotional support to patients, relatives and staff. The chaplains were available to people of all faiths and no faith if they wished to speak to them.
- The support provided by staff was appreciated by patients in general. However, one person said, they had been visited weekly by the chaplaincy and counsellor and also a volunteer and they did not want this. They said, "I feel the volunteer has be-friended me –it's not what I am after." They went on to say they had talked to a nurse about it and were hoping that it wouldn't continue. This illustrated the importance of staff not making assumptions about the support a person would like.

Are medical care services responsive?

Good

The medicine division planned their services to meet the needs of the local population. They had responded to the increases in numbers of emergency admissions and developed services to improve patient flow. Some patients were cared for in wards outside their specialty, but while this was not ideal, the safety of the patients was not compromised.

A number of initiatives had been developed to ensure the service met people's individual needs and those of vulnerable groups. Systems were in place to manage and learn from complaints.

Service planning and delivery to meet the needs of local people

- The medical assessment centre was opened in March 2014 to improve flow through the ED and reduce avoidable admissions. Most GP admissions entered the hospital through the ED prior to being allocated to an appropriate ward. The medical assessment centre had space for seven patients on trolleys and an additional ambulatory care area, where people were treated in chairs. The assessment areas were open from 8am – 10pm, accepting new patients up to 8pm. There was a specific ambulatory care clinic which operated Monday – Friday 8am – 5pm. The medical assessment centre was able to progress treatment of patients who were likely to need to stay less than eight hours and either facilitate their discharge, or admit them to an appropriate medical ward. Staff told us the ambulatory care area had allowed them to safely discharge patients with arrangements to attend the centre for further treatment or investigations, providing an effective safety net and reducing admissions.
- Comprehensive protocols for the management of sickle cell disease were developed in response to the increased number of patients in the local area with this condition.
- The trust had experienced issues in repatriating patients from neurosciences to their local area for rehabilitation, due to a lack of suitable community rehabilitation beds. There was ongoing communication with stakeholders and lobbying to look at improving the situation.
- A Family Stroke Group was developed to help families with decision making in relation to discharge destination.
- The population living in or around Bromley wanted to see development of the Orpington Hospital site to enable care to be provided locally. A decision was made to develop neurology step down beds at Orpington Hospital, but some patients were reluctant to transfer to Orpington Hospital. The needs and wishes of people were taken into account in the development.

Access and flow

- The hospital admitted most emergency patients through the ED, meaning there was unpredictability in the flow of patients. The MAC had been created to deal with some of the pressure this created and there were several pathways for patients requiring medical services, either through MAC, the acute medical unit (AMU), directly to a medical ward, or a combination of these. This provided flexibility for the service, but resulted in several moves for some patients through their admission.
- The creation of an ambulatory care area had increased the ability to prevent a hospital admission, but some patients highlighted the fact they were asked to attend at 9am and waited for extended periods before they had their investigations/treatment, resulting in a visit which lasted for most of the day.
- There was a clear bed capacity escalation plan to ensure optimal management when bed capacity was an issue. A RAG rating (red/amber/green) was used to identify the level of escalation and roles and responsibilities of staff were clearly defined. The plan

had to be put into action during the inspection and operational managers provided support to wards to facilitate the discharge of patients who were delayed for non-clinical reasons.

- We found there were 19 patients who were not placed in the appropriate specialty ward (outliers) on one day of the inspection. Two of these were placed on a surgical or gynaecology ward, while the remainder were placed on specialty medical wards, such as haematology or renal wards. We were told this was not an unusual situation. As a result, some consultants had patients on several wards and some wards had patients for up to five consultants, creating logistical issues in the timely review of the patients. However, we saw there were arrangements in place to ensure patients were seen by their own specialty consultant on a daily basis.
- We observed board rounds and found them to be effective, with input from different members of the multidisciplinary team. Expected dates of discharge were discussed and patients' progress assessed.
- Medical services were achieving the national target of treating 90% of patients within 18 weeks of referral in all specialties except gastroenterology, where they achieved 87.3% (April 2013 to November 2014).
- The average length of stay was longer than the England average in non-elective general medicine and cardiology. The challenging local demographics were felt to contribute to this in general medicine and in cardiology the complex case mix (the hospital provided a highly specialised tertiary service), was also a factor.
- Discharge summaries were sent to family doctors (GPs) electronically.

Meeting people's individual needs

- The hospital was working with a local charity which was based on the acute medical unit (Oliver Ward); and they were providing support to vulnerable people following discharge. They provided help with shopping, collecting prescriptions, signposting people to other services, and contacting social services or the housing department, when required. It was not available to people with a history of violence or challenging behaviour. Staff told us they usually saw approximately 40 people a month.
- A learning disabilities liaison nurse sitting within the adult safeguarding team was able to provide advice and support to staff when caring for a person with a learning disability. They encouraged the use of the 'This is me' documentation to help communication about the person and their individual needs.
- We saw a side room had been converted to an adolescent room with age appropriate furnishings and activities on the haematology ward (Davidson Ward) to cater for the needs of younger patients.
- In order to ensure people over 75 years of age who were not placed on a specialist care of the elderly ward received appropriate support, a King's Older People's Assessment and Liaison (KOPAL) nurse reviewed all patients who were over 75 years old on a general or acute medical ward. They also provided dementia/ delirium support for general nurses and facilitated admission to elderly care wards.
- Staff told us they were able to access a telephone interpretation service or face-to-face interpreters when patients were unable to understand or communicate in English. However, two staff we spoke with said they would only use an interpreter if the person did not have a relative to interpret for them.
- At the time of the inspection, there was a patient on the medical assessment centre who only spoke Mandarin. There were several references within the patient's records that reliance had to be placed on the information obtained when the patient's relative was present on admission as further information could not be obtained from the patient. No consideration had been given to obtaining an interpreter for the patient. This meant the patient received little information about their progress and they could not contribute to the ongoing assessment of their condition.
- The trust told us they had a leading edge dementia ward to meet the needs of people with dementia. However, we were not able to see this in action as the ward was affected by the winter vomiting virus (Norovirus) during the announced visit of the inspection.
- The hospital used a cook chill system and patients were able to choose from the full menu each day, providing a wide range of choices. Menus were available in Braille and other languages. One patient said, "There is a lot of choice and it looks lovely on the menu, but it is hospital food. After three weeks it's difficult to choose something." Another patient receiving chemotherapy said they were able to choose from three menus:

normal, cultural, and additional snacks for chemotherapy patients. They said the choice was very good, but it was not explained to them and communication was poor.
- Patients with liver failure had a special diet and had supplements prescribed. There was good access to a dietician when required.
- Following feedback from a recent 'How Are We Doing' patient survey, one ward manager told us of the steps they were taking to reduce noise at night.

Learning from complaints and concerns

- We saw leaflets on how to make a complaint and about the PALS, that were in the information leaflet racks on each ward. One of the patients we spoke with said they knew how to make a complaint and had been given a leaflet on admission to the ward.
- Staff told us they tried to resolve complaints and concerns at the time wherever possible. They told us they received feedback about complaints and the learning from them.
- A consultant described learning from a complaint in endoscopy. As a result of the complaint, they had worked with endoscopy user groups to explore the issues and now ensured patients were asked what signal they would like to use to alert staff if they wanted their procedure stopped.
- The matrons were responsible for coordinating complaints responses for their areas and had undertaken training in communication led by an external trainer. This was received very positively. Recently, medicine had moved towards telephoning complainants and offering more family meetings, as personal contact with the complainant helped to resolve issues and was viewed positively by complainants.
- Performance in respect of complaint response times was variable in trauma, emergency and acute medicine, across all sites. We discussed this with the head of nursing and they identified the importance of ensuring there was input from all the professions involved and a response which met the complainant's needs.

Are medical care services well-led?

Good

There was strong leadership and management within medical services. Managers were visible and approachable. There was clarity of direction for the future and strategies in place to define this. The opportunities and challenges for the service were recognised and there was an enthusiastic and committed approach to addressing these.

Governance structures and processes were in place and there was evidence of a commitment to continuous improvement.

Vision and strategy for this service

- The divisions within medical services had developed five-year strategies prior to the start of the new financial year. The strategies included further developing cross site and working with the Princess Royal University Hospital for acute medicine and working with other providers and community services in each of the divisions. The strategies included a commitment to further improve and extend seven day working.
- Staff were aware of the work carried out to define the trust's values and of the broad aims but found it difficult to articulate the specific values.

Governance, risk management and quality measurement

- A clinical governance structure was in place in medicine and staff felt it was effective. Each division held monthly clinical governance and risk meetings. We reviewed the minutes of three of the meetings and saw there was good attendance from the multidisciplinary team. Adverse incidents, infection control indicators performance indicators and patient feedback and/or complaints were reviewed.
- We saw evidence of a robust approach to root cause analysis being undertaken in response to serious untoward incidents. We reviewed three root cause analysis reports. There was a detailed analysis of the causes and contributory factors. Actions to prevent recurrence were identified and action plans put into place. Reviews had been completed to examine progress against the action plans.

Medical care (including older people's care)

- We heard about the work being done throughout medicine to reduce falls. This included review of staff breaks, increasing staff presence in the bay areas, and reducing clutter.
- We saw the risk register for the medicine division dated February 2015. Each risk had the 'RAG' rating, controls in place, the review date and the risk owner.
- The medical wards had quality performance information on display. This included an infection control scorecard and performance in the patient feedback survey. We saw evidence of a report for each of the wards bringing together information on their performance in relation to a range of indicators of quality and throughput.

Leadership of service

- A good structure was in place to provide support to staff at ward level through the ward manager, matrons, deputy head of nursing and head of nursing. We saw good communication structures were in place to ensure staff were involved, and aware of the priorities and developments within the service.
- Staff said managers were supportive and approachable and when they raised issues they were listened to and their concerns addressed. The exception to this was on Cotton Ward, where staff said they had raised their concerns about staffing, skills mix and training at a number of levels, but they did not feel their concerns had been addressed.
- Staff said the director of nursing visited their ward once or twice a year but they were not aware of visits from other board members.
- Medical staff were also positive about the support they received from their senior colleagues and peers.
- Ward managers and senior clinicians were visible on the frontline and closely involved with problem solving and the smooth running of the service.

Culture within the service

- Staff were proud to work at the trust and talked about the reputation of the trust for the provision of leading edge services. They said there was an open and transparent culture where people were encouraged to report incidents and where the emphasis was on learning from mistakes.
- We found staff were enthusiastic and committed to improving services for patients.
- There was an emphasis on the "King's way" of doing things and on effective team working. Staff felt valued for the contribution they could bring to the overall care of patients.

Public and staff engagement

- Staff we spoke with were knowledgeable about the plans for their service and the trust as a whole. At a meeting we held with the directorate management team including consultants and other professional leads, it was clear there was ownership of the issues facing the trust and a recognition of need to work together to take the service forward,
- The consultants we spoke with identified the challenges, which the trust had faced in merging with the Princess Royal University Hospital and said this had stretched human and financial resources, but overall they viewed it positively and identified the improvements at the Princess Royal University Hospital that had occurred as a result.
- The comments and results from feedback surveys completed by all patients prior to discharge were reviewed at governance meetings and used to identify changes needed.

Innovation, improvement and sustainability

- An extensive research programme has been developed in cardiology with participation in international, national and local research projects being undertaken.
- The stroke service were early adopters of the use of intermittent calf compression to reduce the risk of deep vein thrombosis (DVT).
- A project to reduce errors in medications at the point of discharge was initiated by pharmacy. A baseline audit had been carried out and there were plans to introduce a checklist for nurses to complete to identify if this brought improvement.
- There were pioneering specialist services in neurosciences, liver and haematology.

Surgery

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

Information about the service

King's College Hospital Denmark Hill Site is part of the King's College Hospital NHS Foundation Trust. Located in South East London on Denmark Hill and serving a population from London's inner city of 700,000 in the London boroughs of Southwark and Lambeth. The hospital is recognised internationally and nationally as a centre of excellence for treating patients with liver problems. The trauma and orthopaedics service is a tertiary centre, accepting complex referrals from surrounding areas.

The surgical directorate is divided into liver, renal and surgery division and theatres are part of the critical care and diagnostics division. There are nine surgical wards providing 199 surgical beds, 18 theatres and associated anaesthetic and recovery areas. There is a separate standalone day surgical unit with seven theatres. Surgical specialties include: neurosurgery, trauma and orthopaedic, cardiothoracic and maxillofacial surgery. Liver transplantation also takes place.

We visited a number of surgical areas, including: Katherine Monk Ward (general surgery), Kinnier Wilson Ward (neurosurgery), Coptcoat Ward (short stay surgery), Trundle Ward (general orthopaedic and maxillofacial) and Matthew Whiting Ward (orthopaedic and general surgery). We also visited preassessment, the day surgery unit (DSU) and operating theatres.

We spoke with 19 patients, which included general surgical patients being cared for on Brunel Ward and Cotton Ward. We spoke with 32 staff from a range of roles and grades and reviewed 14 electronic patient records and associated nursing documentation. We observed staff interaction with patients and general activity in all areas. In addition, we reviewed formal documented information supplied to us in respect to meetings, audit and duty rotas.

Surgery

Summary of findings

Referral-to-treatment times were not being met in a number of surgical specialties. Surgical procedures were sometimes cancelled and not always rescheduled and undertaken within 28 days. Theatre utilisation was not always maximised and there were cancelled procedures and delays in arranging surgery within expected timeframes. Patient flow through the surgical services was limited by availability of beds linked, at times, to delayed discharges.

Staff had not been able to complete all the required mandatory training, which supported the delivery of safe patient treatment and care. There was a lack of understanding regarding Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The recording of required safety checks for surgical patients was not always completed to a consistent standard.

There were good arrangements in place for reporting adverse events and for learning from these. Staffing arrangements in surgical areas were managed to ensure sufficient numbers of skilled and knowledgeable staff were on duty during day and night hours.

Consent was sought from patients prior to treatment and care delivery. Consultants led on patient care and there was access to specialist staff for advice and guidance. Procedures were in place to continuously monitor patient safety and surgical practices and patient care reflected professional guidance.

Surgical outcomes were generally good and results were communicated through the governance arrangements to the trust board. Patient experiences were positive with regard to the treatment and care by doctors, nurses and other staff.

Surgical staff spoke positively about their departmental leadership and felt respected and valued. Staff were generally aware of the trust's values, but had not been made aware of the strategic plans. Staff reported the surgical directorate as being a good place to develop their skills and expertise.

The governance arrangements supported effective communication between staff and the trust board. Risks that had been formally identified were continuously reviewed and discussed. The trust board was informed and updated with regard to service delivery and performance. The views of the patients and staff were sought in respect to improving and developing services.

Surgery

Are surgery services safe?

Requires improvement

Staff had not received all the mandatory safety training required to support the delivery of safe care and treatment to patients. The recording of required safety checks for surgical patients were not always completed to a consistent standard.

There was a formal process for reporting incidents and near misses, which was embedded in staff practice. The sharing of information, including learning from incidents, took place verbally and via electronic messages, in addition to minutes from meetings. Staff understood their responsibilities under the Duty of Candour legislation.

The surgical divisions reviewed mortality and morbidity outcomes in order to identify where improvements or changes needed to be made.

Performance was measured against required safety targets in respect to patient safety and risks. Where risks to patients were identified, these were acted upon. Staff monitored each patient's well-being in line with an early warning alert system and this was acted upon where a deterioration in the patient was identified.

There were effective arrangements in place to minimise infection risks to patients and staff. There was sufficient equipment to support the delivery of treatment and care. Medicines were managed safely. Arrangements were in place to ensure staffing numbers and the skills mix were appropriate to support the delivery of patient care safely.

Incidents

- Incidents were reported under different categories, ranging from general adverse incidents (AI) up to serious incidents (SI). A SI is a serious incident requiring investigation and we saw information which demonstrated that, where SIs occurred, these were investigated and reported to the Care Quality Commission (CQC) and other external agencies. The third category were Never Events, which is a 'serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers' (Serious Incident Framework, NHS England, March 2013).
- All staff we spoke with were aware of, and were able to describe, the reporting process for incidents, including actual or near miss situations. Medical staff told us they did not get any feedback from reported AIs, which they found 'frustrating', as they did not always know what action had been taken.
- Clinical staff understood the incident investigating process and even if not involved in this, reported having feedback as part of shared learning. Examples of the ways in which shared learning took place included through the monthly anaesthetic and surgical bulletins and through the Surgical Safety Improvement Group. We noted improvements had been discussed in relation to positive patient identification in the latter group meeting minutes held on 2 March 2015.
- A newsletter titled 'Safety in Anaesthesia and Learning from Incidents' (SALI) April 2015 was provided to us. This included detailed information around many aspects of anaesthetic matters relating to safety and best practice, including learning from incidents.
- We reviewed the information generated via the formal reporting system for the hospital and noted that this identified the location, type of incident, category and subcategory. For example: the ward name, pressure ulcer, where it was acquired and the grade of the ulcer. A description was seen, along with action taken and progress of the investigation. We noted that, where a serious incident occurred, this was referred for discussion at the surgery quality and risk committee. Serious incidents were also reported to the National Reporting and Learning System (NRLS).
- Minutes from the surgery quality and risk committee held on 19 May 2014 were provided to us to demonstrate learning from incidents. We could not identify from these any specific learning, as the level of recorded information was limited. Similarly, the minutes from the surgical governance meeting of 1 January 2014 did not specifically identify any learning from incident review. We did, however, see information which we considered to be informative for staff within the surgery quality and risk committee minutes recorded for the 16 February 2014. For example, information relating to patient weights and wound management.
- A 'mystery shopper' audit had been carried out in December 2013, related to surgical safety. This identified the progress on actions taken at the time, and included

for example, a site marking policy and revision of surgical count policy. Recommendation included the audit of compliance as part of the divisional scorecards from March 2014.

- Divisional scorecards were viewed for January, February and March 2015, and it was noted there was no information related to safe surgical checks having been monitored. Further, we noted from the March 2015 medical record-keeping audit, that the completion of safety checklists was not included in the review process.
- Safer surgery audit results for December 2014 provided a summary of surgical Never Events for the period January 2012 to November 2014. The majority of which had occurred in oral and ophthalmic surgery, each having three incidents, followed by two in anaesthetics. The three ophthalmic surgery Never Events were reported between September and October 2014 and related to two wrong lens implants and one wrong site surgery. A further Never Event took place in January 2015 in ophthalmology and on this occasion it was a wrong patient.
- Staff working in the theatre departments, including the day surgical unit (DSU) were aware of the Never Events. We observed evidence on display in the DSU staff room, which described the Never Events related to the ophthalmic incidents and the action plan for avoiding similar occurrence.
- There had been 40 serious incidents (SI) reported between the period of February 2014 and January 2015. Each incident was graded in terms of seriousness and was accompanied by root cause analysis, contributory factors and recommended actions.
- We noted from information provided to us that patient falls and pressure ulcers were tracked by ward. These incidents were also rated as 'avoidable' or 'unavoidable', with avoidable incidents generating an action plan review. A pressure ulcer adverse incident summary was reviewed by us and we saw that the formal process for investigating the matter was detailed and thorough. Actions arising from this had been generated and included staff education.
- Mortality and morbidity meetings were taking place as part of the audit half days held on a monthly basis.
- We reviewed the divisional updates respecting the mortality monitoring committee meeting presentation for plastics, orthopaedics, trauma and ENT for January to December 2014. This reported on 21 deaths, of which 19 were expected. Quality issues identified within the review related to venous thromboembolism, where patients were day case admissions or those who had immobilised lower limbs.
- The divisional update for general and colorectal surgery for the same period indicated that there had been 20 deaths in a period of six months and in urology, four deaths. Information reviewed within the report identified case mix issues and quality issues, some of which had been subsequently resolved. Key actions to be taken forward related to the development of more robust governance arrangements. It was also noted that the directorate was making good progress with regard to the governance and reporting process.
- We also reviewed the minutes of the mortality monitoring committee for 16 July 2014. It was reported that for the 12 months up to May 2014, the Summary Hospital-level Mortality Indicator (SHMI) for in-hospital deaths at the Denmark Hill site was 58, which was the same as the peer average and the hospital ranking remained at eighth compared to the peer group of 14 trusts at the time.
- We saw there was a 'Duty of Candour – Being Open' policy, which was accessible to staff. Staff had an awareness of the Duty of Candour. For example, one operating department practitioner said it was about, "Accepting responsibility, apologising and rectifying what could be done." A ward nurse said it was about transparency and honesty. For example, if a patient fell, having a responsibility to tell the family.

Safety Thermometer

- The NHS Safety Thermometer is a local tool used for measuring, monitoring and analysing patient harm and 'harm free' care at a particular point in time. The trust also collected data on all incidents of harm free care and reported on this via the divisional score cards and other reports.
- Variable rates in respect to falls, pressure ulcers and catheter and urinary tract infections were reported to us as part of the pre-inspection information. We saw on wards we visited that information was displayed regarding quality indicators. For example, on Katherine Monk Ward there had been eight hospital-acquired pressure ulcers in the last three months up to our visit. On Coptcoat Ward there had been one hospital-acquired pressure ulcer in the three months prior to our visit.

- Pressure ulcers were also recorded as part of the surgical division performance metrics. January and February metrics indicated that there had been five hospital-acquired pressure ulcers in both months, which exceeded the target set at two.
- Performance metrics for the surgical directorate indicated there had been one patient fall in January 2015 and none in February 2015.

Cleanliness, infection control and hygiene

- Staff working on wards and in theatres told us they had infection prevention and control (IPC) link nurses. Their role was said to include attending IPC meetings and checking that staff followed policies and procedures. In addition, they undertook IPC checks, such as hand hygiene monitoring and checks on the cleanliness of the environment.
- We observed that there were dedicated staff for cleaning ward areas and they were supplied with nationally recognised colour-coded cleaning equipment, which allowed them to follow best practice in respect to minimising cross contamination.
- Domestic staff told us they had enough equipment to undertake their duties and they showed us guidance as to their responsibilities on each shift. Cleaning scores were displayed on wards and we saw, for example, on Katherine Monk Ward the score ranged from 98% in January 2015 to 99% in March 2015.
- Operating theatres were found to be clean on inspection. There were separate clean preparation areas and facilities for removing used instruments from the operating room ready for collection for reprocessing by the external decontamination service.
- Theatre staff told us the theatres were cleaned at night and theatre staff cleaned theatres between cases during the day. Technical theatre equipment was cleaned by staff and we observed items were clean and recorded as ready for use.
- A cleaning audit was completed in respect to theatres and we reviewed an example of this for October 2014. This indicated that the overall cleanliness was 95%. Corrective action had been recorded within an action plan and subsequent reaudit carried out in November 2014.
- Theatre staff received cleaning updates within the main theatre newsletter and we saw evidence of this in the newsletter for November 2014 that was supplied to us.
- The surgical wards we visited were clean and patients we spoke with all provided positive feedback on the level of cleanliness and their satisfaction with the standards. There were formal arrangements in place to direct domestic staff as to the required levels of cleanliness and routines. We saw cleaning results scores displayed on wards. For example, on Trundle Ward they achieved 98% in January and 96% in March 2015.
- As part of the 'Commit 2 Care' award, which surgical wards were participating in, we reviewed audit results for Coptcoat Ward that indicated 100% compliance in the November 2014 audit of infection control and the environment.
- We observed that there was access to personal protective equipment, including gloves and aprons in all areas visited and staff used these during the course of their activities.
- There was access to Infection Prevention and Control (IPC) policies and procedures via the trust intranet and we sampled these and found they were up to date.
- Staff compliance with local infection control policies was noted to be good, with all staff 'bare below the elbows' to enable thorough hand washing. Staff had good access to hand washing and drying facilities. We observed regular use of these facilities by nursing and Allied Health Professionals. We observed that medical staff did not gel their hands on entry or exit on Katherine Monk Ward. However, we saw they used hand gel before attending to a patient.
- Hand hygiene audit results were displayed on some wards. We saw that, on Kinnier Wilson Ward (neurosurgery) results of the most recent audit indicated 97% compliance. On Coptcoat Ward the results displayed indicted 97% compliance on 7 April 2015.
- Hand hygiene results were included in the surgical directorate performance metrics. We saw results for January and February 2015. These indicated a score of 78% and 80% respectively, which was less than the expected target of 95%.
- We observed staff complying with the policy in respect to the handling and management of clinical and domestic waste. We saw bed linen was handled in accordance with best practices and sharps were disposed of safely.
- We observed the handling and management of surgical specimens in theatres was done in a safe manner.

Surgery

- Surgical staff working in theatres were seen to follow National Institute for Health and Care Excellence (NICE) guideline CG74, 'Surgical site infection: Prevention and treatment of surgical site infection (2008)'.
- We saw there was a protocol for staff to follow in respect to identifying and responding to sepsis. During ward handover, staff reported a patient who would need to be cared for as per the sepsis pathway if their temperature was elevated when next checked.
- Infection control scorecards provided to us showed that patients were screened preoperatively for MRSA, in line with local policy. In the November 2014 scorecard for surgery, we noted that 100% of elective patients had been screened and 99% of emergency patients. We observed one patient arrive in theatre, while we were present, having had their MRSA swab carried out the previous day and the results were not known. This was not picked up by the staff member and was pointed out by our specialist adviser.
- Isolation signage was in place, where required, on the doors to patient rooms.
- Equipment used by patients, including shower stools and commodes, for example, were inspected and found to be clean. Labels had been attached to items indicating when they had been cleaned and by whom.
- There was a standard operating procedure (SOP) in place regarding the arrangements for a decontamination service providing surgical instrumentation. The SOP also provided instruction to staff as to when to raise an incident, such as when operations had to be cancelled because of dirty instrumentation or instrument rust. We noted from information provided that one patient had been cancelled because instrumentation was not available in March 2015.
- Data reviewed on the November 2014 infection control scorecard indicated that in surgery there had been no MRSA bacteraemias, no vancomycin-resistant enterococci (VRE) and one meticillin susceptible staphylococcus aureus (MSSA) bacteraemia. There had been two clostridium difficile cases in the month and two the previous month, which remained under the targets for the whole year.
- Performance metric information for January and February 2015 indicated that there had not been any MRSA, VRE or clostridium difficile in either month.
- Wards displayed information which indicated the number of infections. For example, on Katherine Monk Ward they had not had any MRSA infections but indicated the two cases of clostridium difficile had occurred there.
- Infection prevention and control training was part of mandatory training for nursing staff. Infection control training attendance for theatres was provided to us during the visit. We saw 89% of the orthopaedic staff and 81% of general theatre staff had completed training, against a target of 80%.
- Theatre staff also undertook aseptic non-touch technique training regarding wound management. There was 100% attendance from orthopaedic theatre staff and 62% at the half year target for general theatre staff.
- We saw in training figures supplied that the attendance rate for infection control was set at 80% within the liver, renal and surgical division. The attendance rate achieved overall was indicated as 75%. Ward specific training information was also supplied to us and this indicated that, for example, 61% of Coptcoat Ward staff, 65% of Matthew Whiting Ward staff and 90% of Trundle Ward staff completed this training in the year prior to the inspection.
- A brief summary of IPC was seen to be included in the annual report and accounts for 2013/14.

Environment and equipment

- Ward areas were not always designated for specific types of surgery. For example, Brunel Ward was general surgery and gynaecology.
- The separate day surgical unit (DSU) had 27 trolleys and seven operating theatres, with three anaesthetic rooms. There was also a chair area used for ophthalmic patients who did not have a general anaesthetic (GA). The DSU was designed to facilitate flow from arrival in the admissions lounge through the trolley-based ward area, where patients were prepared for surgery, prior to being taken directly into the anaesthetic room and theatre. They were not required to move on to a separate operating table, except if they were having eye surgery under a GA. Patients were recovering in a small area outside of theatres before going back to the ward area.

- There were ten main surgical theatres and three neurosurgical theatres. Laminar flow was available in orthopaedic theatres. Separate recovery areas were provided and these were seen to afford privacy.
- Wards and theatres were accessible to individuals with disabilities and technical equipment was available to support individuals, where required. This included hoists, adjustable beds and bariatric chairs and commodes.
- Emergency equipment for resuscitation was available in each area and we found this had been routinely checked. There was access to emergency equipment in theatres, such as items required for emergency intubation.
- The Association of Anaesthetists of Great Britain and Ireland safety guidelines Safe Management of Anaesthetic Related Equipment (2009) was being adhered to. This included electronic safety checks of anaesthetic machines at the beginning of operating sessions, results of which were recorded on a central server.
- Arrangements were in place to service equipment via the Medical Equipment Management Service (MEMS), including portable electrical items and we saw evidence of such checks on equipment. Staff told us they had enough equipment to enable the safe and effective delivery of care. Equipment was accessed through the library, with a delivery and collection service to support this.
- Single use equipment, such as: syringes, needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner. We did find some items of equipment had expired on Matthew Whiting Ward and that stock rotation was not managed effectively. Items that had expired included: blood culture bottles, spiral manometers, shaving cream and surgical scrub solution.
- Staff told us the corporate induction covered equipment use and the practice development nurse did a three-day induction with newly qualified staff, during which they went through use of intravenous pumps and other items.
- Surgical instrumentation which required decontamination between patient use was outsourced to an accredited unit, with a service level agreement in place.
- Staff had access to training regarding medical equipment. We saw, for example, training information pertaining to Matthew Whiting Ward staff, which indicated average training attendance was 56%. We noted from the information supplied that two staff nurses had not completed any training on the use of technical equipment.

Medicines

- We made checks regarding the ordering, storage, administration and disposal of medicines on surgical wards and in theatres. Staff told us there was regular contact with the pharmacy staff in order to top up supplies and for ordering. We observed that medicines were stored safely and appropriately, including items which needed to be stored in refrigerated conditions. Temperature checks had been carried out on fridges.
- Medicine trolleys were locked securely and could not be accessed by anyone other than staff. Controlled drugs were stored in locked cupboards, which were secured to the wall within a locked room. We checked controlled drug registers on wards and in theatres and record keeping regarding checks and administration were in order.
- Pharmacy staff had undertaken an audit of staff compliance, with requirements around controlled drug management in February 2015. We saw audit results for a number of surgical wards, which were rated as 'green' for satisfactory and 'red' for unsatisfactory. We noted by way of example that, in respect to each entry being complete and having a signature by two nurses, four surgical wards were unsatisfactory in quarter one (2014/15), two of which were also unsatisfactory in the previous quarter. Staff were made aware of the need to improve in areas indicated by the audits.
- Information on the results of theatres audit for quarter four had been communicated to theatre staff via the main theatre newsletter in November 2014. We saw there were three areas which were identified as requiring attention. This included each entry needing to be signed by two nurses, errors needing to be signed by two nurses and dated and to be crossed out with a single line, or bracketed. The audit for February 2015 indicated general improvement in theatres, with only a limited number of identified theatres requiring further improvement. Recommendations were identified within the audit.
- Nursing staff explained how the pharmacy reviewed the medication needs of new patients and completed the electronic patient record. Prescribing of regular

medicines, as required medicines and take home items was undertaken by medical staff. Coptcoat Ward had an efficient system in place for ordering and managing the patients' take home medicines. Pre-packed take home medicines were placed in a designated cupboard and an entry was made of this on a wipeable board. Once the medicines were given to the patient, the name was removed from the record. Pre-packed medicines were checked by the pharmacy staff weekly.

- We observed medicines were given to patients by nursing staff in accordance with the prescription and that safety checks were carried out during medicines administration. Patients told us staff always checked their name band and confirmed their personal details before giving them medicines.
- Staff had access to up-to-date guidance on medicines and received advice from pharmacy staff, as well as newsletter information.
- We were informed by a new member of nursing staff that they were required to complete a medicines administration test before they could administer medicines to patients.
- The Theatre User's Medicines Management Group meeting held on the 2 February 2015 indicated that medicine stock was discussed, along with risk reports, trends and action plans. It was noted that adverse incidents related to medicines were to be discussed at the clinical governance and risk meeting being held on 4 February 2015.
- Antibiotic stewardship was taking place and information reviewed by us for the period November 2014 indicated that clinical indications for antibiotics was recorded in 99% of patient records and stop/review dates had been recorded in 94% of cases. In both indicators this was better than the target.

Records

- The surgical areas used a combination of electronic patient records (EPR) and paper documentation for recording information. We found the EPRs were detailed and provided clear information regarding the patient journey, investigations and treatment. Similarly, paper records had been completed to a standard, which enabled staff to follow the information.
- There was multidisciplinary input to EPRs where required, which included entries made by physiotherapists, occupational therapists and dieticians. We noted evidence of referral to specialist advice, including the speech and language therapy team (SALT).
- The EPRs contained evaluation and progress notes, as well as information regarding discharge planning.
- We observed that separate nursing records were held at the patients' bed ends. These included risk assessments, such as assessment of moving and handling, skin integrity, nutrition, use of bed rails and venous thromboembolism (VTE). Intentional rounding at regular intervals provided an opportunity for nursing staff to check the status of the patient and to update risk assessments accordingly.
- We reviewed formal documentary records regarding specific care plans which were being used. For example, care plan for the management of orthopaedic patients and patients who had undergone maxillofacial surgery. Staff reviewed progress against these plans and updated the EPR to indicate any changes.
- We reviewed an audit of the completion of paper and electronic patient records, which included consent. The results were reported on 23 March 2015 and indicated that there was a higher level of compliance with the electronic record completion than paper records. Conclusions and recommendations were identified within the report, which were to be shared with the patient safety committee and the medical director's office.
- Record keeping was part of mandatory training and we saw that within the renal, liver and surgical directorate attendance by nursing staff had exceeded the target, with attendance at 89%.
- We observed theatre staff following the 'five steps to safer surgery' procedures (Patient Safety First campaign) – an adaptation of some of the steps in the WHO surgical safety checklist, which included team brief, sign in, time out, sign out and debrief. However, theatre staff were not fully completing the checklists based on the World Health Organization (WHO) safety procedures to safely manage each stage of a patient's journey from ward through anaesthetic, operating room and recovery. There was an absence of signatures against staff names on five out of eight of the WHO charts checked. WHO checklists were not complete for day surgical patients in the DSU.
- We noted that theatre site safety checklists were not completed for all surgical patients, despite there having

been three never events related to failure in the safety checking processes. This section of the patient record forms part of the pre- and postoperative patient journey from ward to theatre and back. The discrepancies related to the absence of recording of the site to be operated on.

- Patient records contained evidence of attendance at the preoperative assessment, where relevant. Information included, for example: patient demographics, previous medical and surgical history, allergies, and medicines, along with baseline observations. Anaesthetic risk scores were used to ensure that only those patients suitable for day surgery were admitted as such.

Safeguarding

- The majority of nursing staff had a good level of understanding and knowledge around this subject. They were able to indicate the transfer of knowledge from training by responding to our questions around indications of possible safeguarding concerns. Staff were clear about the escalation process and accessibility of the safeguarding team.
- Staff had access to a safeguarding protocol and named staff who were able to support staff in this area.
- Information provided indicated compliance with level 1 safeguarding training by ward. For example, it was reported that there had been 100% attendance by staff on Trundle Ward and 50% on Coptcoat Ward.
- The training figures supplied to us indicated that there was a target attendance rate set at 80% for level 2 safeguarding children and that 79% of nursing staff in the liver, renal and surgical directorate had attended this. At level 3, it was reported that 82% of nursing staff had attended the training, which was above the 80% target.
- Adult safeguarding training at level 2 had been attended by 79% of nursing staff in the surgical and liver division, against a target of 80%.

Mandatory training

- Staff confirmed they completed a range of subjects as part of mandatory training, with varying frequency, depending on the subject. For example, information governance annually, manual handling once only, slips, trips and falls every three years and venous thromboembolism once only.
- Wards held training records that indicated the individual staff who had completed training. The records also indicated training that was due to expire and those who were out of date or had not completed their training. All wards had gaps of varying degrees. For example, Kinnier Wilson Ward had staff who were out of date with training in moving and handling, information governance, resuscitation and safeguarding. Staff on Matthew Whiting Ward and Katherine Monk Ward were out of date with training regarding information governance, resuscitation and end of life care.
- Mandatory training information supplied indicated a broad range of subjects covered, including health and safety, moving and handling and resuscitation. Target attendance rates were set at 80% and we saw that, in most subjects, this target had not been achieved in the liver, renal and surgical directorate. For example, resuscitation training had been attended by 74% of staff, moving and handling by 66%, health and safety by 79%.

Assessing and responding to patient risk

- Nursing staff undertook a range of patient observations and recorded physical measures as part of an early warning score monitoring system. Recordings were entered into an electronic tool, which calculated the results so that any negative changes within a range of parameters prompted staff to raise an alert. Staff told us they called medical staff and that they were very responsive to requests to review patients who deteriorated. We were also told that the electronic system enabled medical staff to see the results directly and they were able to respond occasionally, even before called.
- Safety briefings took place as part of the staff handover between changes in shifts. Information regarding patient condition and particular risks was discussed.

Nursing staffing

- Clinical staffing on wards and in theatres was managed in a manner which minimised risks to patients, particularly where there were vacancies or staff absences.
- Each ward area we visited had an identified member of staff taking charge of the ward. Optimum staffing levels were displayed on wards, with the number of qualified staff and healthcare support workers on each shift. We saw actual staff numbers displayed, which indicated if the optimum levels were being met or not, with staff to patient ratios stated on some areas. For example, we saw on Katherine Monk Ward, they were short of a healthcare support worker on the early and late shifts of the 13 April 2015. On Trundle Ward the optimum levels

had been met for the days of our visits, based on having four trained nurses on the early and late day shift and two on night duty. There were two healthcare support workers per shift. The ratio of patients to nurse was said to be 1:5 on days and 1:8 on nights. On Coptcoat Ward the ratio of nurse to patients was 1:4.

- We reviewed information supplied regarding the number of agency nursing staff used on each ward to supplement substantive staffing. We saw that all surgical wards relied on agency staff to varying degrees. For example, on Coptcoat Ward, agency use ranged between 10% in June, November and December 2014 up to 35% in August 2014. Christine Brown Ward used 12% of agency staff to support the service in December 2014 and used 35% agency in July 2014. Although we were told on our visit to Kinnier Wilson Ward(neurosurgery) that they never used agency staff, we saw from the data supplied that Kinnier Wilson Ward, along with Matthew Whiting Ward (orthopaedic and general) were noted to be the most dependent on agency staff, with figures frequently above 20% of the nursing workforce during 2014.
- Agency staff worked alongside substantive staff, and therefore had access to support and guidance if required.
- We were told by theatre staff the main theatres at the Denmark Hill site were using regular agency to cover maternity leave and vacancies. Figures supplied to us indicated that the percentage of agency staff used ranged from 3% in October 2014 up to 5% in March 2015.
- We were shown the induction documentation, which was completed for agency staff working in theatres. This covered, for example: orientation to the environment, emergency equipment and accessing trust policies and procedures.
- Bank staff, who, in the main, were substantive staff who worked on their days off, were also used to supplement the staffing levels in theatres. We saw from the information provided, 13% of shifts were filled by bank staff in November 2014. Duty rotas provided for theatres indicated where bank staff were required to bring the staffing levels up to the required numbers.
- Use of agency staff to support the day surgery unit ranged between 4% in March 2015 up to a maximum of 6% in November 2014. Bank staff usage ranged between 11% in December 2014 up to 17.5% in March 2015.
- Staffing figures were supplied to us by ward and were based on bed numbers. Trundle Ward had 28.30 whole time equivalent (WTE) staff, Coptcoat Ward had 26.49 WTE, Matthew Whiting Ward had 40.38 WTE and Lister Ward the highest WTE number of 48.82. Specialist nursing made up 11.91 WTE. In orthopaedics there were 47.46 WTE and in urology, 13.25 staff.
- Theatre staffing figures provided indicated that in anaesthetics there were 38.90 WTE and recovery had 32.45 WTE. There were 146.95 WTE scrub staff.
- Vacancies across the liver, renal and surgical division were 35.92 out of the total number of nurses required.
- We attended a nurse handover from night staff to day staff on Trundle Ward and found this was a very well structured means of communicating patient sensitive information and each patient's condition. In addition to this, there was discussion of the 'big six' issues, which included, for example: focussing on fridge temperatures, completing new admission documentation and checking expiry dates on blood bottles.
- Office based handover was followed by bedside handover, during which, staff introduced themselves and updated the electronic patient records. A whiteboard, placed above the patient bed, was also updated to reflect the named nurse responsible for the patient's care during the shift.

Medical staffing

- Medical staff skills mix in the surgical divisions was made up of 39% consultant grade, 53% registrars, 7% juniors and 1% middle grade, the latter of which related to doctors who had at least three years as a junior doctor or a higher grade within a chosen specialty.
- Although the proportion of junior doctors was reported as being lower than the England average, we reviewed duty rotas provided for the surgical directorate. These indicated consultant and substantive doctors by grade covering the day hours and on-call periods. We saw where a locum doctor was rostered, that this was indicated and generally this locum was the same individual, ensuring continuity and familiarity. There were identified individuals covering out-of-hours weekends and nights.
- Figures on the percentage of medical locum use was supplied to us. These indicated that within the liver, renal and surgical directorate, 4% of the medical staffing workforce was made up of locums in September 2014 and in December 2014, 8%.

- Handovers took place between outgoing and on-coming medical staff, ensuring the communication and transfer of relevant patient information.

Major incident awareness and training

- A new member of nursing staff said that major incidents and continuity plans had not been discussed in their induction. As a result, they were not aware of what action, if any, would need to be taken on the ward they were on.
- There was formal guidance available to staff regarding the actions to be taken in the event of a major incident. This included the cancellation of elective work to prioritise unscheduled emergency procedures.

Are surgery services effective?

Good

There was a lack of understanding regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Patients had been assessed, treated and cared for in line with professional guidance. The majority of patients reported effective pain management and monitoring of this.

The nutritional needs of patients had been assessed and patients were supported to eat and drink according to their needs. There was access to dieticians and the speech and language therapy team. Special medical and/or cultural diets were catered for. Patient surgical outcomes had been monitored and reviewed through formal national and local audit.

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

Consultants led on patient care and there were arrangements in place to support the delivery of treatment and care through the multidisciplinary team and specialists. There was access to diagnostic services out of hours.

Evidence-based care and treatment

- Information reviewed from data supplied and seen during our inspection indicated that patients' treatment and care complied with National Institute for Health and Care Excellence (NICE) guideline CG124, 'Hip fracture: The management of hip fracture in adults'. This included, for example, patients being operated on the day of, or day after, admission and having a bone health assessment.
- We saw, from care records reviewed, and found in our discussion with staff they were following NICE guidance on falls prevention, the management of patients with a fractured neck of femur, pressure area care and venous thromboembolism. The latter included guidance related to anticoagulant therapy.
- We observed that patients who had attended a preadmission assessment had preoperative investigations and assessment carried out in accordance with NICE clinical guidelines. This included following guidance regarding medicines being taken by the individual patient.
- There were processes in place for patients receiving postsurgical care to be nursed in accordance with the NICE guidance CG50, 'Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital'. This included recognising and responding to the deteriorating condition of a patient.
- Within the theatre areas, we observed that staff adhered to the NICE guideline CG74; 'Surgical site infection: Prevention and treatment of surgical site infection', relating to surgical site infection prevention. Nursing staff followed recommended practice in respect to minimising the risk of surgical site infections. There was a sepsis pathway to follow where patient needs indicated.
- We noted from the Divisional Effectiveness Report for Critical Care, Theatres and Diagnostics (updated January 2015) that action was required in respect to adherence with NICE clinical guideline CG65, 'Inadvertent perioperative hypothermia: The management of inadvertent perioperative hypothermia in adults', which concerned perioperative hypothermia. The report indicated this was in progress and would be achieved by October 2014.
- Within anaesthetics, an audit had been carried out as part of the Sprint National Anaesthesia Project (SNAP-1). This was done to profile compliance with standards for perioperative care described in the Association of

Anaesthetists of Great Britain and Ireland (AAGBI) guideline, the Management of Proximal Femoral Fractures 2011. The hospital reported mixed results from the audit with results below the national average for five areas. An action plan had been developed and was being progressed.

- During our observations on ward and theatre areas, we saw staff were adhering to local policies and procedures. For example, in respect to moving and handling patients, infection control and medicines.
- Information provided to us indicated that the trauma centre achieved best practice payment tariffs at level 1 between April 2014 and January 2015.
- Staff had access to guidance on theatre activity and usage from the 'Inpatient Theatre Emergency Pathway for Operating Procedure'. The information therein outlined the importance of providing a service to all specialties, as well as supporting the major trauma service and organ retrieval and donation.

Pain relief

- Staff reported that they had access to the pain team, if required, with direct referrals being made via the electronic patient record. The response from the pain team was described as quick and they supported staff by making suggestions for helping patients deal with their pain. We found there was consideration of the different methods of managing patients' pain, including patient-controlled analgesia pumps. The hip replacement protocol included directives around pain relief.
- The fractured neck of femur analgesia pathway included using the Fascia Iliaca block for pain relief, where patients were suitable. Fascia Iliaca block is used for the localised administration of pain relief as an alternative to other pain management methods.
- We observed, and heard, staff asking patients if they had any pain. We also saw them act on this where patients indicated they had pain. Pain relief, including controlled drugs, were only administered after nursing staff checked patient details against their electronic prescription. Information was recorded directly into the EPR of pain relief given and pain scores as indicated by the patient.
- We asked patients about their experiences of having their pain assessed and responded to by nursing staff. One patient on Brunel Ward said their pain had been "managed well" overall, but said they had waited over an hour for pain relief on one occasion, as a stronger medicine was needed and had to be prescribed. This patient also said they were surprised that one of the night staff "seemed irritated by my request for pain relief".
- Another patient on Brunel Ward said they had waited each time they requested pain relief. They confirmed staff had checked their wrist band before giving medicines, but also said that staff did not check if the pain relief had worked.
- A patient on Cotton Ward said staff had been responsive to them when they had pain.
- Patients on Matthew Whiting Ward and Trundle Ward told us they had good pain management. One patient said, "All the time I'm being asked about pain." Pain relief was said to be given quickly and that the nurses checked their name band and date of birth before giving tablets. Another patient on Trundle Ward said they never had to wait for pain relief and staff always asked them about their pain.

Nutrition and hydration

- Preadmission assessment of patients included dietary plans for bariatric and colorectal patients. A patient confirmed in their discussion with us they had a number of visits preoperatively in respect to their diet as part of the planning for their surgery.
- Patient's comments on the provision of food varied according to their level of wellness and the length of their stay. One patient said they had been 'nil by mouth' when the menu selection had been brought, which they were unable to choose at the time. As a result, once they were told they could eat there was limited choice. Another patient said, in relation to food, "I was pleasantly surprised and was expecting the worst," adding, "I had a good choice as a vegetarian." Food was said to have been served well and to have been at a good temperature. A patient on Coptcoat Ward said the food had been "excellent" and confirmed their vegetarian needs had been met, with good choice and food served at the right temperature. Other positive comments included, "Food is alright, fine, I think, lots of choice, served nicely and at the right temperature." Negative comments included: "Hot food is tasteless and badly presented."
- We were told by more than one patient that drinks and snacks were available in between meals. A patient who had been in the hospital for an extended period of time

said they did not like the food as there was a "lack of choice, taste and variety". This patient said they had to buy their own food and we saw them eating food which they had purchased.
- Where patients required intravenous fluids these had been prescribed by the doctor. We observed fluid balance charts were provided and used by staff to monitor the patient intake and output. However, these had not always been completed as required.
- We observed risks assessments in place for patient's nutritional needs and these had been reviewed as part of the progress reports.

Patient outcomes

- Relative risk of readmission performance was reported to be better than the England average. Information supplied for the period of June 2013 to May 2014 indicated the risk of readmission for the top three elective surgical specialties was as follows: neurosurgery 94, urology 91 and general surgery 98. In each case, the England average score was 100. For non-elective surgery, the one area where there was a relative risk of readmission was in trauma and orthopaedics, which was 11, against the England average of 100.
- Patient Reported Outcome Measures (PROM) were used. These were responses from a number of patients who were asked whether they felt things had 'improved', 'worsened' or 'stayed the same' in respect to four surgical procedures. The majority of responses indicated the surgical areas to be generally in line with the England averages. The one exception was in respect to knee replacement, which performed less well than the England average.
- As a nationally and internationally recognised centre of excellence for integrated liver services we saw a report on the annual report (2013/14) for five-year survival following transplantation. Between 1 April 2004 and 31 March 2014 1,029 transplants were performed at Denmark Hill. Five-year survival rates for adults having their first transplant was seen to be the highest compared with other centres, at 82%.
- The trust was one of five London trusts awarded the orthopaedic Commissioning for Quality and Innovation (CQUIN) payment framework award for complex hip and knee surgery and revision of hip and knee surgery by NHS England. This is due, in part, to performance in the National Joint Registry.
- Information on comparative surgical outcomes, submitted for the National Joint Registry for the period 1 April 2014 to 1 July 2014, was reviewed. The data showed, for example, that the 90-day mortality rate following hip surgery, was based on the type of patients the hospital had seen. The national average 90-day mortality rate following primary hip replacement surgery is around 0.4%. The hospital's results for hip surgery did not indicate a higher mortality rate than expected.
- The King's College Hospital (Denmark Hill site) scored better than the England average for eight of the ten hip fracture audit indicators. This included, for example, the number of patients having a preoperative assessment by an orthogeriatrician was being achieved in 75% of cases, against an England average of 52%. Areas where the location did not perform as well included admission to orthopaedic care within four hours, which was only achieved by 37% in 2014, against an England average of 48%. The mean length of stay was considerably longer, at 29.2 days, compared to the England average of 19.
- The Denmark Hill site participated in the National Emergency Laparotomy Audit 2014. Results from this indicated a number of policies not being available. This included, for example: the policy for deferment of elective activity to prioritise emergencies and a pathway for the management of patients with sepsis. The latter had subsequently been put in place.
- The hospital also participated in a national bowel cancer audit and scored better than the England average in relation to three areas: 100% of patients had a CT scan reported on and were discussed by the multidisciplinary team, compared with the England average of 89% and 99% respectively. Overall, 98% of patients were seen by a clinical nurse specialist, against the England average of 88%.
- The hospital participated in the South East London, Kent and Medway Trauma Network. Information supplied to us demonstrated they had contributed data to the 'Trauma Audit & Research Network', clinical report. This compared core measures for all patients with thoracic and abdominal injuries and patients in shock. Data had been submitted for the periods 1 April 2013 to 31 March 2014 and 1 April 2014 to 31 December 2014. As a major trauma unit, the greatest number of admissions in all categories were accepted by the Denmark Hill site. In year one of the data collection, 80% of patients were seen within five minutes of arrival by a

consultant and, in year two, 77% of patients were seen by a consultant. In both instances this was far higher than other trauma network units. The median time to operation was noted to be earliest at Denmark Hill: 6.7 hours in year one and 11.8 in year two.

- There was evidence that the surgical division followed the Royal College of Surgeons standards for unscheduled care, which included having consultant-led care, prioritising the acutely-ill patient and ensuring that preoperative, perioperative and postoperative emergencies led to appropriate outcomes.

Competent staff

- Clinical staff told us there was a new system in relation to the annual appraisals, which was linked to pay increments. On Katherine Monk Ward we were told all staff that were due to be appraised had been completed with the exception of one staff member who was on sick leave. There were thirteen appraisal reviews due later in the year and these had been planned. Coptcoat Ward staff appraisals were said to be up to date, with the exception of those on sick or maternity leave.
- Nursing staff told us they had a preceptor who supported them through their initial year after qualifying. This included sign off of various competencies. A recently appointed member of nursing staff said they had completed their induction the previous week. This had been corporate induction followed by a ward-based period where they were not counted in the staffing numbers. This staff member said they had "great mentors". They also told us they were going through a period of preceptorship, which included completing competencies. A study day was attended every two months and assessments took place along the programme.
- We saw information that demonstrated there were planned clinical updates for dates in May, June and July this year. Content of these study days covered skills related to life support and infection control, for example.
- Nursing staff on Coptcoat Ward took responsibility for designated areas, such as: dementia, infection control, manual handling and tissue viability. A team away day took place on an annual basis with band 7 and band 6 staff, during which they discussed the link nurse role and changes in responsibility to facilitate development of skills and expertise.
- Ward staff told us they had regular supervision and had practical training during the course of their work. We observed teaching taking place in the DSU theatre and in various multidisciplinary team meetings and handovers.
- In main theatres, anaesthetic staff said they had limited educational and training opportunities once they completed their formal anaesthetic course. A member of staff who worked in both scrub and anaesthetic roles interchangeably said their depth of knowledge regarding surgical specialties was not as good as they would like, due to inconsistencies in practice.
- Staff undertaking adaptation training in theatres so they could be band 5 staff, said they had gained a lot of experience and were working through various competencies under the supervision of staff.
- Information from the revalidation team indicated that there were 137 doctors due for revalidation and 87 who were not due for revalidation. The number of doctors at the Denmark Hill site who had been revalidated was said to be 30.
- Medical staff reported having had an annual appraisal and that their job plan was reviewed yearly. The appraisal process was recognised as a positive opportunity to have a "two way conversation between colleagues". One member of medical staff said there was huge support for medical staff who wished to undertake research.
- Information on comparative outcomes by clinician for neurosurgery and orthopaedic specialties was reviewed on the NHS choices website and we did not identify any concerns.

Multidisciplinary working

- We observed high levels of positive engagement between members of the multidisciplinary team. This included active working on ward areas and participation in multidisciplinary team meetings. We saw ward rounds taking place on, for example, the trauma ward round, which was attended by doctors, physiotherapists and nurses. Similarly, the ward round on Katherine Monk Ward was multidisciplinary with the presence of the physiotherapist. Ward rounds provided an opportunity to review each patient and discuss treatment, progress and discharge arrangements. There was good input from all members of the multidisciplinary team.

- We attended the trauma multidisciplinary team meeting, which took place at 8.30am daily. This was attended by 13 staff, including the major trauma consultant, consultant radiologist, general surgical consultant, a trauma fellow who was a senior specialist registrar (SpR), trauma nurses and the local trauma therapist. In addition, there were representatives from surgical specialties. Discussion took place around a number of patients who had been admitted through the urgent care department and any problems highlighted. The meeting was well run and included contributions from all staff.
- The lead nurse for trauma was a nurse consultant and demonstrated a passion for the service, staff education and networking with the South East London and Kent region.

Seven-day services

- There was provision of emergency theatres out of hours. For cardiac and neurosurgical cases there was an on-call scrub team and anaesthetic practitioner available. Orthopaedic, musculoskeletal and trauma as well as maxillofacial was delivered by the emergency confidential enquiry into patient outcome and death (CEPOD) team, with additional support from an on-call specialist orthopaedic practitioner.
- Out-of-hours physiotherapy was provided between the hours of 4pm and 8.30am Monday to Friday and on a Saturday and Sunday between 8.30am and 4.30pm. A physiotherapist told us that, when it came to weekend and out-of-hours provision it was done on a priority basis only.
- There was 24 hours a day, seven day a week access to interventional radiology cover for all specialties, which was delivered on site. The following medical staff were available to support the service: two radiology SpRs on site for out-of-hours, on-call consultant of intervention and an on-call consultant for non-intervention.
- An out-of-hours pharmacy service was available as an emergency service only for patients who urgently required medicines or advice. This was provided by a single pharmacist who was not based on-site, but who could be accessed via the main switchboard at King's College Hospital through a senior member of staff.
- Patients were reviewed by consultants at weekends and were contactable out of hours. This was important for first year doctors, who said they were covering all surgical patients at night.

Access to information

- Staff had access to information through the intranet. They also received newsletters, copies of which we saw. Staff also attended departmental meetings, where information was communicated.
- Staff told us that audit mornings were used as an opportunity to cover learning and development, as well as to share information.
- Patients who had attended the preadmission assessment clinics reported positively on the service. For example, "It was very good, all was explained very clearly." One patient said they had been seen by the physiotherapist, who explained exercises and they also attended the 'escape sessions' with regards to exercises as part of the enhanced recovery pathway.
- A patient on Trundle Ward said, "I have had plenty of information and know what is going on."
- Patients on Brunel Ward told us they had been given information from nursing staff. For example, one patient said the nurse had spent a "lot of time going through everything with me". They told us they had been seen by the physiotherapist who had explained the exercises they had to follow. This patient also told us they did not get to speak to the doctor until 24 hours after their surgery. They were aware of what had been done during their operation to a certain extent, but wanted more detail and to see their x-rays so they could understand better. Another patient on Brunel Ward told us they did not get much information while in the urgent care department, but had since been well informed. They did say, however, that there was poor communication between diagnostics and the ward in respect to a scan they were due to have. They said, "I waited all day only to be told I couldn't have a scan."
- Other comments included, "Excellent nurses and doctors who have kept me informed and discussed everything fully." One patient said they had been seen by the dietician, who had provided advice to them, which they found useful.
- A patient on Coptcoat Ward said, "Information provision has been very good." They said they liked the 'whiteboard' above the bed, which, although they had not used it themself, they appreciated that they could write on it if they wished to.
- We found there was access to a range of information on the public trust website. Leaflets were readily available

in ward and preassessment areas. For example, we saw leaflets on bimaxillary surgery, abdominal aortic aneurysm repair and femoral popliteal distal bypass grafts.

- Coptcoat Ward had a welcome pack for patients, which was commented on positively by a patient. They also provided laminated, double-sided information document. This explained to patients amongst other matters how they could work the bed, use the call bell, provided information about volunteers and advice on how they had permission to challenge staff in respect to hand washing. A 'leaving hospital' information leaflet was also given to patients on Coptcoat Ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We noted patients who had a surgical procedure had completed a formal consent record and a copy had also been given to them to retain. We noted that information recorded on consent forms often contained abbreviations and jargon, which we were unable to decipher and which patients may not have understood.
- Patients told us they had been given information about the benefits and risks of their surgery prior to signing the consent form. They also told us staff explained aspects of their treatment and care and sought their consent before proceeding. One patient who had been admitted as an emergency confirmed the consent process had included the fact that the surgeon did not know exactly what would need to be done until they explored the operative area. This patient added, “I was seen by the anaesthetist who was especially comforting and explained about the anaesthetic and the risks.”
- A patient on Coptcoat Ward told how they had been seen by medical staff and their operation had been fully discussed in respect to consent. Further discussion had taken place the following day to make sure that, “[The patient] hadn’t changed [their] mind or had further questions.”
- However, a patient on Katherine Monk Ward told us that while they were on Twining Ward staff proceeded to wash them, even when they had not given their consent.
- There was a limited range of understanding about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards amongst the nursing and theatre staff. Most staff below band 7 could not answer questions about these areas. Higher grade staff had a better understanding. Staff who were able to respond to our questions about mental capacity said they were able to make a direct referral to the respective teams. They said they would involve the patient's next of kin regarding consent where an individual had difficulties associated with mental capacity. They were aware the family could not sign consent on the patient’s behalf.
- Training figures supplied to us indicated that there was a target of attendance was set at 80% with regards to the Mental Capacity Act 2005. The figures indicated for the liver, renal and surgical directorate that 525 staff needed to complete this training and 181 had done so in 2014/15. This represented 34% of the total. We saw from ward-level information provided to us showed gaps relating to Mental Capacity Act 2005 training. For example, on Matthew Whiting Ward, this once only training had not been completed by 17 out of 39 staff. Of the 33 staff on Kinnier Wilson Ward, nine staff had not attended this training and on Katherine Monk Ward, 25 staff out of 45 were yet to complete the training.
- Regarding theatre staff attendance at Mental Capacity Act 2005 training, 125 of the 373 staff required to attend had done so in 2014/15. This represented a total of 33%.

Are surgery services caring?

Good

Feedback from patients was overwhelmingly positive when it came to the quality and standards of care they received from doctors and nurses. Patients reported that their privacy and dignity was respected and they were involved in decisions about their treatment and care.

We observed, and heard, staff treating patients courteously, with respect and professionalism. Staff were kind and caring in their dealings with patients.

Patients reported that their relatives and those closest to them were involved and kept informed as much as they wished them to be.There was access to counselling and other services where patients required additional emotional and psychological support.

Compassionate care

- The NHS Friends and Family Test response rates achieved at Denmark Hill location were above the England average. The response rate was 42% and this contributed to a 40% trust-level response, against the

England average of 32%. The scores for all wards were also, generally, very good in November 2014 and we saw updated results on some of the wards visited. This included a score of 97% on Trundle Ward for February 2015. We saw 'How are we doing' comments, which indicated they did well at caring and not so well with regards to patient bed moves. On Kinnier Wilson Ward, Coptcoat Ward and Katherine Monk Ward, 100% of respondents to the NHS Friends and Family Test in February 2015 said they recommended the hospital. Slightly lower scores were achieved on Lister Ward and Matthew Whiting Ward.

- Patients who spoke with us were satisfied with the provision of care and the manner in which they were treated by ward and theatre staff, although one patient said, "Some nurses were better than others." Comments made included the staff being, "Very good regarding respect and dignity," and, "Staff have been considerate to my needs." One patient said the staff had been "very calm" when dealing with another patient who was challenging. Theatre staff were said by one patient to be "Great, jolly in approach, which dispelled any fears." They also said they were professional and, "I felt I was in the right place."
- A patient who spoke with us on Katherine Monk Ward reported that when they were on Twining Ward, which they had moved from, staff were "rude and did what they wanted to". They said they were woken up between 5am and 6am so staff could attend to their needs, even though they did not want this at that time.
- One patient said it had "all gone as planned, perfect," and added that, regarding being treated with dignity and respect, "Definitely, they have done their best." Another patient said they had always been treated with dignity and respect and, as far as possible, staff afforded them privacy.
- A patient on Trundle Ward said the care had been "Excellent" and "better than before." When asked in what way was it better, they said staff on this occasion had been more caring, both on days and nights. The doctors were described by this patient as being: "Very understanding and they do more than is expected." Another patient on this ward said, "I think it is wonderful, everyone is so kind." They added that they felt well cared for.
- Other comments from patients included, "Absolutely wonderful, wonderful nurse and nothing is too much trouble." On Coptcoat Ward, a patient said they had been, "Genuinely impressed, staff are absolutely superb." They added that, regarding respect and dignity, staff had been discreet in their questions and ensured their privacy. Another patient on this ward said, it had been, "Amazing, the quality of the ward, space, environment, happiness of staff and general level of care."
- A number of patients on Kinnier Wilson Ward and Matthew Whiting Ward confirmed that their individual care needs had been met and that they felt safe and happy about the care provided.
- Patients told us the nursing staff came to the bed to handover between shifts and they were made aware of the nurse who would be responsible for their care. We were able to observe a bedside handover, which took place between off-going night and on-coming day staff. The communication was informative and included introductions and brief discussion with the patient. Patients were addressed by their preferred name and staff spoke with them in a respectful and professional manner, using humour, where appropriate.
- Patients reported the hardest thing about their stay was the noise at night. They did tell us and we saw that ear plugs had been provided to address this. Eye masks were also provided to reduce disturbance.
- A long stay patient described having moved wards on numerous occasions so they could have a side room. Overall, they said, "Staff here are quite good and are lovely, although temporary staff not so good." When asked in what way they were not so good we were told, "They take a while to come and don't see much of them especially at night."
- Overall, patients reported being happy and said they would recommend the wards they were on and the hospital.
- We made many observations of staff interactions with patients across all areas visited. Staff were seen to be courteous, attentive and kind in their approach. Patients were not hurried for example, when we saw a physiotherapist walking a patient on the corridor, the manner in which they provided support was very caring and encouraging.
- We also followed a patient from the ward area through into theatre in the day surgical unit, having gained their permission. We observed staff to be respectful of the patient's choice not to know too much detail about their operation, but at the same time to make sure safety checks were carried out. The patient was treated in a

calm and respectful manner by all staff and time was taken to explain procedures once in the operating room. At all times staff made sure the patient's dignity was respected.

Understanding and involvement of patients and those close to them

- Patients reported that they felt involved in decision making around their treatment and care and, where relevant, family or next of kin were included too. One patient explained how they had been seen by the physiotherapist every day and how they had been "taught a lot". Another patient said, "My wife, son and daughter have been involved."
- A patient on Coptcoat Ward said their partner had been able to ask questions and was kept informed about their treatment and care. Another patient on Trundle Ward commented on the improved level of communication from the previous time they had been in the hospital. They said the level of "education provision" was much greater.
- 'How are we doing' comments on Coptcoat Ward for March 2015 indicated the results to be above the benchmark except in regard to question: 'Patients being involved as much as they wanted to be in decisions about their care', where they scored slightly under the 85 benchmark.

Emotional support

- There was access to a range of clinical nurse specialists, including the stoma nurse who was said to review patients prior to surgery. The enhanced recovery nurse also saw patients prior to their joint replacement, advising on, for example, pain control. There was access to tissue viability nurses, diabetic expertise and oncologists for the provision of expert advice and support.
- We saw information was displayed in areas indicating there was access to chaplaincy.
- Patient admission assessments included information about their psychological wellness and any previous issues, which would need to be considered within their treatment and care. Staff also said they observed patients for signs of depression.
- The involvement of the psychiatric and social care teams was found to be very good, with the former present and reviewing a patient during our visit to Katherine Monk Ward.
- There was access to the renal counselling and psychotherapy team. Breast care nursing staff provided a counselling service to women with breast-related problems. Patients requiring additional information about their medicines could also be referred to the medicines counselling service. Regarding retrieving livers and providing a donor organ, there was access to an appropriate counselling service.

Are surgery services responsive?

Requires improvement

Referral-to-treatment times were sometimes not being met in a number of surgical specialties. Surgical procedures were sometimes cancelled and not always rescheduled and undertaken within 28 days. Theatres were not always effectively utilised and this impacted on performance.

Patient flow through the surgical services was limited by the availability of beds, which was linked, at times, to delayed discharges. The individual care needs of patients were fully considered and acted on by staff. Arrangements were in place to support people with disabilities and cognitive impairments, such as dementia. Translation services were available and information in alternative languages could be provided on request.

The complaints process was understood by staff and patients had access to information to support them in raising concerns. Where complaints were raised, these were investigated and responded to, and where improvements were identified, these were communicated to staff.

Service planning and delivery to meet the needs of local people

- The majority of surgical activity at the Denmark Hill site was a day case at 53%, elective surgery contributing 27% of activity and emergency procedures 20%. General surgery accounted for 22% of work with trauma and orthopaedic and ophthalmology both 15% respectively and other procedures were 48% collectively.
- The Denmark Hill site was also recognised, both internationally and nationally, as a centre of excellence for managing surgical and medical patients with liver disease.

Surgery

- As a member of the South East London, Kent and Medway Trauma Network, the Denmark Hill site provided emergency access and treatment to patients who had major injuries, not only from the local area, but further afield.
- Patient needs had been assessed and their treatment and care was planned, in order that these could be met safely and effectively.

Access and flow

- Access to surgical services was via GP referral, subject to consultation review or via the urgent care department. Patients who had been referred by the out-of-hours GP reported that the process had been organised well and their assessment and subsequent admission via the urgent care department had been managed well.
- There was provision for preadmission assessment and a number of patients confirmed they had been preassessed in one of the formal clinics set up for this. There was an admissions nurse based on Trundle Ward, who started their shift at 7am in order that they could admit and prepare patients for surgery. They also had a responsibility for screening the admission list for the following day and for liaising with patients regarding their admission or any delays.
- Patients who met the admission criteria and were not identified as being 'at risk' were treated in the day surgical unit (DSU). The DSU ran theatre lists on a Saturday in response to demand, which initially had been ad hoc, but were now scheduled routinely.
- Referral-to-treatment time (RTT) performance was below both the standard and the England average since April 2013. Seven of the 10 specialties were not meeting the standard, including, for example: general surgery, trauma and orthopaedics, urology and neurosurgery. Two surgical areas were meeting the 18-week RTT target for the start of consultant-led treatment, which were oral surgery and plastics.
- More recent figures were provided to us in relation to RTT by month, which indicated fluctuations. For example, in December 2014, we saw the RTT was achieved in 70% of general surgical patients, in 83% of urology patients, 71% of trauma and orthopaedic patients and 97% of oral surgery patients. Specialties where the RTT was less well achieved included: neurosurgery at 56% and cardiothoracic surgery at 37%. However, in the February 2015 figures, only oral surgery achieved above 80%.
- One surgical patient who spoke with us told us they had not been booked in for their treatment within the 18-week target and they waited an extra month.
- There had been a big increase in cancelled operations since October 2013, both in terms of numbers and percentages. The number of patients not treated within 28 days of a cancelled procedure for the trust indicated a higher than England average over the period October 2013 to September 2014. Between January and March 2014, 92 patients had their operations cancelled and were not treated within 28 days. Figures related to the Denmark Hill location indicated there had been 18 cancelled surgical procedures, which were not treated within 28 days between the periods of April 2014 to March 2015.
- Information provided to us indicated that 13 patients in February and 18 patients in March 2015 had their surgery cancelled, as emergencies took priority.
- We asked nursing staff about the cancellation of patients through the DSU and were told cancellations usually happened because patients did not attend. They self-cancelled, were not medically fit, or had not fasted. We were told data for cancellations was not always accurate because of communication problems. For the week of the 13 April 2015 up to our visit there had been four cancelled operations on the 13 April, two on the 14 April and five on the 15 April.
- Between the periods of June 2013 and July 2014, the length of stay (LOS) at site level was as follows for surgery: the top three elective patients having neurosurgery stayed an average of 5.9 days against England average of 4.1. In trauma and orthopaedics (T&O) the average LOS was 4.3, compared to the England average at 3.5 days and hepatobiliary and pancreatic surgery patients stayed on for an average of 8.5 days, against the England average of 5.8. For non-elective work LOS was higher in general surgery, T&O and neurosurgery.
- Delayed discharges were associated with arranging rehabilitation and social care needs, which could not always be arranged or funded in a timely manner.
- Readmission rates for the Denmark Hill location regarding elective and non-elective surgery were less than the England average in all specialties, with the exception of non-elective trauma and orthopaedics, which were slightly above the England average.

- Theatre utilisation for the periods of October to December 2014 was provided to us. The utilisation range for all theatres on the Denmark Hill site varied between 66.4% at the lowest (theatre 12) up to 94.3%, (neurosurgery theatre 2).
- We observed from patient records reviewed that discharge planning commenced as early as possible and involved the multidisciplinary team. We saw too, from recorded information and heard information discussed in board rounds about patient needs on discharge, progress with making arrangements. This included the provision of equipment, social support or rehabilitation beds.
- Nursing staff told us there was a discharge coordinator, who concentrated on the more complex discharges. This included liaising with social services and working with the physiotherapy and occupational therapy teams.
- Patients told us they were involved in discussions around their discharge. For example, a patient on Trundle Ward said they were in the process of discussing their discharge and they had seen the physiotherapists and occupational therapists with a view to ensuring they were safe to go home. Another patient on this ward said discharge planning had included arranging their medicines and follow-up appointments.
- Other patients confirmed, in their discussions with us, that there were arrangements taking place for adaptation of their home environment in preparation for leaving hospital. One patient said they were waiting to see the occupational therapist in regard to the installation of rails in their toilet.
- A patient from another ward said their discharge had been delayed, as they required a rehabilitation bed and this could not be funded at the time. This had resulted in a lengthy hospital stay.
- Discharge arrangements included provision of information to patient GPs and community nurses, where relevant.
- The Denmark Hill site scored better than the England average for eight of the ten hip fracture audit indicators. This included, for example, 76% of patients having their surgery on the day, or day after admission, against an England average score of 74%.
- Surgical outliers were identifiable through the bed management system. We saw there was a pathway in place for the management and repatriation of surgical patients who were on wards outside of the specialty.

Meeting people's individual needs

- During our visit, we found that there was single-sex accommodation on the surgical wards.
- The day surgical unit (DSU) environment was not particularly spacious in the ward and recovery area. This made it difficult to afford patients privacy, although staff did their best by closing curtains and speaking quietly. Staff did, however, make sure there were separate days for male and female patients attendance.
- Nursing staff told us that, where an interpreter was required, this was identified at preassessment and arrangements would be made in advance of the patient being admitted for their surgery.
- Nursing staff told us they would be made aware if a patient with learning disabilities was being admitted for surgery. They described providing 'normal' care to the individual, but took into account any specific needs, which would be identified in their 'Health Passport' or by carers and family. With respect to day surgical unit patients staff told us the individuals carer could accompany them into the anaesthetic room and also in recovery post-surgery.
- Patients who had additional needs associated with living with dementia were identified to staff by the use of a small blue flower sign. Staff told us there was a dementia team who assessed patients in order to ensure that specific needs were addressed. Staff also said as part of their observations they monitored patient for signs of delirium, depression and dementia.
- A healthcare assistant gave an example of the action staff took to ensure a patient who was deaf received information in a suitable manner. This included careful positioning to facilitate lip reading and the provision of a whiteboard for writing more complex information on.
- A registrar told us that it was easy to transfer patients to different surgical specialties where the needs of the patient indicated this.
- We heard information during the patient board handover, which alerted staff to patients who needed to be supervised when mobilising. We heard too that specific needs of individuals were discussed in terms of planning for discharge home or for ongoing care.
- We observed that there was a range of cultural and medical-related diets available for patients to choose from. For example, low fat, kosher, halal, diabetic, vegan and African or Caribbean main courses.

- Information about the food services was visible on some wards we visited and we saw signage that indicated that menus could be translated into alternative languages if required.

Learning from complaints and concerns

- Clinical staff were aware of the complaints reporting and investigation process, although there was a general feeling from staff that they did not get many complaints.
- A complaints procedure leaflet was available in areas, which provided information to patients about the process.
- We saw information about the Patient Advice and Liaison Service was available to patients. However, a newer member of nursing staff did not know what the Patient Advice and Liaison Service was.
- A patient on Coptcoat Ward said they had been given information about complaints and added that they would speak to the person in charge if they needed to express a concern.
- Complaints data was collected by the surgical division and we saw that, in the December 2014 data, there had been five complaints and seven for November 2014, one of the latter of which had been classified as 'high-severe'. Three of the responses to the December complaints had not been managed within the 25 working days and indicated a 'red' status for patient experience on the surgical directorate performance metric. This indicated that the performance was less than expected.
- The surgical directorate performance metric also included information on complaints by month. Figures for January and February 2015 indicated there had been five complaints in each month. This was rated as a 'green' status, indicating they were doing better on the overall trend.

Are surgery services well-led?

Requires improvement

Senior leaders understood their roles and responsibilities and were committed to overseeing the standards of service provision in all surgical areas.

The senior leaders of the surgical divisions had a clear direction of focus underpinned by the values of the trust. Work was in progress on developing the surgical directorate strategic aims and principles, with a draft prepared for liver services. Work was required to cascade to staff the strategic objectives to enable these to come to fruition.

Robust governance arrangements were in place to monitor, evaluate and report back to staff and upwards to the trust board. The surgical directorates identified actual and potential risks at a service and patient level but did not always monitor and manage such risks or monitor progress.

Staff reported positively on their leaders, their approachability and support. Staff felt valued, respected and enjoyed working in the surgical areas. Patients and staff were encouraged to contribute to the running of the service, by feeding back on their experiences and expressing ideas.

The surgical directorate encouraged innovation, learning and continuous development.

Vision and strategy for this service

- There was some awareness of the trust's vision by ward and DSU staff, although staff could not always state the specific terminology. Feedback to our questions included the vision being about: "Continuing development, striving to improve and excellence." A healthcare assistant said the vision was about, "Inspiring others, working together for the community, supporting one another and improving communications." All the staff we spoke with in main theatres did not have any awareness of the values or vision.
- There was a five year strategic plan in place for the trust, which identified surgical related areas of focus.
- We asked members of the senior medical and clinical managerial team if there was an overarching surgical strategy. We were told about and provided with a copy of the 'Liver Services at King's College Hospital Draft Strategy Document 2014-2024'. This contained the broad vision and objectives underpinned by the values and culture needed to meet these. On reviewing the document, we saw there was extensive information which took account of risks, aims and expectations, along with timescales.
- We were told that each care group had a strategy, with a central strategy team looking at elective surgery. At the time of our visit there was no formal strategy in place for trauma and orthopaedics and we were told, "A

fundamental decision is needed from the trust board about what it wants in respect to elective surgical work." We were told there had been some development of options, supported by data regarding the acute side. It was said there was a clear end point, which encompassed the management of major trauma patients. We were told that an informed decision on the direction of travel was awaited and a three point plan was being presented later in April this year to the trust board. However, staff we spoke with did not have any awareness of the work taking place to develop the strategy and we did not see reference to the strategy being discussed within the board agendas reviewed for February, March or April 2015.

- We saw a copy of the South East London, Kent and Medway work plan for 2015/16. This included various workstreams, which included the Denmark Hill site, a lead person responsible and timeframes. We saw updates had been made on the 6 February 2015.

Governance, risk management and quality measurement

- The governance structure in the surgical division included monthly risk and governance meetings, chaired by the governance lead and attended by the head of nursing and senior managers. This fed into the Deteriorating Patient Group and Safer Care Forum and upwards to the serious incident committee. The latter was chaired by the medical director. We reviewed minutes of risk and governance meetings and concluded from these that there was a process in place, which enabled review of incidents, review of patient safety reports and the risk register
- We were told the surgical divisions had a strong clinical governance framework, which followed the London Strategic Clinical Networks Governance Framework Toolkit (August 2014).
- Within the renal division, there was a rolling programme of meetings on Mondays, which were multidisciplinary and covered business issues and the patient experience. Feedback was said to be given to the respective care groups. Performance meetings were also held, during which the scorecards were reviewed with relevant leads and reports were presented to the trust board.
- Medical staff reported receiving regular governance newsletters and we were told that the nursing staff tabulated green and yellow incidents for each unit, so that ward areas and theatres received governance feedback. We saw such incidents were discussed in minutes of meetings and communications to staff.
- We reviewed the surgical division and corporate risk registers and saw that potential and actual risks had been identified.
- We reviewed minutes from the surgical safety improvement group for March 2015 and saw reference to the importance of auditing compliance with safety checks across all surgical areas.
- Staff in the DSU reported their highest three risks as being related to unplanned admissions, patients turning up, but not having been booked in for a procedure on the system and maintenance problems, which were dependent on the estates department.
- Divisional clinical effectiveness reports, led by the respective governance leads provided detailed updates. For example, regarding performance, areas for improvement, audit and priorities of action. We saw the report for the Critical Care, Theatres and Diagnostics Report for 2104, updated January 2015, to confirm this. However, we noted that there was no information to indicate that there was any auditing of compliance with patient safety checks, despite the risks of adverse events occurring by not adhering to these.

Leadership of service

- We observed and heard from members of the leadership team who spoke with us, demonstrating a passion, commitment and enthusiasm for their roles and towards the staff and services provided.
- Staff in all areas reported positively on their immediate leadership. For example, staff said they felt "valued, respected and listened to". A member of ward staff they enjoyed working at the hospital very much and that it was "absolutely fantastic". They said they felt very well supported by staff and the leadership and teamwork was cited as a positive aspect.
- A newer member of staff explained how they had regular communication from the hospital prior to commencing their role. They said that because of this: "I felt I knew them before I even got here." They described the leaders as being very welcoming and supportive. In addition to this, they said: "They are all very competent in their jobs and lead by example."
- Matrons were said to have had their responsibilities reduced so they could be closer to the patient and

provide stronger leadership. There was an expectation that every patient was seen by the ward manager and matrons went to every area they were responsible for when on duty.
- Although some staff said they saw the head of nursing (HoN), they had not necessarily seen the chief executive officer (CEO). Staff in the DSU said the HoN sometimes came and spoke at the audit learning days that took place. Matrons and the general managers were said to be “good” and leaders were said to be "open and approachable". One staff member said, “I like this style as it is more respectful and makes us willing to do more.”

Culture within the service

- We observed that the culture in all areas we visited was open and included active engagement across the team and other members of the multidisciplinary workforce. Comments made by staff included having a “feeling of family, team King's and working together”. In relation to the culture and what worked well, comments included, “The people, some are phenomenally talented and they are prepared to work hard,” and, “It’s all about the patients.” Staff were said to be open and receptive when things were not quite so good and there was a commitment to care.
- Staff felt comfortable when it came to reporting incidents and near misses as well as raising concerns. Staff generally felt able to challenge colleagues if needed and to put forward ideas. A new member of nursing staff said their opinion was valued regarding patient care and this was not disregarded.
- Staff said they enjoyed working at the hospital. One member of the medical staff in the DSU said: “Although it was a major teaching hospital, it had the atmosphere of a district general hospital.” They added that it was “friendly and welcoming” and they were valued and respected by staff in what was said to be a “cohesive department”.
- Therapists reported having a good working relationship with nurses and medical staff and felt there was good multidisciplinary teamwork.
- We saw and heard from staff that there was a culture of sharing information. Formal communications from the CEO, newsletters and emails provided methods of communication to keep staff updated and informed.
- Staff found there were opportunities for learning on the job and teaching was actively encouraged.
- The turnover rate of nursing staff in the directorate was 15%, up to February 2015.
- Sickness rates within surgical nursing workforce ranged between the lowest level of 2.17% in November 2014 up to a maximum of 3% in December 2014. The overall figure up to the end of February 2014 in the renal and surgical directorate was 3%.

Public and staff engagement

- Staff engagement took place as routine on ward and surgical department areas, with 'huddle' meetings in DSU and theatres, which allowed staff to put forward matters, both positive and negative. Where staff meetings took place these were said by staff to enable discussion of issues and sharing of ideas. We saw in the DSU staff area a noticeboard covered in Post-it notes where staff had shared their thoughts about three positive things about the unit.
- The NHS staff survey results for 2014 indicated an overall score of 3.78, which was above (better than) average for staff engagement, compared with trusts of a similar type.
- Patient engagement was monitored through the surgical division ‘heat map’, a copy of which was provided to us for the period January to December 2014. We saw from this respecting patient responses the majority of outcomes scored above the benchmark. There were, however, areas rated as 'red', particularly in August 2014 where questions relating to having their questions responded to by nurses and doctors and being involved as much as they wished to be in decisions about care fell below the benchmark.

Innovation, improvement and sustainability

- The Denmark Hill location was very proud to provide us with information of their achievements. This included setting up the first national training for trauma skills course in the country. The course teaches trauma team skills, trauma networks and hands on clinical skills in a multi-disciplinary course. The course was the first in Europe to teach 'Resuscitative Endovascular Balloon Occlusion of the Aorta' (REBOA) on cadavers' (publication accepted) and was expected to form the basis of the UK REBOA working group training course. So far, over 200 members of the trauma network had completed the course, which takes place twice a year.

Surgery

- The Denmark Hill location was said to be the only one in the UK with a general surgical trauma model and, therefore, they met the design of the new curriculum in trauma surgery. All future trainees in trauma surgery would be based in general surgery.
- The surgical team told us they had the United Kingdom's first SpR in trauma surgery, with 24 hours a day, seven day a week trauma registrar level cover on the trauma team independent of the surgical registrar on call.
- We were told a combined general surgery/orthopaedic trauma fellowship had been approved by the Royal College of Surgeons of England and that this was the first fellowship ever in the UK to combine general and orthopaedic training in one post.
- An emergency theatre pathway project had developed from the emergency theatre audit in 2013, which had revealed poor data availability, due to a paper and whiteboard based booking system with no standardised quality control or data collection. An electronic booking system was implemented in 2014, along with an electronic emergency theatre board on the electronic patient record. Data was produced from this regarding theatre activity and access to the emergency team (CEPOD) during the year. Audit and re-auditing of both appendectomy and damage control pathways showed improvements. The appendectomy pathway had been presented as a best quality improvement project.
- There was recognition and acknowledgement within the senior management team that capacity planning needed to develop further, that a trauma ward was required and the junior doctor's rota required additional support.
- A copy of the divisional clinical effectiveness report for critical care, theatres and diagnostics outlined a number of innovations. This included the new Safety in Anaesthesia and Learning from Incidents (SALI) newsletter. The report also described information that was going to be collected respecting enhanced perioperative care for high risk patients.

Critical care

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

Information about the service

Critical care at King's College Hospital (Denmark Hill site) was described by the trust as having 16 intensive care unit (ITU) neurology beds (Jack Steinberg Ward), 14 ITU medical beds (Frank Stansil Ward), 17 ITU surgical beds (Christine Brown Ward), 15 ITU liver beds (liver intensive care unit - LITU), four high dependency unit (HDU) liver surgery beds (Todd Ward), ten HDU cardiac beds (Victoria and Albert Ward), four HDU renal beds (Fisk Ward) and 11 HDU neurology beds (Kinnier Wilson Ward). The HDUs were managed within the divisional governance structures of the lead division.

Over 2,500 patients a year were admitted to the ITU areas with increasing admissions in the last five months. The hospital is also a tertiary service for transplants as well as trauma, so some of the patients admitted were for organ transplants, particularly liver, which made up 249 patients in 2014/15. However, we found that the ITU beds were more used as general ITU beds that mostly specialised in liver and neurology/neurosurgery in two units. We visited all these areas, plus where level 2 patients were being cared for in obstetrics.

We spoke with over 15 patients, families and friends, over 90 members of staff, including: nurses, doctors, allied health professionals (including pharmacists and therapists), administrative/clerical/ancillary staff, iMobile staff (who provided the critical care outreach service), the liver transplant coordinator team, as well as clinical and managerial leads. We also checked over 25 patient records and 25 pieces of equipment, observed care, and reviewed hospital and stakeholder records such as policies, procedures and audits.

Critical care

Summary of findings

Although the critical care service at the hospital had positive patient feedback, produced better than average outcomes for patients, were involved in innovative practice and treated highly complex patients, due to its transplant and trauma services, there were fundamental areas of the service that required improvement.

Although there was work in place to build a new set of critical care units, current facilities were not adequate, with a lack of bed and storage space. There was a lack of bed capacity and a lack of infection control facilities. Some of the HDUs did not always meet patient to nurse ratio standards.

Medicines management was not appropriate in a number of areas, particularly storage. There was a high, but improving rate of pressure ulcers. Patient records were not always complete, although there were also plans to improve this via a new electronic system. Mental Capacity Act 2005 awareness and recording was not always in place. There was multidisciplinary working, but it was not taking place across all the staff groups. Governance arrangements were fragmented.

There was an innovative iMobile service (who provided the outreach service), patient outcomes were better than peer services, incident reporting and learning was in place, patient harms were mostly well managed, public engagement was proactive, and staff development was positive.

Are critical care services safe?

Requires improvement

The critical care service did not meet basic safety standards in some areas, particularly on some of the HDUs. The liver and renal HDUs did not always meet patient to nurse ratio standards. There was a high number of acquired pressure ulcers in the ITUs, although this was on a much improved trend. Infection control guidance was not always complied with, particularly regarding hand washing sinks, personal protective equipment, colour coding and facilities. Equipment was stored inappropriately in a number of areas. Medicines management was not always appropriate, particularly relating to intravenous fluids and storage. Patient record completion was not always complete in areas such as nursing assessments and signatures.

However, incident reporting and learning was mostly well embedded, with improving audit results as a result of changes. Medical staffing levels were mostly appropriate. Safety thermometer results in areas other than pressure ulcers were very positive. Management of deteriorating patients was well established, with a clear process and actions. Plans in the event of a major incident were appropriate.

Incidents

- One surgical never event occurred in critical care in November 2014 with regard to retention of a wire following the insertion of a femoral vein line. No further never events have taken place since November 2014. The Trust told us that staff had been made aware of this incident through teaching, procedures to prevent it in the future were put in place. In addition to the standard line audit, a further audit was initiated to assess changes in practice. The audit started to show improvements with documentation completion overall improving from 78.5% to 88.1% over a four month period although sometimes the lack of recording was due to other areas of the hospital. Particular areas that still required improvement were documenting the assistant name (54.7% completion) and recorded witnessing of the guide wire being removed (54.7% completion).
- There had been two reported serious incidents since February 2014, categorised as one delayed diagnosis

and one suboptimal care of a deteriorating patient. One was where the medical registrar did not escalate a deteriorating patient and another where a patient was not well managed on non-invasive ventilation (NIV) prior to discharge, so they were readmitted and subsequently died. There had also been a necrotic pressure ulcer post surgery in critical care. The deteriorating patient incident investigation showed there was no concern with the treatment given, as the patient being intubated had an impossible airway to intubate. Nonetheless, signs were put up in bed spaces regarding sedation and airway procedures. The learning after the NIV discharge was also appropriate as, although the root cause reported it was due to known complications post procedure, learning was identified in cardiology to set up a working group for discharge and to ensure consultants reviewed a patient to prevent them being discharged too early.

- There had been a number of amber (moderate harm or near miss incidents that warranted a root cause analysis) reported in critical care. These included: a line removal causing a patient to have a haematoma which on investigation was escalated to the medical team at the time, reviewed by medic and pressure applied. The trust told us the patient was discharged to the ward because of the need of admitting a new level three patient and the patient was handed over to the ward where the patient was managed and reviewed by the iMobile team, the patient was treated with a unit of blood on the ward. Another amber incident was where a prescription of penicillin (tazocin) was written although the patient was allergic to it, the allergy status was not transferred from the old to the new drug kardex and the junior doctor did not challenge the consultants' instructions who was unaware of the allergy. There had been a number of infection incidents where goggles had not been worn by staff although the trust told us the equipment was available on all occasions.
- On LITU, incidents included delays with cleaning and a number of medicines safety incidents, so a risk review with pharmacists had been completed. However, since iMobile had been introduced, there had been a reduced amount of incidents occurring across the hospital.
- Minutes from the risk and governance meetings showed that there was a high amount of medicine incidents in the directorate that included critical care, mostly relating to morphine. These minutes showed there was confusion on signing of controlled drugs, so the service arranged training and developed a new policy to address this. There had also been two systems for blood tags in LITU so the service aligned them.
- In December 2014, there had been seven health and safety incidents, but zero amber and above incidents in the directorate.
- Staff at all levels in most ITUs were able to tell us how to report an incident and told us they received feedback both on individual incidents they reported and on incidents that affected their unit with learning shared at handovers. Briefings were sent out by each unit, which included highlights of learning from incidents each month. Staff understood their responsibility under the Duty of Candour regulations and we saw examples of the correct process being followed. Drop in sessions with governance managers took place regarding incident reports. The HDU senior staff said they had monthly meetings discussing incidents. Medical staff had brief safety meetings before their handovers. Pharmacists were able to give examples of learning from incidents, such as when there had been issues with medicine infusions. Folders of incidents were kept on the units. A risk nurse was in place for the ITUs who attended a forum regarding root cause analysis into incidents. A team day regarding risk was also held once a year.
- However, we were concerned that staff in some of the HDUs and one ITU were not as aware of incident learning and did not receive feedback, particularly on Fisk Ward.
- Staff told us mortality and morbidity meetings took place once a week and were informed by a deceased patient summary. The trust told us patient notes and other documents were also reviewed.

Safety Thermometer

- There were 59 pressure ulcers reported since December 2013 (variable month to month) in critical care. There were five pressure ulcers and one deep vein thrombosis (DVT) on Kinnier Wilson Ward reported since October 2014. Frank Stansil Ward had 22 pressure ulcers and zero falls last quarter with 13 grade 3 and ten grade 1 pressure ulcers in the last year – mostly nose and ear pressure ulcers. Christine Brown Ward had 23 pressure ulcers and zero falls. Nine were grade 1, 13 grade 2 and

one grade 3 pressure ulcers. These were mostly located on patient lips and nostrils due to nasogastric (NG) tubes. Jack Steinberg Ward reported 12 pressure ulcers and zero falls.

- The ITUs were trialling new full/total face masks for continuous positive airway pressure (CPAP) and new NG tube tape to reduce the amount of ear and nose pressure sores, but staff told us the main reason for the increase of pressure ulcers was due to the amount of patients over winter who had a high length of stay.
- The trust told us that a flow chart was in place to guide staff to when to use pressure relieving devices; however staff raised concerns that pressure reliving mattresses may not be used early enough and that there were not enough mattresses and cushions. Records showed critical care units were adhering to best practice to reduce the amount of acquired pressure ulcers and to improve pressure management of those patients who already had them, such as using gel padded devices.
- Senior nursing staff told us all patients with pressure ulcers were reviewed by tissue viability nurses (TVNs) and discussed pressure area management at a Safer Care Forum. A pressure ulcer group also reviewed all pressure ulcers that had been acquired, to share any learning. There had been a noticeable decline in acquired pressure ulcers since nurses stopped rotating between units although it was not clear this was the reason for the decline. TVNs were available and we were told they responded immediately when referrals were made to their service. However, we were not told about TVNs on all units.
- There had been seven falls and nine urinary tract infections (UTIs) in critical care since December 2013. Neither was currently concerning to staff as incidence of these was low. Staff told us that, when there was an increase in falls, this was raised with staff to try and reduce them. However, the cause of this increase was usually felt to be a high number of patients with delirium and agitation.
- Safety thermometer results were displayed in all the units we visited and discussed at unit meetings. These showed improving results, with a competitive element between the units to have the least pressure ulcers. However, some staff were not aware of the link between the boards displayed and the Safety Thermometer information reported. Some band 5 and band 6 nurses demonstrated a lack of awareness of their areas safety performance on the units.
- All patients had stockings and medicines to prevent deep vein thrombosis (DVTs) and we saw no omissions in venous thromboembolism assessments.

Cleanliness, infection control and hygiene

- We observed all but one HDU to be clean with appropriately-sited hand gel dispensers and observation of infection prevention and control guidance, such as hand washing between patients, 'bare below the elbows' and wearing personal protective equipment, such as aprons and gloves. Appropriate signage was also displayed on doors or barriers if a patient was infectious or immunosuppressed. Equipment was mostly clean and had been labelled to show they had been cleaned within the last 24 hours.
- Some side room doors were left open when patients were infectious. Some clinical waste bins on Fisk Ward were left overflowing and we observed a full sharps bin on Victoria and Albert Ward.
- There was a lack of side room availability across all critical care units although this was on the risk register. None of the side rooms were arranged to be negative (no air out) or positive (no air in) airflow which meant they did not have the correct facility to differentiate rooms between immunosuppressed patients and those that were infectious although pressure was higher in the corridors than cubicles and LITU had filtered air. Staff reported, and we found, patients having to be barrier nursed in bays rather than side rooms, with screens in place on Kinnier Wilson Ward. To mitigate the risk, a hierarchy was in place to prioritise those patients that should be moved into side rooms, with patients with diarrhoea, tuberculosis, influenza, measles and chicken pox regarded as being high priority. In addition, deep cleans were conducted between each patient stay. If more than one patient was infectious in the ward area, those with a similar infection were cohorted together so they could be treated without being spread with other patients.
- There was a lack of bedside sinks in one ITU and two HDUs as each bed space did not have a sink to hand wash. On one HDU, hand washing sinks were not within patient bed spaces. We did observe some staff did not wash their hands in some of the HDUs. There was no hand washing facilities at the entrance door to Victoria and Albert Ward, but hand gel was available.

Critical care

- Hand hygiene across critical care was at 93.97% compliance, up from 83.82% in May 2014. On LITU, it was 90.3% in April 2015 and averaged between 92% and 95% in previous months. Only one staff member out of 15 did not clean their hands in LITU according to a spot check audit in April 2015. The hand hygiene audit for Kinnier Wilson Ward was 95% and 100% in the last two weeks. Frank Stansil Ward's last hand hygiene audits varied between 96.3% and 100%. Christine Brown Ward's were 95.5% overall. Jack Steinberg Ward's were 93.1% and 94.7% in the last two recorded months prior to the inspection.
- Critical care had a just better than national average rate for patients who acquired methicillin-resistant staphylococcus aureus (MRSA). Each critical care unit had an infection control scorecard which showed trends and year round results for infections, hand hygiene, cleaning, infection prevention and control (IPC) training and documentation. Year to date LITU had zero MRSAs, three cytolethal distending toxins (CDTs), 27 vancomycin-sensitive enterococcis (VREs), 15 Enterobacteriaceae, 15 resistant non fermenters and ten other acquired infections. Intensive care national audit and research centre (ICNARC) data showed acquired MRSA rates were better than the national average, C difficile incidence was around the national average. Sepsis was improving to better than the national average. There had been no infection outbreaks in any of the critical care units. Senior staff were aware there had been a trend of C difficile appearing, but reported that none were attributed to cross contamination between patients, and told us they were mostly likely to do with the lack of side rooms. The same issue was reported that caused the high amount of carbapenem-resistant Enterobacteriaceae (CRE) infections.
- For the other ITUs, ICNARC showed acquired MRSA was below (better than) average after recent variable performance. Acquired C. difficile had increased (worsened) with a recent slight decrease (improvement). Sepsis was below (better than) average.
- MRSA screening was 100% for elective patients and 90.9% for emergency patients. Intravenous (IV) line audits were 100% compliant with guidance other than documentation completeness which was 91.2%. Antibiotic stewardship recording was 93% for clinical indication, 87% for recording of the stop and review date and 100% followed the guideline. Medirest cleaning (a healthcare support service) was 98.3%, nurses cleaning was 93.8%, commode cleanliness was 100%.
- The trust WIRED training system showed compliance with infection prevention and control (IPC) training was 75% for nurses, and 51% for doctors across the critical care service. On the Victoria and Albert Ward, training rates were at 86% for aseptic non-touch technique (ANTT), and 73% for IPC. However the trust told us the WIRED system was not up to date and other figures they had showed IPC training at 100% for nurses.
- Continuous central venous catheter (CVC) audits were undertaken in all of the ITUs on a monthly basis although we only reviewed those in three units. Results showed that the last catheter-related bloodstream infection (CRBSI) was in November 2014 and there had been a total of ten infections since April 2014 out of 9,487 bed days, which was low.
- One HDU unit did not have a sluice, and other sluices were located far away from some patient beds meaning staff had to carry commodes and dirty linen quite far for cleaning.
- There were infection control link nurses for each unit. Microbiology and infection control staff conducted clinical rounds daily, three by a consultant and two by a registrar. However, staff told us microbiology did not have routine cover for the HDUs and some staff told us the IPC team was not very visible. However the Trust told us microbiology cover was provided to all HDUs by the microbiology consultant aligned with that specialty area.
- IPC meetings took place weekly and monthly and weekly meetings involved microbiology.
- Some staff reported they had not been trained regarding the Ebola infection although the trust told us core members of staff had been trained that had the competency to care for patients with Ebola.
- We saw some blood stains, including on the bedside linen of a couple of patients, but they were on dialysis at the time, which meant there was likely to be some blood drips at times.
- Confidential waste bags were in use and, although they were not always secure, they were located away from public areas.

Critical care

Environment and equipment

- Most critical care areas had a lack of space and did not conform to national standards. Particularly on LITU and Todd Ward, where the lack of space meant only one bed could be transferred through the corridor at any one time with a lack of space for staff either side of a bed in the corridor. As patients were critically ill, we were concerned that, in the event of an emergency, if a patient was being transferred through the corridor at the time, there would be a high risk that both staff and resuscitation equipment would not be able to pass a patient being transferred on the corridor, thus delaying potentially life-saving treatment. However, no incident of this kind had been reported by the time of our inspection. Most of the units did not comply with national guidance regarding bed space. To reduce the impact, the units conducted declutter days to ensure equipment was not blocking space and equipment was manoeuvred to create space to rehabilitate patients.
- Emergency equipment, such as resuscitation trolleys were available throughout the units and checks for these were up to date apart from on Christine Brown Ward and Jack Steinberg Ward, where around 10% of the checks had not been recorded. However, we were concerned there was only one resuscitation trolley on a HDU and this was placed at one end of the unit, which was a full length of a corridor away from the other side. The HDUs did not have their own resuscitation trolley, as these were shared with the rest of the general ward they were on.
- Some oxygen cylinders were stored inappropriately on their sides in a room that was not secure on Jack Steinberg Ward, and they were incorrectly stored on one HDU where staff were unaware of whether they were full or empty.
- We checked a range of equipment, of which a few items were out of date, two by over three years.
- IV fluid storage was inappropriate in both Victoria and Albert Ward and Fisk Ward, where they were stored in open areas, due to a lack of clinical rooms.
- We were concerned that mobile x-rays conducted in one of the HDUs did not meet radiation protection guidelines. Staff told us they were not aware of any specific precautions. Todd Ward had identified a risk regarding protection of staff and patients during x-rays, but there were no plans to address this. However the trust told us they had reviewed their practice and stated that they were in line with radiation protection guidelines.
- There was inappropriate storage of blood gas machines on Christine Brown Ward, as they were in the sluice. There were concerns regarding blood gas machines breaking down across the ITUs, however, they were able to share blood gas machines in the event of one needing repair.
- There was an appropriate amount of ventilators available on the units and these were regularly serviced. They were standardised between the units, so nurses did not have to be retrained if they were rotated between the units.
- Although the risk register highlighted the lack of scopes as a concern, none of the staff told us this was a problem.
- Staff reported having good access to technical support when there were problems with equipment. However, this was not available seven days a week.
- LITU environment audits were conducted for nursing, cleaning and estate, which showed mostly above 90% compliance, although the most recent estate result was 74.3%.
- LITU staff were concerned by the lack of rehabilitation equipment such as tilt tables and hoists stating accessing them was “luck of the draw”. However the trust told us that there was sufficient equipment available which are shared between the units.
- A quality round took place on Kinnier Wilson Ward, which included a check of all the equipment and facilities, such as the blood gas machine, resuscitation trolley and oxygen cylinders. Our inspection showed there were no concerns regarding equipment checks on this ward.
- Hand rails were in place in bathrooms and all ligatures were risk assessed, which were mostly graded as ‘low risk’ with some graded as ‘medium risk’.

Medicines

- Most medicines were appropriately stored and managed on the ITUs. Medicine fridges on the HDUs were checked and at the correct temperature, although one was not locked and one ITU fridge had no record of temperature checks. Controlled medicines (those that required security) on some of the HDUs were inappropriately stored. Some medicines were stored

loose and were out of date by up to three months. Medicines were sometimes signed for by initials rather than full signatures. Three drugs fridges had the keys left in their locks. Some non-controlled drugs were not locked away and, therefore, were accessible to unauthorised persons.

- The controlled drugs policy was up to date.
- There was a conflicting message regarding who should create and retain the lists of authorised signatories for medicines. There was no list of authorised signatories available in the areas we visited and staff were not aware of who the accountable officer for controlled drugs was.
- Nursing staff had medicine management training, which included tests on drug calculations and IV fluids. However, medicines training was not always up to date. There was an attendance rate recorded of 27% for medical staff and 92% for nurses at refresher days as it was not part of the trust's mandatory training and there were no specific requirements in critical care for it. However, all staff had to pass a medicines assessment test before they were able to administer medicines. No agency staff gave oral medicines unless they were regularly employed by the trust and would still have to pass the competency test.
- An audit showed that critical care met most controlled drug standards. However, areas for improvement were identified on Christine Brown Ward in two areas, Frank Stansil Ward in two areas, Jack Steinberg Ward in three areas, LITU in all but one area and Todd Ward in four areas.
- In December 2014, an antibiotic audit showed all units were 100% compliant with standards.
- IV fluids in most units were not stored appropriately in a number of areas where rooms were not locked and temperatures were not controlled.
- There had been a recent increase of heparin incidents on the ITUs, which most staff were aware of. In response, a medicines group was set up with link nurses, which had led to improvements and a reduction in these incidents.
- There was a mix of paper and electronic prescribing charts and there was inconsistent practice. This had led to an incident where there was a prescribing duplication error.
- We observed that medicines to take home by the patient were not formally handed over to staff and were left on a cupboard in an unlocked area.
- There was a dedicated pharmacist that covered all neurology services, including Kinnier Wilson Ward and there were pharmacy teams for all critical care areas.
- A recent medicines management audit showed most of Christine Brown Ward and Frank Stansil Ward were compliant with guidance, but there were a number of concerns in Jack Steinberg Ward, including: a lack of documented reasons for medicine omissions, nurses not knowing where the medicines management policy was located, and inappropriate drug fridges.
- Allergies were clearly recorded as part of the medicines administration record and we reviewed only one record where the medicines administration record did not include a patient's known allergy, although it had been recorded on the previous chart.

Records

- A new critical care patient safety analysis document was in place on the ITUs. This included assessments in psychosocial needs, falls, restraint, and actions taken if a safeguarding referral, Deprivation of Liberty Safeguards, lasting power of attorney or best interest assessment was required with relevant guidance and flow charts incorporated as part of the document to aid staff. However, staff said this still required “bedding in”. There had been no formal programme introducing the new patient record templates before they were used although it had been brought in a measured way. These documents were different depending on the HDU. Kinnier Wilson Ward had three separate assessment booklets, each differing in recording of assessments. These booklets included some, or all, of the following assessment criteria: falls, bed rails, moving and handling, nutrition and Waterlow risk assessment (for pressure sores), swallowing, mobility, breathing, communication, personal care, continence, blood, psychological, pain, social and sleep assessments.
- There was a mix of electronic and paper records in the critical care units, whereas other wards were fully electronic. This meant records changed when patients transferred to other units and this was causing some concerns. However, basic information for stepping down patients was electronic, such as discharge summaries. When we checked the paper records against the electronic records for when patients stepped down,

there was very little missing information other than some handovers that were not signed off and one central venous catheter (CVC) check had not been completed.

- Nursing records were often incomplete in all the HDUs and one of the ITUs, with gaps in recording, such as: comfort rounds, consultant review on admission and reviews of sedation. Some patient records had loose leaf sections and some records were illegible. Discussions between relatives and doctors were not always recorded in the notes. When we spoke with senior staff, no nursing assessments audit had been undertaken to ascertain if these were being completed. They felt any issues would be picked up and corrected through the Safety thermometer, when records were reviewed as part of mortality and morbidity meetings and on quality ward rounds by matrons. Quality rounds reviewed venous thromboembolism (VTE), pressure areas, catheters, falls risks, social interaction and the overall nursing documentation, but in a summary way without particular checks, such as legibility, signatures and some assessments.
- There was 80% compliance with ventilator-associated pneumonia (VAP) care bundles.
- Electronic notes did not have comprehensive guidance on how they should be completed. Abbreviations were being used, which were not clear or in line with trust policy.
- Information governance training was 70% on Kinnier Wilson Ward and 60% on Victoria and Albert Ward. Critical care mandatory training for health records was 64% for medical staff and 88% for nurses. We observed some receptionists not locking their computers when they were away from their desks.
- Most patient records were kept away from public areas and stored either in bedside drawers or behind the nurse's station.

Safeguarding

- According to WIRED, compliance with safeguarding training on the ITUs was at 65% for level 2 adults (19% for administrative staff, 82% for nurses and 37% for medical staff), children level 2 safeguarding training was 85% for medical staff, 89% for nurses, children level 3 safeguarding training was 36% for nurses, and not recorded for medical staff. On Victoria and Albert Ward safeguarding adults training was 65%. The trust stated that safeguarding training rates were higher as their electronic training records system was not accurate. However, staff were aware of how to report a safeguarding concern via the electronic system and who the safeguarding trust wide team was.
- Each unit had a social worker to refer to if there was a safeguarding concern. Matrons and managers were also alerted, so staff were kept informed.
- We saw appropriate examples of safeguarding referrals, but reviewed some patient records where a referral may have been needed where the assessment and discussion had not been recorded. However staff were aware of the safeguarding concern and had recorded the subsequent action electronically.

Mandatory training

- Training rates provided to us by the trust via their WIRED system showed, for critical care, that equality and diversity was 71% for medical staff and 96% for nurses. Fire was 54% for medical staff and 64% for nurses. Health and safety was 61% for medical staff and 97% for nurses. Manual handling was 27% for medical staff and 63% for nurses. Resuscitation was 54% for medical staff and 75% for nurses. However, when we checked the training matrixes for the ITUs, they were all at 85% or above for their overall training rates. Lower rates were recorded for the HDUs. A lot of staff were not up to date with their training on Kinnier Wilson Ward, but they had been booked in for sessions. We were informed the practice development nurses (PDNs) monitored training rates and kept staff informed about what training they were required to complete, or update. The trust told us training rates were higher at 85% or above as their WIRED system was not accurate.
- All relevant staff told us they were trained in immediate life support (ILS). However, on Victoria and Albert Ward, we were told 80% were ILS trained.

Assessing and responding to patient risk

- Early warning scores (track and trigger system to monitor and escalate patients whose condition may deteriorate) were recorded on an electronic system outside of critical care. iMobile (who provided the outreach service) were alerted and were able to monitor if patients were deteriorating to the level that they needed to review their treatment. All the staff we spoke with praised the iMobile service. They particularly supported the HDUs for patients that were stepped down from the ITUs or patients at high risk of deteriorating. Any patient potentially needing escalation

of care required a review by iMobile first. The iMobile service included nurses, an intensive care consultant and registrar during the day and a registrar at night who was advanced airway trained.
- We observed patients being escalated to iMobile and the response was immediate. One patient required level 3 care, so a consultant from critical care reviewed the patient and admitted them.
- Out-of-hours access to liver transplant coordinators were available in case a patient required urgent assistance.
- Emergency resuscitation simulation training and screening for dysphagia took place.
- All HDU staff were trained in an ALERT course (a multi-professional course to train staff in recognising patient deterioration and act appropriately in treating the acutely unwell), which aids staff in managing a deteriorating patient. Staff feedback from this was positive.
- The hospital audited the 'failure to rescue/deteriorating patient' process, which was where staff had failed to identify or act on patients that were deteriorating. It showed a total of 180 patients had some omission regarding failure to rescue between February and May 2014. 16% cent were not recognised, 13.4% were not responded to when a call out was made, 9.6% had no record of deterioration and 8.3% had not been escalated. However, these errors were reducing month on month.
- ICNARC records showed iMobile reviewed nearly all patients stepped down from the ITUs other than from LITU although the trust told us they reviewed LITU patients other than those post-transplant. There was also a ward round by one of the iMobile nurses once a week on Kinnier Wilson Ward to review step down patients. LITU staff were not able to explain why there was no review after discharge other than the fact that HDU wards were physically close to LITU, so any concerns could be followed up rapidly.
- HDUs had their own track and trigger sheets, which was a step up in observations from general wards, such as hourly observations with individual checks on all the areas within critical care guidance, such as: responsiveness, movement, blood pressure, respiration and so on. When we checked these, they were mostly complete, although some observations were not done as frequently as required.

Nursing staffing

- Christine Brown Ward's establishment was 77.56 nurses (75.44 were in post), 5.38 HCAS (seven in post) and it was using 12% of bank staff. Fisk Ward's establishment was 26.23 nurses (22.61 in post), 7.24 healthcare assistants (seven in post) and using 17% bank staff. Frank Stansil Ward figures showed their establishment as one nurse (none in post), zero healthcare assistants (zero in post) and 3% bank usage. However, seven nurses had started since January 2015 and there actual staffing figures were included within those reported by Jack Steinberg Ward. Jack Steinberg Ward had an establishment of 172.62 nurses (177.78 in post) eight healthcare assistants (10.77 in post) and using 8% bank staff. Kinnier Wilson Ward had an establishment of 23.11 nurses (25.99 in post) 10.2 healthcare assistants (9.5 in post) and using 29% bank staff. When we inspected, they had two vacancies. LITU had 22% bank staff. This was slightly higher than the 20% guideline for the Faculty of Intensive Care Medicine standards and was acknowledged as borderline by LITU. On-going recruitment was taking place, which included an additional 20 nurses from the Philippines. Victoria and Albert Ward had an establishment of 63.7 nurses (48.11 in post), 13 healthcare assistants (9.45 in post) and were using 14% bank staff, which matched what we were told by staff, particularly at night where there was a higher reliance on bank staff.
- The usage of agency nursing staff in critical care was 3.2%. Vacancies were reported as 0% for technical staff, 0% for additional clinical staff, 11.04% for administrative staff, 16.36% for allied health professionals (AHPs), 9.59% for scientific staff, 0.12% for medical staff, and 11.17% for nurses. Senior managers estimated there was around a 5% vacancy rate, with very little use of agency staff, due to a six month recruitment drive to employ nurses for Christine Brown Ward when it opened.
- Nurse staffing levels across all the ITUs and all but two of the HDUs were within national guidance. All the ITUs had 1:1 nursing care for patients. The only patients that ever received 1:2 care were level 2 or below patients. All but the renal and liver HDUs had 1:2 care during the day. Records and rotas showed that one unit, which was not at this ratio, had an established ratio of 1:4/5 and they cared for dialysis and confused patients, but not all patients were level 2. One HDU had a ratio of 1:3 at night. One ITU was using a high level of agency staff and

one HDU had no supernumerary nurse, but the rest had low levels of agency and bank use. We saw one nurse on a HDU caring for a level 2 patient, two postoperative patients and a patient with 1:1 support by a healthcare assistant (HCA).

- Supernumerary practice development nurses were in place for each unit. Overseas nurses that were recently appointed were initially supernumerary and supervised for three weeks before they became part of the establishment numbers. Other new recruits were supernumerary for two weeks. Student nurses on placement were also supernumerary.
- There was not always a supernumerary floating nurse, or healthcare assistant on each level 3 unit, which meant that sometimes staff felt stretched, particularly during breaks. There was also not always a band 7 nurse to manage the unit at night, though there was always a band 6 nurse and always one band 7 on shift across critical care. If staffing levels were below requirement, taking into account the acuity of patients, they were able to move staff to other units to fill any gaps. Sometimes the practice development nurse or matron had to take on a clinical caseload when there was a staffing shortage. One practice development nurse estimated this happened around 30% of the time. LITU assessed that they did not always meet the requirement for supernumerary nursing staff outside of the clinical coordinator at times, due to high patient acuity.
- Extra corporeal membrane oxygenation (ECMO) patients had three nurses to two patients due to their acuity.
- Matron rounds took place informally, but nothing formal was in place.
- Nursing staff had recently stopped rotating between units to provide standardisation and consistency of care. This also allowed for the units to be more generic, so nurses did not lose their competency for caring for patients with different conditions. However, there was an acknowledged concern that this meant the units could become specialist.
- Nursing staff undertook two handovers each day. These included a handover for the whole unit and a one-to-one handover between the nurses looking after each individual patient. Handover sheets were comprehensive and there were full discussions about a patient's social and medical history, the treatment plan, and details regarding current observations.
- iMobile had a high workload from the HDUs, but staffing was at establishment.
- None of the patients we spoke with reported that there were delays in receiving support from nursing staff if they pressed their call bell, although a minority of patients felt there should be more staff.
- Some of the HDUs reported they struggled to recruit band 6 nurses.

Medical staffing

- Medical cover for three of the ITUs was within national guidance. A consultant was on site for each unit every day and they were on either a four or three-day rota, with 12 hours on site and 12 hours on-call, which had been introduced in March 2013. This was a tripling in the number of consultants from a few years ago. Each consultant was then on-call during the night and located so they could come into the unit within 30 minutes. During the day, each unit had at least one registrar and two year 2 or more senior doctors with two floating doctors who worked across the units attached to iMobile and the emergency and trauma departments. At night, each unit had a registrar on site and there were registrars in cardiology, trauma and neurology available as well as two advanced trainees covering critical care and the emergency department, iMobile and trauma. Job plans were also arranged so the consultants had enough professional activities to be critical care competent, as required by national guidance.
- Critical care doctors were the primary clinicians for patients on the units, so although they should still be seen by medical and/or surgical doctors, responsibility for care rested with critical care. There was also support from the iMobile doctor and emergency department (ED) anaesthetist, who were both airway trained. Rotas were arranged so consultants did not have additional commitments elsewhere in the hospital. It was rare for a consultant to be called in on-call, which we were told was due to the junior doctors having suitable experience as many of them were clinical fellows and consultants were often on site until 10pm.
- LITU conducted an audit against the intensive care society standards which showed they had a 1:19 ratio of consultants to patients which is contrary to the recommended 1:8 to 1:15. They assessed this as appropriate for LITU but no rationale was given in the audit although the trust stated that this was due to a

lack of emergency cases and patient turnover. However, there were no incidents related to this ratio and other parts of their practice were within national guidance such as twice daily medical reviews.

- The HDUs sat within their own medical or surgical specialty, so they had no rotated anaesthetic support. Critical care doctors would only review patients on a reactive basis. However, the units had dedicated medical or surgical doctors depending on what speciality they were, such as neurologists, renal consultants and cardiologists/cardiac surgeons. For instance, Kinnier Wilson ward had a clinical fellow as its lead clinician and a junior doctor was on shift 24 hours a day, seven day a week. There was also input from neurologists and neurosurgeon consultants.
- Medical rounds were appropriate, with a full review of a patient's history, the medicines and treatment they were receiving, as well as any social aspects that required highlighting, such as informing next of kin. On the HDUs, different ward rounds took place. For example, on Kinnier Wilson Ward, the clinical lead conducted a round, but also neurology and neurosurgery conducted their own separate rounds.
- We observed part of a critical care handover and this included a checklist, such as an introduction by all the doctors, review of the unit's capacity, and discussion on any meetings that day. They also discussed each patient's situation, such as their social and medical history, treatment plan, observations and ensured any plans were within current guidelines.
- There was anaesthetic cover in obstetrics at night, but they were often stretched if there was a caesarean and epidural occurring at the same time. However, 85% of patients were reviewed within 24 hours of admission by a consultant or registrar.
- Board rounds were scheduled daily, but did not always occur. However there were always safety briefings.

Major incident awareness and training

- The major incident policy was up to date and had appropriate action cards for critical care staff on how to act in the event of an emergency. Staff on LITU were aware of where to locate it and could describe the unit's responsibilities.
- Emergency procedures were in place if a patient required an urgent procedure on the unit, such as a laparotomy.

Are critical care services effective?

Good

Critical care services achieved above average outcomes for patients, particularly regarding mortality and the impact of the iMobile service. Most national and local guidance was up to date and being followed. Pain relief was well managed. Staff were mostly competent to care for patients and had access to a range of development and training programmes. Seven-day services were mostly in place.

However, rehabilitation guidance had not been followed, despite showing positive outcomes. There was a lack of some therapists and AHP support, both directly and as part of multidisciplinary teams. The Mental Capacity Act 2005 was not followed for some patients we reviewed with a lack of mental capacity assessments and some staff showed a lack of understanding of the Act. Training rates for mental capacity were also well below the trust target.

Evidence-based care and treatment

- All the policies and procedures we reviewed other than the one on health and safety were up to date. LITU staff told us they were currently updating policies relating to gastrointestinal bleeds, acute liver failure and use of therapeutic plasma exchange.
- The health and safety folder was out of date, with policies and procedures dated from 2010/11. However, staff told us the most up-to-date guidance was on the trust intranet and the introduction folder to the critical care service was based on current national guidance. Mobile computers were available for staff to find up to date guidance while they were working. Staff told us they were alerted if there were changes to protocols.
- The LITU performed an audit to assess whether it was meeting the Faculty of Intensive Care Medicine standards. They assessed that they met 44 standards out of 57 with the rest rated as amber such as critical care trained staff at 50%, rehabilitation of patients and lack of critical care trained pharmacist although there was mitigation for each of these.
- iMobile measured themselves against the Operational Standards and Competencies for Critical Care Outreach services, which included measures for both the way

patients are escalated and the work iMobile did themselves. There was use of track and trigger (early warning scores) in the appropriate manner, such as levels of escalation and types of observation.

- The hospital achieved 73% on its self assessment of its critical care services – 19 of the 26 weekday and weekend critical care standards were met against London Quality Standards in 2013 with only four not met in 2015.
- Only 2% of National Institute for Health and Care Excellence (NICE) guidance required action. These included updates relating to perioperative hypothermia, critical illness rehabilitation, neuropathic pain, and drug allergy. There were continuous audits and monitoring to ensure the units were complying with national guidance.
- The service had poor rehabilitation guidance compliance, with only 50% of patients having a short-term goal and 8% a medium-term goal. Recommendations from their audit showed a need for a rehabilitation ward round, a records tool, rehabilitation prescriptions on discharge, and goal attainment scaling (GAS) for tracking goal settings. Physiotherapists said rehabilitation was not a priority and agreed that the hospital was not complying with guidelines. There was no on site weekend cover to ensure patients were assessed for their rehabilitation needs within 24 hours of admission, or that they were discharged with a rehabilitation prescription, as required by NICE guidance although there was an out of hours service seven days a week. Out of hours cover was being discussed with the therapies team. Only 'at risk' patients on LITU were given active therapy five days a week and this was only for 30 minutes when Faculty of Intensive Care Medicine standards require 45 minutes for all patients requiring rehabilitation. However the trust told us a new multidisciplinary advice and goals in intensive care (MAGIC) document and new rehabilitation process had been introduced since the audit which had improved rehabilitation goal setting.
- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) showed compliance with their standards, at 80%. Still to complete were tracheostomy care gap analysis. However, the service had implemented recommendations from acute problems (26 of 29 done), caring to the end (16 of 24) perioperative care (one of 11) and cardiac arrest procedures (eight of 20).
- An audit in December 2014, for IV lines in the ITUs showed compliance with dressings at 100%, date 100%, line needed 100%, documentation complete 75%, less than 72 hours 100%. These were consistent, or improving, in the next three months with documentation at 95% and 86% in two of the units in March 2015. In LITU, IV line audits showed 100% in March 2015 in all areas, but date recorded, which was 91.3%. This was fairly consistent with previous months. However, the IV line audit for Kinnier Wilson Ward showed overall compliance was at 60%.
- The March 2015 VAP audit for the critical care units showed a result of 86.8% compliance, with particular concerns regarding: oral care/oropharyngeal suction, sedation hold, humidification, cuff pressure monitoring and in-line catheters. However, this result was worse than the previous few months, where compliance was above 90%.
- Concerns were raised in an audit regarding parenteral nutrition. This showed there was a need for a formal parenteral assessment, and that staff required further education on the parenteral nutrition guidelines as it should start at five to seven days post admission when staff were commencing it at two days post admission. However, the trust told us new evidence suggests guidance should be changed to allow parental nutrition on admission.
- There was a tracheostomy folder, which included relevant and up-to-date information for staff, such as: emergency care for blockages, environmental checklists, a suctioning guide, monitoring cuff pressure and decannulation.
- The matron-led quality round that we observed on LITU took place weekly to ensure adherence to policies and procedures. The latest round showed some issues with record keeping.
- Each ward had a noticeboard reminding staff about policies and procedures, such as: the management of sepsis and delirium, guidance for inotropes, and how to refer to iMobile, among others.
- Pharmacists were using national guidance in their work, such as NICE and South London Cardiac and Stroke Network Group guidance.

Pain relief

- Patients reported that they received pain relief when they required it and that it was reviewed regularly.

- Pain scoring was in place and records showed these scores were well managed.

Nutrition and hydration

- Staff, including: nurses, housekeepers and healthcare assistants were enabled to support patients to eat .
- Enteral nutrition plans were nearly all complete, but sometimes more detail was needed. These were completed electronically so the necessary protocols for the patient could be calculated.
- We observed nasogastric (NG) tubes in place for some patients and these were appropriately inserted.
- There was good nutrition compliance, but the service reported there were issues with calorie intake by patients, such as lack of prescribed nutrition support, and insufficient calories. Therefore, the service was looking at high protein feeds, better records, and energy balances. Some nurses felt they observed patients being malnourished, but couldn't do anything due to a lack of expertise. However, we found patients were monitored for their calorie and energy intake during our inspection. Food charts were also in place and were complete. They were compliant with the NHS London standard for dietician, speech and language and occupational therapist support.
- Food and drink on patient surveys was reported as being 'adequate' other than some concerns regarding taste and texture.
- There was only one permanent dietician allocated to the ITUs who conducted a daily round and was part of the allied health professions meeting. However, the rest of the dietician service was reactive to any referrals. If an allocated dietician was on leave, the lead dietician had to cover them, which meant they were very stretched and could only review high risk patients. We were told this situation was due to cost pressures and the divisional difference between therapies and critical care.
- The food we observed looked appetising and a stock was always available in the kitchen if a patient was hungry overnight. Drinks were placed within reach of patients.

Patient outcomes

- The Intensive Care National Audit & Research Centre (ICNARC) showed critical care services had a better mortality rate than the national average, although a slightly worse than average rate for patients who were less than 20% risk of mortality and much better than average for patients with an above 20% risk of mortality.
- The ICNARC audit for Frank Stansil Ward, Jack Steinberg Ward and Christine Brown Ward for July to September 2014 (which was the latest published at the time of our inspection) showed their data was mostly complete other than NHS number, length of stay (LOS) and outcome. Physiology variables were mostly complete, other than arterial blood gases and blood lactate. The services were reducing the use of cardio-pulmonary resuscitation (CPR) to just better than average. Ventilated admissions showed variable mortality rates and better than average sepsis. Severe sepsis admissions showed around average mortality. Pneumonia admissions showed variable mortality. Elective surgery admissions showed improving to average mortality, and average to below average sepsis. Emergency surgery admissions showed variable mortality and better than average sepsis. Trauma admissions showed just better than average mortality.
- The service had worsening (more) early deaths after being better than the national average and variable between better and worse than the national average for late deaths. Mostly patients required respiratory, cardiovascular or gastroenterology organ support (machines supporting the patients organs to work) with a small amount of patients requiring renal, neurological and dermatological advanced level support. Most patients required between one and three of their organs supported, but there were small amounts of patients requiring four and above organs supported with high amounts of bed days. Post unit deaths were improving to better than the national average at 6%. Most patients stayed as independent as they were before admission but a minor amount had increased dependency. 8.4% of patients suffered a brain stem death and of these, just less than 10% of patients donated organs. The mortality ratio was 0.90 according to ICNARC and 0.84 according to the Acute Physiology and Chronic Health Evaluation (APACHE II) which was better than the national average and showed the units were the best ITUs for the top three admitting units in the country.
- ICNARC results for LITU from October to December 2014 showed data completeness was 100% or near 100% apart from ethnicity, NHS number, neurological status, average length of stay (ALOS), and outcome. Physiology details were complete other than arterial blood gases with most others just below 100%. Cardio-pulmonary resuscitation (CPR) rates were just better than the national average. Ventilated admissions had a better

than national average mortality rate, and reducing rate of blood infections. Severe sepsis patients had a better than national average mortality rate and this was improving. Pneumonia patients had a better than national average mortality rate and this was improving. Elective surgery patients had a better than national average mortality rate which was improving and were around the national average for sepsis. Emergency surgery patients had a mortality rate that was better than the national average and improving and sepsis was around the national average. Trauma patients had a variable mortality rate between better and worse than the national average but this was recently improving. The amount of early deaths were better than the national average and late deaths had recently improved to around the average. Patients required mostly respiratory, gastroenterology, renal and cardiac organ support. Organ support was at advanced level in up to 40% of cases with high amounts of renal and liver support. Admissions were roughly equally spread between one and six organs supported. Post unit deaths were variable between better and worse than the national average. A small amount of patients were discharged with decreased dependency. Just below 50% of patients that did not survive had treatment withdrawn before their death. There were no brain stem deaths and no patients donated organs. Mortality was around 7.5%. The mortality ratio was 1.04 according to ICNARC and 1.20 according to APACHE II, which was improving, but slightly worse than average for similar units. It was fifth out of nine on mortality and sixth in the number of admissions according to ICNARC, worst of nine on mortality and eighth for the number of admissions according to APACHE II although the trust told us the units compared to had differing case mixes which affected comparing their mortality rates.

- Critical care services had a better than average sepsis rate and had a better than average 'unplanned readmissions within 48 hours' rate. When readmissions did occur, staff on the HDUs said ITUs took them within 30 minutes of them being identified as needing care.
- The Donor Audit showed they had received 116 donations (which was part of a rising trend), 73 kidneys, 14 pancreas, 26 livers and eight hearts. In seven areas the units performed better than average including referral to the Specialist Nurse in Organ Donation – SNOD. Three areas performed similar to average (staff tested to see whether death was neurological, and that consent was given by the patient's family), and two areas required improvement measures (the patient's family was approached for donation and the amount of actual donors from each pathway was recorded). The trust told us they have investigated the areas of requiring improvement and said they had found no concerns.
- There were good outcomes for most patients receiving extra corporeal life support (ECLS) or extra corporeal membrane oxygenation (ECMO), other than cardiac patients, where the survival rate was average and had a mortality rate of 0.76 . For all ECLS patients, the survival rate was 49% and all liver patients it was 60%. The predicted survival rate was 34.5% for patients with ECMO and less than 10% if patients had only standard critical care intervention with an overall mortality rate of 0.78.
- Patient rehabilitation outcomes were assessed using nationally recognised quantified tools but we did not receive audits for these.
- iMobile were involved in an international study on short term outcomes after rapid response. This showed 58% of patients had an improved outcome after involvement by iMobile with one unexpected death out of 63 referrals in the first 24 hours. After four weeks, 30% had a ceiling of care (patient treatment wishes/limits on care) with 73% still alive and which 93% of deaths that occurred were expected.
- iMobile conclusions from their audits showed that less than 10% of referrals to them were inappropriate. There were better resuscitation outcomes, patients were identified earlier as deteriorating, there was a reduced length of stay, better quality of care and treatment was cost effective. However, there was no change in mortality rates, no change in cardiac arrest rates, a rise in unplanned admissions, mortality in delayed admissions and unexpected deaths and a worry that gaps were appearing between the wards and the critical care team. However, SHMI showed intervention by iMobile reduced mortality by 12.3% and cardiac arrests were also reduced by between four and 10 per month, depending on the statistical method used. There was no change in readmissions.
- A pharmacy Clinical Interventions Audit showed 44% of medicine interventions resulted in a patient's length of stay not increasing or improving.

Critical care

Competent staff

- In December 2014, WIRED showed that appraisals were at 31.7% within critical care, but other figures received showed they were at 4% for technical staff, 3% for additional clinical staff, 9% for administrative staff, 14% for allied health professionals, 12% for scientist staff, 0% for medical staff, 7% for nursing staff. The trust reported that appraisals were actually at 70% in March 2015. However, all staff reported that they had received an annual appraisal and had had one-to-one meetings with senior staff or supervision. We were told the figures were reported as being so low, due to changing from a paper-based to an electronic system.
- Over 70% of nursing staff were critical care trained on two ITUs, but other units only had around 50% trained nursing staff, which was the minimum amount required under national guidance. We were told that a number of new staff had been recruited within the two years prior to the inspection, but all were on courses to become critical care trained. Shifts were arranged so critical care trained staff were always on shift and were balanced between trained and untrained staff. LITU were seeking alternative funding to ensure nurses were on training courses. Courses were university recognised, but not accredited, which was being discussed with King's Health Partners. Staff on the HDUs were speciality trained, but the trust no longer provided a HDU specific course although there was access to a university course. The course they had included a cardiac element, which nurses in critical care and other cardiac areas undertook. HDU staff felt competent to care for patients with tracheostomies and weaning.
- Staff were complementary about the induction training they received. There was a checklist for agency and bank staff to complete to ensure they were competent on a ward before they started working, which we saw was being completed. This included training on ventilators. This was also tailored to the unit worked on. The checklist was in depth. On Victoria and Albert Ward, it included areas regarding: respiratory care, haemodynamic assessment, neurology, liver, gastrointestinal tract, fluid management, catheterisation, hygiene/mobility/wound care, psychological care, practice development, people development, team building/problem solving, and drug administration. This was prioritised within a preceptees first two years to ensure the most important areas were learnt within the first six months. An orientation handbook was also given describing: relevant contacts, type of patient records used, reporting of incidents, security protocols, fire safety, IT, intranet, policies and procedures and leave. There was a checklist that accompanied this, which involved going through the handbook areas in more depth, plus orientation that involved being taken around the unit, meeting members of staff, reading through policies and procedures and an introduction to the various IT systems. These were signed off by the staff member and mentor.
- There was access to development opportunities throughout most of the critical care units, including programmes for staff to progress grades, such as from band 5 and 6 as well as leadership courses for senior staff. External studies, conferences and courses were also available. Development days occurred once a month for Kinnier Wilson Ward staff. Band 5 nurses were asked to lead shifts under supervision as part of their development. However, LITU and Jack Steinberg Ward staff both reported that access to training programmes was becoming more limited and funding for these was being cut.
- All but some of the consultants for Jack Steinberg Ward were either intensivists or critical care airway trained or were in training, and some of the registrars at night and other doctors were not airway trained. We were told that an intensivist was always available elsewhere if an anaesthetist on Jack Steinberg Ward needed them. Where there were shifts with doctors who were not airway trained, this was highlighted at handover.
- Junior doctors we spoke with were happy with the training and teaching they received in critical care. We observed that registrars were empowered to lead a ward round with consultant support.
- iMobile staff met the Operational Standards and Competencies for Critical Care Outreach Services as the lead practitioners had a postgraduate qualification in critical care and they had at least three years experience. All nurses either had, or were working towards, a clinical qualification. They also ran teaching sessions each month that included education and training in tracheostomy care.
- Each unit had practice development nurses allocated to them. Practice development nurses were trained in teaching, but their teaching was not formally assessed on an on-going basis. We could find no evidence that they had a structured personal development programme although the trust told us there was one

which included peer assessments, learning objectives and manage under performing staff. All nurses had two mentors. Mentors had their competencies assessed to Nursing and Midwifery Council (NMC) standards.

- Band 6 staff did 90% clinical work, band 7 staff members did 80% clinical work and band 8 staff did 40% to 50% clinical work to stay competent, according to the practice development nurses.
- There was appropriate training for speech and language therapists (SALTs) and other allied health professionals.
- A variety of teaching and courses were available throughout critical care services, which was specific to the units. SALT teaching for nursing staff was in place. Weekly teaching sessions for LITU and the renal HDU wards were in place for CVC care, accountability, nursing documentation, and medicines management. Invites to nursing, medical and Allied Health Professionals were made for these training sessions. A liver specialist course was also available for nurses in LITU. Training was in place for dysphagia, tracheostomies and simulation. Kinnier Wilson Ward had access to trauma brain injury specialist nurses. Critical care staff were due to be trained in peripherally inserted central catheter (PICC) line insertion to reduce their dependency on radiology, and one nurse had already done this. Respiratory workshops were held with physiotherapists every three months. Competency-based transition courses were in place for staff that transferred from a general ward to critical care.
- Sixteen nurses and eight consultants were ECMO trained. IV training was at 75.9% for nurses and 58.9% doctors. Most staff were ALS trained. Overall, training for equipment in LITU was 83.25%.
- Staff on Kinnier Wilson Ward felt underutilised, as they felt competent to take critical care patients, such as patients on inotropes and continuous positive airway pressure (CPAP) and biphasic positive airway pressure (BPAP), but the ward no longer cared for these patient groups.
- Where staff were registered with the professional regulator there were systems in place for registration checks to be carried out, and we saw evidence that they were happening.
- Professional registration checks on staff were carried out.

Multidisciplinary working

- Internal multidisciplinary team working was described as ‘strange’ by some staff. Although consultant ward rounds were conducted with a pharmacist on the ITUs, there were separate board rounds that did not include a pharmacist, but did include therapists. There was one band 7 and three band 6 speech and language therapists (SALT) allocated to the critical care beds, but occupational therapists (OTs) were not allocated to the units, so only reviewed patients that were referred and could not attend all the board rounds, as they were at the same time on each unit. However, we were told they contributed to multidisciplinary team meetings. Staff said they could access pharmacists and physiotherapists easily and that they were supportive. Pharmacists were not part of ward rounds on the HDUs, but did have daily face-to-face meetings with the nursing staff. There was one 0.5 whole time equivalent (WTE) band 7 pharmacist, and one band 6 pharmacist. There were also two band 5 pharmacists dedicated to the liver intensive therapy unit (LITU) who attended handover.
- There was no dietician allocated to the overall multidisciplinary team meetings for LITU, but this had been escalated. However, we did observe good multidisciplinary team working when discussing individual patients, such as a tracheostomy patients being discussed with a SALT. SALTs undertook tracheostomy ward rounds once a week but there was no dedicated SALT support for weaning patients.
- Therapists were on some ward rounds on HDUs. Pharmacy and microbiology conducted their own ward rounds on the HDUs, but the rest of the microbiology team's work was reactive. There was no lead OT for critical care and three OTs in total for critical care. There were three physiotherapists, one band 7 and two band 6 physiotherapists for each unit, which was at establishment level.
- Critical care staff were involved in external meetings with another trust regarding their ECMO service to share good practice and discuss patient options.
- There was a positive relationship between critical care staff and transplant coordinators. Staff told us critical care patients were flagged if they required an emergency donor transplant. Recipient coordinators were involved in daily meetings to discuss post

transplant outcomes and LITU patients with a range of specialist consultants, including LITU and hepatology consultants, as well as social workers, pharmacists and substance misuse workers, but there were no therapists.
- LITU were developing their work with the critical care operational delivery network and had a lead nurse for this. HDU staff felt they had developed good links with the ITUs.
- There were multidisciplinary team meetings within the cardiothoracic department that involved staff on Victoria and Albert Ward.
- Multidisciplinary team meetings took place weekly to review all long stay patients, those requiring rehabilitation and patients with complex needs.
- The research team for critical care was cross specialty and undertook a number of projects that included both critical care and other areas, such as a project on brain injuries with neurology staff.

Seven-day services

- Seven-day working was in place, with nursing levels not reduced and appropriate medical staff available at weekends. Pharmacists were also available seven days a week on site. However, there was no SALT or occupational therapists at weekends for critical care.

Access to information

- Formal handover documentation was in place for patients being stepped down. This was mostly complete, but was not always signed off.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- There was varied awareness of the Mental Capacity Act 2005 and records regarding patients' mental capacity was inconsistent. Some staff were aware of their responsibilities, but some nurses said they had not been involved in a capacity assessment.
- WIRED showed training for consent was at 72% for medical staff. Mental Capacity Act 2005 training was at 15% for medical staff and 65% for nurses. Victoria and Albert Ward Mental Capacity Act 2005 training was at 56%. Training courses had been booked for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However the trust told us training rates were higher at 80% or above.
- Deprivation of Liberty Safeguards applications were being appropriately recorded, but Mental Capacity Act 2005 assessments were not being conducted when required. Referrals were made to external psychiatrists to carry out mental capacity assessments and we saw evidence that these had been requested for some patients. Advocates were also being utilised during mental capacity assessments.
- A restraints audit was conducted in November 2014 over a two-hour period across all the ITUs. This showed that 11 out of 54 patients were restrained by staff. The audit did not check the assessments for medicine-based restraint, but did check when physical restraints were in place. This showed three of the four patients who had been physically restrained had no mental capacity assessment. However, staff were aware that restraints had to be prescribed. We observed patients with 'mittens' on to prevent them removing wires and tubes, but no capacity assessment for these had been recorded. On one ward, they had a protocol for using 'mittens' with an assessment, but no capacity assessment was part of this. When we reviewed a patient who had them, there was no entry in the medical notes, or daily review.
- Social workers and psychologists were available, but senior staff felt they needed more of them.
- Consent forms, with accompanying information booklets were in place for those patients receiving transplants, which included what information to share with the NHS Blood and Transplant service. The booklet fully explained how the patients' information would be used.

Are critical care services caring?

Good

Most of the feedback we received, and our observations of care, showed that staff were kind, compassionate and caring towards patients, family and their friends. This was reflected in the surveys. Although it was not always easy to identify staff, they introduced themselves and gave clear explanations to patients, involving them in their care. Emotional support was available and had been assessed, although there were areas to improve.

Compassionate care

- Patient, family and friends feedback was mostly positive. One family told us they "could not praise staff enough". The only negative feedback we received from a

minority of people was that the doctors could be "stand offish" and staff on the level 2 units were not always friendly. Patients told us they felt safe and they were being cared for in a calm environment.

- Almost all observations of care we made were positive, showing kind and compassionate care. We observed nurses assisting patients to the bathroom and giving clear advice on when to use the call bell if there was a problem. However, curtains were not always fully drawn when patients were being cared for and we observed one doctor speaking to a patient from the corridor into their side room without entering it, meaning their conversation was overheard by other patients and visitors.
- All the survey results we reviewed were positive, although there was a poor response rate. For Jack Steinberg Ward, the results from December 2014 to February 2015 showed there had been 29 responses with the worst score of 4.1 out of five (five being excellent, one being poor) for the atmosphere of the waiting room. Most responses were above 4.6 out of five. Particularly high scores were concern and caring by staff, skill and competence of nurses and likelihood to recommend the unit all scoring 4.89 or above. Most additional comments were positive, but there were some negative comments regarding poor communication with a next of kin, long waits for information, lack of lockers, lack of a quiet room, quality of food and noisiness of cleaners. Action plans were put in place for these, including reminders about ascertaining next of kin, a map for rest and café areas, review facilities for relatives, review provision of lockers and reminders to cleaners. The action plans showed where these were completed, with some provision in place, while others needed further work. Staff told us they received the feedback from these surveys from management.
- In the LITU, they received 148 responses to their family satisfaction survey in 2014. The lowest score was 4.2 out of 5 for the atmosphere of the waiting room with all other responses being 4.6 or above. Most additional comments were positive, with some negative comments about lack of information, waiting room facilities, refreshments, and toilet availability. A further survey was conducted in February and March 2015 which had 13 responses. This showed that most results either stayed the same or improved while issues around the environment remained.
- For Frank Stansil Ward, they had 11 responses in February and March 2015. The lowest score was the atmosphere of the waiting room at 3.9 out of five. However, all other responses were 4.4 or above and most showed improvement from their previous survey. All the specific comments were positive other than the size of the waiting area.
- Kinnier Wilson Ward had started trialling their own family survey for a month. Responses had so far been positive. The NHS Friends and Family Test for this ward was also above average, but this did not separate the level 2 unit from the rest of the ward.
- iMobile were capturing ad hoc feedback from patients, which was reported as part of their service evaluation. One comment was, "Care has been marvellous, we would never have got this from our local hospital." In addition, they conducted a patient, family and friends survey in 2015, which received 43 responses on a 88% response rate. Almost all the results were positive and none of the specific comments received were negative.
- We saw a number of 'thank you' cards in all the units.
- Boards on Fisk Ward showing patient details and conditions were in public areas, which meant they did not maintain a patient's privacy and confidentiality.
- We observed screens being used on units that were tight for space to maintain privacy and dignity.

Understanding and involvement of patients and those close to them

- Patients, families and friends overwhelmingly reported that they felt involved in their care and were given explanations about their treatment. We also observed this happen where a family queried a patient's physical position and the rationale for this was explained in a kind manner. One family member told us that staff had "communicated at every stage". Staff said they involved the families in patient care if they wished, such as washing and bathing. Any risks were explained.
- It was not easy for patients to identify staff. The noticeboards only displayed staff at matron level or above. The uniforms between nurses, doctors and Allied Health Professionals did not easily distinguish between them, with both nurses and doctors in blue and patients reporting they could not clearly see name badges. Only the matron and team leaders wore different colours. However, we observed all staff introducing themselves and patients told us staff identified themselves before talking to them.

Critical care

- There was a lack of recording of whether patients were involved in their care on Jack Steinberg Ward.
- The iMobile surveyed patients and their family and friends about their involvement in their care and if questions were answered in an understandable way. All comments were positive.
- Patient diaries had not been started in Christine Brown Ward, although staff wanted to introduce them. This was despite them having been started at the Princess Royal University Hospital.

Emotional support

- The intensive care social work team conducted a report between March 2014 and February 2015 on emotional support for friends, family and patients. It reported there was no lead for bereavement care, there was no policy regarding bereavement care in intensive care, there was no training regarding bereavement support, staff felt the need to be supported, and that there were concerns regarding bereaved children. However information needs were met and reflective practice would be beneficial. It was also said there was regular teaching on team days, there was bedside teaching, teaching sessions with junior doctors, support by the trust for a lead role and good senior management meetings in critical care. Recommendations included having a bereavement guideline, study day, informing families about information and support, give staff support regarding children, having a resource box on wards with information, pilot reflective practice groups, embed a lead role within critical care at band eight with lead in safeguarding and development of a bereavement service. There was also a suggestion of putting forward a business case for a band seven role to cover six days. Research ideas included assessing a family's needs. Since the audit, the trust told us a bereavement lead consultant had been named, with lead nurses and multidisciplinary training since January 2015.
- There was access to a chaplaincy service and we observed staff signposting families and patients to them when they needed to.
- Counselling services were available and a bereavement clinic was due to be set up.

Are critical care services responsive?

Requires improvement

Critical care services were not responsive to patient needs, although plans were in place to address this in the long-term via a new critical care unit. Currently, there was a lack of critical care beds, which affected LOS, and delayed discharges. The environment was not fit for purpose, with inadequate storage space, rehabilitation space and visitor facilities.

However, the service was mostly coping with the facilities it had, with well conducted bed meetings and some flexibility in bed capacity. Patients who required additional support mostly had their needs addressed.

Service planning and delivery to meet the needs of local people

- There was a lack of storage space in most units we visited. Former bathrooms and sluices were being used as storage areas in some of the ITUs. Staff had very few lockers to store items in. Some items, such as hoists and chairs, were left in corridors. Some storage areas were left unlocked or had no door at all. There was a lack of space for rehabilitation of patients and a lack of chairs. The waiting area and relative's rooms for friends and family of patients were very cramped and small. The chairs were uncomfortable, but there were drink holding facilities in some of them. There was only one shower and toilet on Fisk Ward and these were at the end of the ward corridor. Therefore, patients either had to mobilise over a long distance, or had to be provided with a commode even if they were able to mobilise. There was no procedure room in Fisk Ward. Jack Steinberg Ward had a poor ward environment, with beds too close to each other and a lack of patient facilities.
- A patient-led assessment of the clinical environment (PLACE) survey was conducted in two of the HDUs. In Kinnier Wilson Ward and Victoria and Albert Ward, the environment passed. However, there were concerns regarding dustiness, facilities that required minor repairs and lack of storage.

Critical care

- There was a high amount of noise from the building work for the new critical care units, which was effecting Kinnier Wilson Ward and Jack Steinberg Ward in particular although the trust told us the noise was not breaching health and safety standards.
- There were call bells in all the ITUs and HDUs in each bed space.
- Critical care admitted 45 cases for ECMO in two years, but only admitted two at a time onto LITU to ensure safety.
- iMobile reviewed 518 patients a month on average, which mostly were referred by a nurse or junior doctor with some high percentages by registrars, or as a proactive response by iMobile. In six months, they had reviewed 2,686 patients. Most resulted in a full review, or advice by iMobile, a critical care discharge review or other intervention. Most referrals were by the trauma, emergency and acute medicine directorate, with high referrals also from surgery, neurosurgery and cardiology. Referrals mainly related to respiratory reasons, an escalated early warning score, hypoxia or hypertension. Around half of referrals were out of hours.
- A follow-up clinic was available for patients, family and friends to attend after they were discharged from the ITUs.
- Accommodation was arranged with the Salvation Army property opposite the hospital if family and friends required it. Staff estimated that this accommodation was available around 80% of the time, when required.

Meeting people's individual needs

- The social work team for critical care produced a report for March 2014 to February 2015. This showed that 68% of psychosocial assessments were being completed, with some parts of the form not used, such as: communication and preferences, safeguarding issues not acted upon, staff reporting the form was not fit for practice, staff feeling uncomfortable asking questions regarding patients' wills, staff reporting that a better communication section was needed and better outcomes would be reported if the family were involved in information gathering. A new critical care patient safety document was introduced to reflect these findings, such as a family section to be completed.
- Patients' mental health status was recorded, including a psychosocial assessment. Referrals were made to the psychiatric team and HDUs said they would ensure patients had 1:1 care with a healthcare assistant. However, staff reported that they did not always get enough input from psychologists.
- Learning disability Health Passports were in place. The learning disability team were referred to if a patient was identified as requiring additional support for their needs. Doctors told us they would write things down if a patient was hearing impaired. However, we saw no evidence of 'This is me' documents or easy read documents.
- Visiting times were flexible outside of the advertised hours, so friends and family could visit when was convenient for them.
- A trust wide specialist team of nurses in delirium was in place, who conducted teaching in this area, although screening for delirium was not 100%.
- A range of patient and family information was available for those who required support from the transplant team. This included a liver transplant group called 'LISTEN', which gave support to pre- and post-transplant patients. Other information, such as financial/social support, about the transplant process (including pre- and post-surgery) were also given to patients and their families once they were referred, to allow for a greater understanding of the transplant process and treatment options.
- An alcohol liaison team was in place and staff in critical care reported being well supported by them.

Access and flow

- The ICNARC audit for Frank Stansil Ward, Jack Steinberg Ward and Christine Brown Ward for July to September 2014, (which was the latest published at the time of our inspection) showed transfers in were higher than the national average. There were no non-clinical transfers which was just better than the national average. Most admissions into the hospital for critical care stays were planned surgical or transfers in, though just over a quarter were unplanned admissions. Most patients were level 2 or 3, but a small number were level 1. Patient length of stay (LOS) showed over half had less than one, or one day stay, but nearly a quarter stayed over seven days. Most patients were admitted to the hospital who had a critical care stay were from home and were fully independent. Most admitted patients came to ITU having been admitted from theatres, other ITUs or wards. Ventilated admissions showed LOS had just

increased to worse than average. Severe sepsis admissions showed variable LOS. Pneumonia admissions showed variable LOS. Elective surgery admissions showed variable LOS. Emergency surgery admissions showed worsening LOS. Trauma admissions showed worsening LOS.

- The wards above had improving early and out-of-hours discharges after recent spikes, though the spike was due to using recovery beds as level 2 beds. They had a low amount of out-of-hours discharges to ward. There were worsening delayed discharges by mostly a day to two days, although there were small amounts more than that. Most patients were discharged at level 1 or 2, though there was a high amount who were discharged at level 0. The service had improved early and late readmissions, but they were still worse than average and the trust stated that this was due to the case mix they received as a tertiary centre. The units were better than average for transfers out and non-clinical transfers out. Most patients were discharged to comparable critical care, or they no longer required critical care standard treatment. Most patients had delayed discharges. Most discharges were to a ward, or HDU. 96.4% of patients were visited by iMobile post-discharge. However, this was improving. Most patients were discharged home from hospital. LOS was longer than the national average particularly for survivors. ICNARC showed occupied beds increased from around 30 in March 2015 to around 42 in April 2015 which the trust commented was due to an increase in capacity by 15 beds in April 2015.
- ICNARC for LITU from October to December 2014 (which was the latest published for this unit at the time of our inspection) showed they were variable for patients being transferred into the units. They had no non-clinical transfers. They had a small amount of level 1 care in the first 24 hours. Most admissions came from patients who lived at home and were able to live without assistance though a small amount of patients were in need of minor and major assistance. Most admissions came from the ED, theatres or wards. Ventilated admissions had average LOS. Severe sepsis patients had average LOS. Pneumonia patients had average LOS. Elective surgery patients had a longer than average LOS on an increasing trend. Emergency surgery patients had better than average LOS on an improving trend. Trauma patients had variable LOS, but this was on a recent improving trend. However all of these were on very small numbers of patients. Early discharge was better than average and improving. Out-of-hours discharges were worse than average. Out-of-hours discharges to ward were variable, but now were worse than average.
- There was better than average delayed discharges, with most were delayed by less than a day. Unit survivors were mostly discharged at level 0, but a high minority of patients were transferred at level 1 and 2. Early and late readmissions were worse than average, though they were improving. Most discharges were for comparable critical care, or were due to the patient no longer requiring critical care standard treatment. A small amount of patients had delayed discharges. Most discharges were to a ward or HDU. No visits were conducted by iMobile after discharge from the LITU. Most patients were discharged home rather than to a nursing home or other place of residency. The LOS was worse than average. Occupied beds were between 10 and 16 but mostly between 13 and 15 although high occupancy can be due to more than one patient using a bed the same day due to a transfer out.
- In December 2014, the trust scorecard reported that there were 165 discharges, 155 level 1 bed days, 1,522 total bed days. Four days was the median stay (longer than the trust target), there was 104.4% bed occupancy, three readmissions (at 1.7% in July to September 2014, which had improved from six months prior to the inspection), 158 unplanned admissions, 153 delayed discharges (93%), 46 single sex breaches, 11 out-of-hours discharges (eight in Christine Brown Ward, which equates to 15% of discharges).
- In February 2015, a trust scorecard for the LITU showed they had 45 admissions, 10 level 1 days, 106% bed occupancy, a LOS of six days, 46 discharges/deaths, no out-of-hours discharges, four patients who received ECMO, and 21 liver failure or liver disease patients.
- Senior staff were concerned about out-of-hours discharge rates, but assured us the patients were being identified for stepping down before the night, but most times, nights were when ward beds became available. Staff told us most of these were tracheostomy patients, as there was no dedicated elective ward where tracheostomy patients could be stepped down to. They said this was also affecting the flow throughout the hospital.
- Critical care services were better than average for 12-hour and 24-hour delayed discharges. However,

delayed discharges affected 85% of patients. One patient had their discharge delayed by 670 hours and delays of over four hours occurred in 19% of cases. LITU did not always meet the four-hour target to discharge once a decision to discharge had been made.

- They were above the national average for bed occupancy (100% or just below against 85% average) with between 47 and 32 beds occupied at a time, mostly averaging between 40 and 46. Admissions had also increased by 10% in 2014/15. These figures showed there was a lack of critical care beds. There was a plan to open a new 60-bed critical care unit (of four 15 bed pods) in 2016/17, which had been delayed nearly a year, due to site foundation issues. Senior staff expected only one or two of the existing units to close due to the current lack of capacity and expected an increase in the need for critical care beds. To mitigate this, in the meantime, an additional three beds could be opened in the current ITUs and staff told us less acute level 3 patients were sometimes stepped down to HDUs beds if there was a lack of capacity. The service had also opened the Christine Brown ITU in July 2014. Before this, there were HDU beds in different areas of the hospital, such as recovery. A plan had also been discussed to convert another ward into a critical care unit before the new build was finished. However, HDU staff told us they had not been engaged in the plans for the new critical care unit and were worried about the impact this would have, due to the lack of space for the HDUs to expand unless they increased into the general surgical and medical ward spaces.
- Bed management meetings were held four times a day. We observed a bed management meeting, where patient flow was effectively managed, with any deteriorating patients highlighted, as well as discharges. Individual patients were discussed so that the appropriate ward bed could be allocated for their condition, including any current patients in outlying wards. The meeting also displayed that constant conversations between specialties were undertaken between bed meetings, so each specialty was prepared for any patients they were admitting. Bed managers were also aware of which patients iMobile had reviewed, in case any patient needed to step up to a level 3 bed. The particular bed meeting that we attended showed there was some flexibility in capacity, but it was limited and there were some wards experiencing difficulties in keeping patients flowing through.
- There were a small amount of elective surgeries cancelled due to lack of critical care beds, with the most in February 2015 with 11 cancelled, whereas, in most months since October 2014, only one or two had been cancelled. Senior managers felt most cancellations were due to a lack of beds on Kinnier Wilson Ward and an upsurge in neurological trauma patients who require long LOS.
- ICNARC showed iMobile reviewed almost all of the patients discharged from three of the level 3 units, but none from LITU although the trust told us they reviewed all non transplant patients that were transferred from LITU. Staff on the liver units told patients would be reviewed by an LITU doctor if necessary, but nothing formal was in place, nor was there a follow-up clinic. Staff in Todd Ward did not feel the lack of an iMobile review meant there was any impact on care, such as readmissions or poor patient outcomes. However, we saw no plan to address this although the trust told us liver patients would be reviewed via various meetings.
- LITU tried to keep most patients as liver specialty patients, but had around 10% of patients that were non-liver speciality.
- Length of stay for a hepatectomy was two days. Audits showed iMobile had hospital reduced post critical care length of stay by 7.3 days and prevented around four critical care admissions a month.
- We observed one patient on Kinnier Wilson HDU that had been on ITU for a year before being stepped down and had been on the HDU a further 90 days although the trust told us this should be sometimes expected due to their case mix of patients.
- Level 1 patient breaches occurred on all critical care units and these were declared.

Learning from complaints and concerns

- December 2014 showed there were no complaints for critical care and no unresolved complaints in LITU or the Victoria and Albert Ward. Very few complaints were made about critical care units in the year prior to the inspection. Most were regarding the rest of the patients' pathway. There were some concerns regarding early discharges, but these related to the transition to the ward, not the decision to discharge itself. The units most relied on patient surveys and comment cards for feedback.
- Jack Steinberg Ward had evidence to show they were encouraging complaints and they learned from them,

with staff reporting they received feedback if there were any issues. One example was where the visiting policy for patients with learning disabilities was reviewed and found to be more flexible after a complaint. However, learning was not consistent elsewhere.

- Most complaints on critical care units were dealt with informally. However staff were not always aware of the processes by which patients could complain, such as through Patient Advice and Liaison Service.
- Kinnier Wilson Ward had very few complaints, but had introduced a nurse in charge round where they talked to patients and their relatives to keep them updated after feedback from a complaint.
- Not all wards displayed a leaflet showing how people could complain. However, we saw the leaflet contained all the information to complain, such as: how to complain informally and it listed the contact details for the Patient Advice and Liaison Service, the complaints department, Parliamentary and Health Service Ombudsman and advocacy services. It also signposted a link to an online complaints form. However, the leaflet did not have any information in another language and merely signposted people to Patient Advice and Liaison Service to get support.

Are critical care services well-led?

Requires improvement

The ITUs were better led than the HDUs, although there was still room for improvement in the ITUs. There was a clear vision and strategy in place within the ITUs we visited, as well as iMobile. The vision for the HDUs was very limited. The ITUs were led by a different directorate than the HDUs and LITU which meant leadership was fragmented and often disorganised.

Public and staff engagement in the ITUs was well advanced and varied, but there was a lack of engagement with staff in the HDUs. Risk and governance of all the units was mixed between the units and, although there were attempts to ensure good communication, this was still fragmented at times. Research and innovation was well established in the ITUs but some staff were concerned it did not match its peer trusts.

Vision and strategy for this service

- All ITUs we visited had a 'Big three' or 'Big four', which were three or four identified themes for the month for staff to focus on, such as ensuring relatives filled in questionnaires or being aware of heparin guidelines.
- There was a strategy to continue with the model of not rotating the nurses between the ITUs, to improve team building and build staff competencies with the different types of patients which staff told us was partly based on a model they reviewed in Melbourne, Australia. There was an awareness that this had the potential of specialisation of staff, but it would increase familiarity with the units and ensure continuity of care. Most staff we spoke with seemed to be on board with not rotating, but there were some that wanted the variety of rotating.
- The vision of iMobile was to present their model to other hospitals, expand the model to other sites and develop the pathways between outreach and the highest referring areas.
- Staff were aware of the values of the trust.
- There was a clear vision and strategy to improve ITU care at the hospital. Individual units had their own short-term goals. However, there was no vision within the HDUs other than trying to expand.

Governance, risk management and quality measurement

- There was a mix of governance arrangements for critical care. Three of the ITUs were governed under the critical care, theatres and the diagnostics department. However, the LITU was governed within the liver specialty, although there were some governance meetings for the ITUs that included LITU. The HDUs were governed within their surgical or medical specialty rather than within critical care. This may impact on leadership and governance issues that require cross-divisional working. Some staff in critical care felt the HDUs should be within their directorate and patients treated by critical care doctors as their primary clinician.
- Critical care governance meetings took place monthly. These included: managers, consultants, matrons and pharmacists, but we saw no minutes that included other allied health professionals or LITU attendance. They highlighted results of audits, serious incident investigations, and overnight admissions. However, there was little recorded discussion of learning from incidents.

Critical care

- The critical care risk register did not show when each risk was added. It highlighted the capacity and facility risks we found, but only some of the safety risks, such as patient records, awareness of the Mental Capacity Act 2005, medicine management, and pressure ulcers were captured on the register.
- When we spoke with senior staff, there was some lack of awareness of the concerns we found during our inspection.
- Monthly risk meetings took place involving Victoria and Albert Ward staff.
- Safety briefings occurred each morning and an operational meeting occurred weekly to discuss safety, infections, capacity, and staffing which was attended by consultants, divisional leads and nurses.

Leadership of service

- Most staff told us they felt supported within the ITUs by senior management, including the clinical director, divisional manager and head of nursing. If there was a concern, division-level staff were responsive.
- We were concerned about the leadership on the HDUs. Some staff told us they reported concerns within neurosciences division, but did not get feedback.
- Some staff on Fisk Ward felt concerns they were raising were either not being listened to, or not being actioned by their management team.
- Leadership within the ITUs was visible, with a matron on each unit when there had previously been just one for all the ITUs. However, beyond the division, leadership was not always visible to frontline staff, despite 'back to floor Friday' where senior staff came onto the wards.
- Senior management felt critical care was supported as a service by the trust and research staff felt supported by senior management.

Culture within the service

- Staff, including domestics told us there was a good team ethic in all the units. There was no reporting of bullying or harassment by anyone we spoke with who was currently working on the units. There was peer support and staff reported that it was a friendly environment to work in. The Jack Steinberg Ward received an award for team of the month in January 2015. Staff reported that they understood each other's social circumstances, so were able to offer support when necessary. We were constantly told the units were better now than they had been a few years ago. There was a good rapport between doctors and nurses.
- Sickness levels were 1.3% for technical staff, 2.9% for additional clinical staff, 3.7% for administrative, 1.5% for Allied Health Professionals, 2.1% for scientists, 1.5% for medical staff, 3.1% for nurses. Kinnier Wilson Ward had a high amount of sickness, but this had drastically reduced recently. Senior staff acknowledged sickness was concerning at times, but there was good support from occupational health with face-to-face meetings and 'return to work' interviews.
- Turnover of staff was 16.4% for technical staff, 17.4% for additional clinical, 11.0% for administrative, 17.9% for Allied Health Professionals, 11.1% for scientists, 44.5% for medical staff, 14.4% for nurses. Staff said they were concerned pay grades could be causing the high turnover and leading to staff resigning, but then returning as bank staff. Senior staff acknowledged turnover meant the service did not expect to be fully established across both its sites until September 2015. To reduce turnover, the service had a training programme in place to enable all staff to develop by moving up to the next grade, but there were no figures yet to show whether this was having an impact. Exit interviews of staff leaving were taking place.
- Senior staff within the units said they felt supported by the human resources department if there were any concerns regarding performance management. However, one staff member complained about the length of time human resources took regarding contracts and pay queries.
- Critical care units had a social night once a year, which was open to all staff on the units, including Allied Health Professionals and ancillary staff.
- There were sometimes tensions between critical care doctors and other specialty doctors, particularly regarding reviews of patients and when transferring the primary clinician from critical care to a specialty doctor. We received reports and observed patients having delayed discharges, or transfers due to disagreements about which specialty would become the lead. Patients were sometimes not reviewed by a specialty doctor.
- Staff feedback regarding iMobile was overwhelmingly positive and this matched the reports iMobile produced.
- Some staff felt they were thanked by management for their work but were not aware of a reward scheme even though the trust had one.

Critical care

Public and staff engagement

- Staff on the ITUs had been engaged in the planning of the new critical care unit and plans for the new IT system. They had also been engaged in a project called ICARUS which focused on medical handover, ward rounds and inter-professional communication. However, staff in the HDUs told us they had not been involved and LITU staff were concerned their unit would not be adjacent (near) to step down HDUs. There was a lack of staff involvement in day to day business planning.
- There were a number of public engagement initiatives to promote feedback. Patients, friends and family had been involved in a pathfinder group to plan the new critical care unit as well as set other priorities, such as improved communication, improved facilities and the use of technology. Relatives' questionnaires were being completed and boxes for these were in waiting rooms, although they had a low response rate at times. Follow-up clinics were held with patients and their family and friends, which included a feedback element. Patient forums were also held. The latest patient survey results were emailed to staff and were discussed at unit meetings.
- Doctor's meetings involved all grades of doctors from juniors to consultants. Consultants told us they felt engaged in the operation and vision of critical care at the hospital.
- The ITUs had a staff newsletter, which included information such as: any forthcoming changes forthcoming, bed occupancy, risk, safety and quality.
- A number of noticeboards were in staff rooms showing current performance.
- Multidisciplinary board rounds had been arranged and were attended by relevant staff including physiotherapists.

Innovation, improvement and sustainability

- Critical care were treating patients with ECMO, which they were not commissioned for, but this was still considered an innovative practice, due to its specialty.
- Critical care had a research team that joined with emergency care, which had been involved in a number of audits and trials to encourage and promote innovative practice, such as Vasopressin versus Noradrenaline as Initial therapy in Septic Shock (VANISH), Crash Three, Eurotherm and other medicine trials. New ways of working had been rolled out after being trialled by the research team, such as video fluoroscopy, and changes to the sepsis protocol. Medical staff told us pressure from other areas of the hospital was not affecting their work, as they were still able to do 50% research, 50% clinical work. However, some staff told us they were under resourced in research compared to their peer trusts and some units felt they did not get involved in research as much as they would like, although there were link research nurses. Nevertheless, doctors felt there was a good research culture at the hospital.
- Cost improvement plans (CIPs) were in place, such as reducing the use of expensive medicines when there were cheaper and as effective alternatives. Although senior staff acknowledged there were financial pressures, they felt current CIPs would not compromise care as they focused on reviewing the skills mix, and better procurement deals. There was no pressure to close beds.
- There was a plan in place to bring in a new IT system for critical care so patient notes could be fully electronic and that it would integrate with the current trust systems, other national critical care systems and primary care, so information could move between each division. There was also a project to give patients Skype access to increase nurse to patient time. These had been approved and part funded by NHS England. Suppliers were currently being procured at the time of our inspection.
- The service had developed using Optiflow as an alternative form of oxygen therapy, which could be managed on the wards without the need for critical care trained staff.
- iMobile were not just an outreach and rapid response team, but also followed up critical care discharges and delivered critical care in ward beds. It was made up of a multidisciplinary team and was proactive as well as reactive, monitoring early warning scores electronically without requiring a referral.
- Kinnier Wilson Ward had access to electronic prescribing and administration (ePMA) for examining critically ill neurological patients and was involved in some research such as Transcranial Dopplers (tests of velocity of blood flow in the brain and trials in haemorrhages).
- Frank Stansil Ward had iPads on order to help aid communication with patients, their family and friends.

Critical care

- The new critical care unit planned to have a simulation centre for teaching staff, and to facilitate learning from incidents.
- A variety of link nurses were in place at band 7, including trauma, pressure ulcers, nutrition, renal, records, deterioration, IPC, neurology, safety and rehabilitation. Staff representatives for each unit were also arranged at each band for involvement in service improvement projects.

Maternity and gynaecology

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

Information about the service

King's College Hospital Denmark Hill Site is part of the King's College Hospital NHS Foundation Trust. The hospital is recognised internationally and nationally for its foetal medicine and specialist gynaecology and maternity services. Women's services provide inpatient and outpatient gynaecology services and all services relating to pregnancy. They are part of the women and children's division of the trust, which also provides services at Princess Royal University Hospital.

Facilities at the Denmark Hill site include: the Nightingale Birth Centre (with a 10-room labour ward), a triage facility, a four-bed observation bay and two birthing rooms. The centre has two operating theatres, a recovery area with five beds, a two-bed high dependency unit and an additional room with two beds for 'transitional' care. William Gilliat Ward has 50 postnatal and antenatal beds. There is a maternity assessment unit open from 8am to 7pm.

Community midwifery services provide an initial assessment for pregnant women in the area, and deliver antenatal and postnatal care at locations in the area. Six per cent of births are at home, supported by community midwives. There were about 5,400 births in 2014.

The hospital is a regional centre for a number of specialisms. The Harris Birthright Centre, a foetal medicine unit for the assessment and treatment of unborn babies, sees for more than 10,000 women each year. There are joint antenatal clinics for women with diabetes, hypertension or sickle cell, and clinics for women with mental health, liver or neurological conditions. Gynaecology specialisms include urogynaecology, gynaendocrinology and infertility and reproductive medicine. King's College Hospital undertakes diagnosis of gynae-oncological conditions and provides a combined service with another trust.

The gynaecology unit provides both inpatient and outpatient services and has about 3,000 visits to the outpatients department each year (about half of which are follow-up visits). Gynaecology surgery takes place in the day surgery unit and in main theatres. There is also an ambulatory care unit where women can have procedures under local anaesthetic or attend for other day treatments. Gynaecology inpatients stay on Brunel Ward, which is also used for female surgical patients.

We inspected all maternity and gynaecology areas within the hospital and visited the community antenatal clinic and a community midwifery clinic. We spoke with 12 women and received comments from people who contacted us to tell us about their experiences. We spoke to over 60 members of staff, including: maternity support workers, midwives, nurses, medical staff of all grades, administrators, senior managers, porters and domestic staff. In addition, we held meetings with midwives, nurses, support workers, trainee doctors, consultants and administrative staff to hear their views. We reviewed information provided by the trust, such as reports, minutes of meetings, audits and activity data.

Maternity and gynaecology

Summary of findings

Maternity inpatient care and treatment was not always received in the right place and/or at the right time at times of peak demand. These issues were long standing, and although the service had taken action to deal with the flow of women through inpatient areas, they had not been resolved at the time of our inspection.

Midwifery, support and medical staff worked hard to keep women safe. However, sickness levels among midwives had risen and consultant leave was not covered, bringing additional pressures to maternity staff.

It was recognised by senior staff that medical cover at night, which was provided across gynaecology and maternity inpatient services, was insufficient to guarantee prompt review and treatment of patients.

There were a number of gynaecology and maternity services offering innovative and ground-breaking services. Care and treatment was evidenced-based and the audit programme monitored adherence to guidelines and good practice standards. Actions were identified following audits and these were re-audited.

There were robust care pathways for pregnant women to access appropriate services.

The safety of maternity and gynaecology services was enhanced because reporting of, and learning from, incidents was promoted. There was systematic, multidisciplinary review of incidents. Risks were recorded and plans put in place to address, or mitigate these risks. Nevertheless, some risks of which we were informed, such as challenges with medical and consultant cover, were not on the risk register.

Senior management in women's services had succeeded in establishing integrated clinical governance structures, including risk management, across the newly merged trust, which now included Princess Royal University Hospital.

There were clear reporting routes to the trust-wide committees and the board. There had been changes to the delivery of gynaecology services at the Denmark Hill site as a result of the merger, and senior management in maternity services had spent time supporting and developing maternity services at Princess Royal University Hospital. Following the structural reorganisation, the aim of the women's service was to achieve stability and the delivery of high quality care.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Inpatient maternity services had high bed occupancy levels at times of peak demand. The challenges of caring for women at these times were exacerbated by the high acuity of some women using the service and the physical capacity of the unit. Midwifery staffing levels had improved and there had been a review of the workforce to optimise their deployment, but at the time of our inspection leaders of the maternity services and front-line staff reported that midwives and support staff were under stress. Women were not always reviewed in a timely way by medical and consultant staff and there were sometimes delays to planned caesarean section procedures. The service relied on the commitment and hard work of midwifery, support and medical staff to provide safe care.

The safety of maternity and gynaecology services was enhanced because reporting of, and learning from, incidents was promoted. Medical staff took part in the review of incidents and the investigation of serious incidents, but they did not routinely report incidents and this meant that concerns were not always recorded and reviewed.

All areas we visited were visibly clean and there were regular audits of infection control policies. However, the triage area was not suitable for its purpose. Equipment checks were not always recorded and these discrepancies had not been noticed. The processes for managing medicines safely and for checking equipment in community midwifery services were not robust.

There were well-developed care pathways in maternity services for women identified as being 'at risk' because of medical conditions or vulnerability.

Arrangements for assessing and responding to patient risk in gynaecology services were generally good, although venous thromboembolism (VTE) assessments needed to be improved.

Incidents

- Maternity and gynaecology services promoted the reporting of, and learning from, incidents. Midwives, nurses and support staff told us they were encouraged to record any incident that might affect the care of women and their babies. Staff we spoke with said there was an expectation of openness, and the divisional risk management policy stated that incident reporting would not lead to disciplinary action unless there were breaches of professional conduct.
- A high percentage of staff at King's College Hospital NHS Foundation Trust reported incidents. In the 2014 national staff survey, 98% of staff (compared to the national average of 90%) said they had reported errors, near misses or incidents witnessed in the month prior to the survey. We saw that 475 maternity incidents had been reported between September 2014 and January 2015. Serious incidents were discussed weekly at a multidisciplinary meeting in maternity and gynaecology services and were allocated for investigation.
- In maternity services, the weekly meeting was chaired in rotation by the consultant obstetricians. There was a review of incidents, with serious incidents allocated for investigation. These included incidents that had not been reported at the time of the event, but that had come to light as a result of a case review or the provision of additional information. We saw an example of the investigation of 'red' rated serious incidents in maternity services, undertaken by senior medical and/or midwifery staff, supported by the trust risk manager, with a full root cause analysis. There were four red rated incidents from September 2014 to January 2015. The trust serious incident committee reviewed and monitored recommendations and actions arising from these investigations. A further 19 incidents were categorised as amber, investigated by the senior staff and discussed at divisional meetings. Amber incidents included cases of no harm, such as when a midwife did not follow the birth plan of a high risk woman. The majority of incidents were categorised as 'green' and were low or no harm. These were allocated for local review by managers for trend analysis.
- The 'Duty of Candour' was integrated into the response to incidents. The trust had appointed a 'Candour Guardian' to lead on the trust-wide work.
- Medical and consultant staff in maternity services did not routinely report incidents on the electronic reporting system. The incidents we reviewed sometimes indicated that a midwife had reported an incident at the request of a consultant. We did not see reports of

incidents that medical staff told us affected the treatment of women, for example, the difficulty in providing timely treatment when a consultant was on leave.
- There were multidisciplinary perinatal morbidity and mortality meetings with paediatric services.
- A group debriefing was offered to staff present after a serious incident. There was no systematic approach, however, to ensure that staff were offered a debrief. Midwives gave us examples of when they had approached their matron or supervisor of midwives to discuss something that had caused them anxiety, but said this was not automatically offered. Senior staff told us supervisors of midwives were expected to offer support in these circumstances, but agreed there was scope for improvement to ensure a consistent approach. We were told that the debrief for medical staff was part of the investigation process of serious incidents.
- There were 490 gynaecology incidents reported between August and the end of 2014.
- There had been one 'Never Event' for gynaecology (a Never Event is a serious, largely preventable patient safety incident that should not occur if the available preventative measures had been implemented). A woman had passed a retained foreign object post procedure. A full investigation was carried out, during which the instrument concerned was withdrawn from use. The manufacturer was informed, the Surgical Count Policy was amended, and all staff were informed of the need to include all disposable instruments, including detachable pieces in the count in future. Action plans were in place for each of the root cause analyses (RCAs) we reviewed. The action plans included: details of the objective, actions required, start date, due date, person responsible, as well as an update on progress made.

Safety Thermometer

- The NHS Safety Thermometer is a local improvement tool for identifying harm free care. The hospital used a variant of this called the 'ward accreditation scheme', which assessed environmental standards, hospital-acquired infections and other standards. However, this tool had not been adapted to maternity services, and was, therefore, of limited value for staff or patients viewing the results. Expected and actual staffing were displayed. During our inspection staffing was mostly in line with expectations, with one support worker short on the labour ward.
- Brunel Ward, the gynaecology ward, had scored bronze in the previous period and was working to improve on this. Information was on display about hand hygiene 95% (on target). There had been one pressure ulcer, and no falls. Expected and actual staffing levels were on display. There was one healthcare assistant (HCA) short at the time of our inspection. The 95% target for venous thromboembolism (VTE) assessments was not being met – the rate was 90%.

Cleanliness, infection control and hygiene

- All divisions had put controls in place to address the risk, identified on the trust risk register, that infection control policies had not been consistently implemented at the Denmark Hill site. Standards of environmental cleanliness had been set and there were regular infection protection and control audits. An infection control scorecard was maintained for maternity services and for the gynaecology ward.
- All areas we visited were visibly clean. There was gel at the entrances to the wards and receptionists reinforced its use. We observed staff regularly washing their hands and using hand gel between women. The hospital's 'bare below the elbow' policy was adhered to, and there was ready access to personal protective equipment, such as gloves and aprons. Cleaning schedules were on display in the ward and other areas where women were treated. There had been no reported cases of MRSA or MSSA bacteraemia on the inpatient wards in 2014/15.
- Midwifery staff were aware of cleaning and infection control procedures for birthing pools.

Environment and equipment

- We were told there was adequate equipment on the labour ward and saw new cardiotocography (CTG) machines were in each labour room. The medical assessment unit was well-equipped, and had a scanner. Community midwives were able to access equipment and there was a storeroom for homebirth equipment. However, community midwives who might be called to a homebirth did not all have the neonatal resuscitation bag, which was only available with emergency equipment. The postnatal ward had used the 'productive ward' programme to identify improvements to the way stock was ordered and stored.

- The processes for checking equipment and stock were not robust in inpatient areas or in the community midwifery centre we inspected. For example, although we found the equipment to be in working order on a resuscitation trolley in the antenatal/postnatal ward, checks were not recorded every day, as instructed. The following number of checks had been recorded in 2015: in January there were 18, in February there were 17, in March there were 23. On the labour ward checks were even less frequent, with checks recorded 26 times in the first three months of 2015. Community midwifery equipment was only checked about every two months, and the checks were not clearly recorded for each piece of equipment.
- Brunel Ward (the gynaecology ward) was accessed by a narrow staircase or lift. The doors were not wide enough to take a bed. A trolley had been purchased to avoid waiting for porters where an urgent transfer needed. It was recognised that the transfer of patients in the event of fire was a risk. A plan had been agreed with the fire officer to restrict the number of patients with mobility problems on that ward.
- At one end of the inpatient ward was new ambulatory care unit for women attending for procedures under local anaesthetic or day treatments such as rehydration for women with pregnancy sickness. There was a waiting area, treatment room and recovery area with four couches.
- The gynaecology clinics and the one-stop and rapid access services for women with early pregnancy concerns or with pelvic pain was co-located in the Golden Jubilee Wing. There was a large waiting area with treatment rooms and ultrasound scanning facilities.
- We observed that some lifts were out of order during our inspection, with people waiting in the lobby for 10 minutes or more, and, on one occasion, we were in a public lift that was being used by staff to transfer soiled linen. These lifts were also used to take babies to the neonatal ward for their medication. Portering staff told us the problems with transfers between floors were frequent as there was only one lift that was for use by staff alone that was large enough for a trolley.

Medicines

- We saw that medication was stored appropriately in inpatient areas. Medicine administration was recorded and signed for, with two signatures for controlled drugs.
- Medicines in the community midwifery offices were not stored appropriately. Fridge temperatures were not regularly checked and medicines stored there were not checked to see if they were in date. A drug in the on-call bag did not have a 'use by' date. Stock drugs were not routinely checked, but they were checked when dispensed.
- Midwifery and gynaecology ward staff recorded errors in medication administration on the incident reporting system and these were analysed for trends. Pharmacists supported services in the management of medicines. Microbiology supported services in the appropriate use of antibiotics and in understanding the pattern of infections in maternity services.
- Managers were responsible for making sure midwives were up to date with training in medication administration. Midwives competency for administering drugs was assessed and support provided for those who were not successful.

Records

- We reviewed a small number of patient notes on the gynaecology and maternity wards. These had been completed with relevant clinical information and signed and dated in accordance with guidelines. Record keeping was part of mandatory training. Three-quarters of midwifery staff had competed the training.
- A standardised clinical record-keeping tool had recently been developed, which would be used by supervisors of midwives to undertake regular audits. Information collected about record keeping at other audits was disseminated to staff to remind them of the importance of consistent recording for the audit programme.
- Administrative staff on the wards obtained the main patients records from the medical records department, and we heard from administrative staff that this system worked well. They entered information on the electronic patient record system.
- All pregnant women receiving services carried their own hand-held notes.
- A rolling audit was carried on out on compliance with HAS1 paperwork for the termination of pregnancy required by the Department of Health, and compliance was 100%. Records were in line with the Abortion Act 1967.

Maternity and gynaecology

Safeguarding

- Managers and staff in maternity demonstrated understanding of what was important to promote women's safety and protect them from abuse and to protect unborn and newborn babies.
- Community midwives assessed vulnerability of women early in antenatal care. Safeguarding alerts were made on the maternity system. There was a safeguarding midwife at the hospital, who was available for advice, who was part of the trust safeguarding team. There was a named doctor for safeguarding.
- Mothers who missed antenatal appointments were followed up and an alert was put on the maternity IT system. An audit of reasons for non-attendance was planned.
- Midwives and medical staff were required to attend level 3 safeguarding children training updates. Eighty-eight per cent of midwives and 68% of medical staff had completed this level. Nearly all (93%) of midwifery staff and 80% of medical staff had completed level 2 safeguarding children, 90% of midwifery and 17% of medical staff had competed level 2 safeguarding adults.

Security

- There was a receptionist on the labour ward at all times.
- Access to each area of the maternity and gynaecology wards were restricted by use of swipe cards. A member of staff released the door once it had been confirmed who was entering the ward.
- There was a draft abduction policy. The service had tried a system for tagging babies, but found this unsatisfactory. They were now exploring the use of another tagging system.
- Some community midwives we spoke with were not aware of the lone worker policy. Some staff had personal alarm devices, but these were not consistently allocated or used. The service was in the process of piloting new devices, which would be allocated to all community staff, but it was not clear that it would be mandatory to use them.

Mandatory training

- The recently-appointed practice development midwife had taken on the overview of training for midwives and was in the process of setting up systems to monitor the uptake of training. There were four days of mandatory training a year. Ninety per cent of midwifery staff had completed resuscitation training, 86% moving and handling and 75% infection control. Other mandatory training included risk management, bereavement and skills and drills for obstetric emergencies. Medical staff had lower rates of attendance, with 60% completing infection control and 50% resuscitation training.
- Completion of mandatory and statutory training was mostly above the trust's target for all staff groups in gynaecology services. Staff we spoke with said they had completed mandatory training.

Assessing and responding to patient risk

- Women were assessed in the medical assessment unit or in triage before they were admitted to the wards.
- There had been action to improve assessment of risks to women and their babies. For example, there had been improvements in the identification of rhesus negative women to increase the number of women who received immunoglobulin.
- Staff said they had been trained in the modified early obstetric warning score (MEOWS) to recognise women who were becoming unwell. Recent audits on the use of the MEOWS on both wards had found improvements in the completion and scoring of the MEOWS, which were 89% and 87% respectively. Babies were monitored using cardiotocography (CTG)when this was necessary.
- There had been training and other initiatives to improve the interpretation of ECG and the introduction of the new machines, linked to a central consult, was expected to improve consistency. Senior staff were able to review all traces and to easily access medical history to aid decision making. Nevertheless, we observed (and staff reported) that, at times of high demand, it was challenging to provide timely review of women and their babies. For example, frequent monitoring of high-risk women having an induction of labour.
- There had been audits of the records in the high dependency unit (HDU) and new documentation introduced to improve recording. A repeat audit was planned to assess the effectiveness of this.
- Observations of women in recovery were recorded on the trust-wide recovery chart.
- Midwives on HDU valued the availability out of hours of the iMobile team, who provided the critical care outreach service. The midwife on the HDU, who was caring for two women and their babies on her own at the time of our unannounced inspection at the weekend, said if a woman deteriorated, she would contact the team. Figures from the iMobile team

indicated they had been called seven times in five months to the labour ward. The team identified an intensive care bed and facilitated the transfer of women when this was necessary.
- There were arrangements for monitoring the deteriorating conditions of women on the gynaecology ward.
- Adapted World Health Organisation surgical safety checklists were used for gynaecological and obstetric procedures and their use audited. The trust had introduced an improvement plan to increase adherence to the checklist, which included observational audits of its use**.** We did not see a recent audit of the use of the checklist for gynaecological or obstetric surgery. We were told the consultant anaesthetist, obstetrician and trainee doctor discussed each case before the caesarean section list, but the full team pre-list brief and post-list debrief, part of recommended practice of the 'five steps to safer surgery' did not take place. Theatre staff told us there was not time for reflection or discussion after lists about what went well and what could be improved. It was not clear whether the theatre staff, who worked for another division, or the maternity staff were responsible for reporting incidents, such as the late starts of the elective caesarean section lists.
- There was a blue code alert, which was specific to obstetric emergencies and facilitated a prompt response from all those involved in emergencies, including porters who collected blood.

Midwifery staffing

- The establishment staffing level for midwives was 1:26, lower than the England average. Nevertheless, we were told of, and observed, pressures on the labour ward and the postnatal/antenatal ward because of high demand, the high proportion of women with medical and social needs, and the limited physical capacity of the wards. Bed occupancy rates at the trust were consistently higher than the England average. The establishment staffing levels for support workers were not being met, with only half the posts filled, and there was regular use of agency staff. Agency midwives filled shifts that were vacant because of leave or sickness. Sickness rates were 11% on the labour ward and 18% on the postnatal/ antenatal ward at the time of our inspection. On average, four agency staff were used every 24 hours on the labour ward to compensate for sickness or vacancies. There were additional pressures on permanent staff because agency midwives were not able to complete computerised records and agency support workers were unfamiliar with the system for ordering and distributing supplies.
- Some midwives said they reported incidents of staffing shortages, but other people said this was so usual they did not submit reports.
- One-to-one care of labouring women was prioritised and this was nearly always provided. At times of staff shortages, managers were available for advice. Community midwives were called in to support the labour ward and there were also occasions when staff from the antenatal/postnatal ward went to the labour ward to assist.
- Because of lack of capacity on the labour ward, there had been at least one birth in antenatal beds every month in the year up to January 2015, and sometimes this had been a weekly occurrence. Midwives from the labour ward were expected to come and assist, but we were told that, on some occasions, there was no additional staff and two midwives in the antenatal area shared the care of 20 women so that the third midwife was able to provide one-to-one care to the woman in labour.
- Midwives and medical staff reported concerns about the support given to other women who might be at risk. This included women with medical conditions, or a high risk pregnancy admitted to an antenatal bed and high-risk women having induction of labour. On one day of our inspection, a midwife was looking after two women in the four-bed bay and was also running triage. Women in the HDU with complex needs, some of whom were postnatal and had their babies with them, were being cared for by one midwife. Out of hours, a midwife cared for women recovering from an emergency caesarean section and their babies.
- The postnatal/antenatal ward was very busy, and we observed midwives and maternity support workers asking women to wait until they had finished another task before they responded to their request. In addition to concerns about the pressure of caring for women who might be at risk, members of staff felt that the care was not responsive, and women did not always receive the attention they needed, for example in support with breastfeeding.
- Midwifery staff told us that they had sometimes been unable to take a break in a 12-hour shift. This had been

recognised by management and steps were being taken to make sure every midwife had a break during her shift. Midwives said things had improved recently. However, staff attributed the high levels of sickness in recent months to the stress of the non-stop pressure of work at busy times.

- The service had taken steps to mitigate the risk of insufficient midwives to care for women appropriately. Additional staff had been recruited, including additional senior midwifery staff to monitor demand and provide support to the labour ward and the ward coordinator. A ward coordinator said this had made a "massive difference" to her ability to manage demand. She also said she could always get support out of hours when she needed it.
- The director of midwifery had undertaken a workforce review in 2014, which had been released in March 2015. The plans included redeployment of staff, such as staffing the birth rooms with community midwives to free more midwives to staff the labour ward.
- There had been a decision to cap bookings from outside the local catchment area, in particular from the London Borough of Croydon, and we were told of cases when referrals had been refused. Guidelines were in place to facilitate early transfer home from the labour ward, when possible. However, less than 6% of mothers were discharged home from the Nightingale Birth Centre in 2014.

Gynaecology staffing

- The average percentage of nursing bank staff in the second half of 2014 had been16%. Staff told us that most bank staff worked regularly on the ward, and no agency staff were used. Staff said there was sufficient administrative support on the ward. The level of vacancies had fallen in recent months.
- Core nursing staff on the ward had roles as champions for particular areas. For example, for IV drugs or infection control and these nurse champions were responsible for auditing these.
- Nursing staffing in the termination unit was satisfactory and stable.

Medical and theatre staffing

- There was 94 hours of consultant cover for maternity services at the Denmark Hill site. Consultants were present on the maternity unit from 7am to 9pm every day and were on call from their homes at night. Trainee doctors and midwives told us consultants came in when they were needed. However, the room used by consultants to sleep overnight had been converted for other use and there was no other space at the hospital provided for them.
- During our inspection, we observed that there were senior, middle grade and junior specialist trainee medical staff on duty on the maternity unit during the day shift seven days a week. There was a junior trainee covering both obstetrics and gynaecology at night. The senior trainee doctor also covered both services and we were told they were usually dealing with gynaecology patients. If the on-call gynaecologist attended the hospital, the senior trainee might be released for duties on the maternity unit, but we were told this was happening less frequently during the last year because they were often at Princess Royal University Hospital. This limited the availability of doctors at night in for women in labour, on triage or in the HDU who required medical review. The junior trainee doctors we spoke with said they had access to consultants for advice and support when this was necessary, but there were inevitably delays to medical review at times at night.
- When women went to triage after hours, there were sometimes waits of up to two hours to be reviewed by a doctor. We were told that, occasionally, women (for example, those who were past their due dates), went home rather than wait. Women were only admitted to the wards after they had been assessed on the maternity assessment unit or triage.
- There was no cover for consultant leave, so the remaining consultant covered both labour ward and the daily elective list. Senior trainee medical staff sometimes covered the theatre list, but a consultant might also be needed for an emergency caesarean section. There were nine obstetricians and three obstetrician/gynaecologists working at the hospital, so there was frequently one consultant down because of leave or study days.
- Obstetric theatres were staffed by main theatres. There was only one recovery nurse allocated to the maternity unit during weekdays, who might have to care for up to five women. A support worker provided care to the babies.
- There were ten general consultant gynaecologists, three consultants in urogynaecology and three working in the assisted conception unit. These were supported by clinical nurse specialists and trainee medical staff. Two

consultants shared the work in the termination clinic. There was back-up consultant cover in place should the surgeon be absent, to ensure that late gestation women could always be accommodated.
- Specialist physiotherapists worked in gynaecology clinics and on the ward, seeing patients on referral from consultants.
- Registrars and more junior doctors covered both obstetrics and gynaecology. Some consultants covered obstetrics and gynaecology, but others specialised in one or the other.

Are maternity and gynaecology services effective?

Good

Women's care and treatment was planned and delivered in line with current evidence-based guidance, standards and legislation. There were arrangements in place to audit the care and treatment provided and to identify improvements to practice. Women had a choice of pain relief as required, but there were sometimes delays to requests for an epidural.

There were opportunities for professional development for midwives and nurses in women's services. Trainee doctors were well supported. Multidisciplinary team working was good.

Some newly qualified midwifery staff had not received appropriate training for them to carry out their role effectively. This had been identified and action taken to address this shortfall. Three quarters of midwives had not received an appraisal in the last year.

Evidence-based care and treatment

- Women's services at King's College Hospital NHS Foundation Trust had a strong record of initiating and participating in research, and in producing evidenced-based clinical management publications.
- There were audit programmes in place in maternity and gynaecology services, which was informed by changes in national guidance, patterns of incidents, research projects and clinical outcome data. Some of the audits were conducted across the two sites, others were hospital specific. There was a guidelines review committee, which met monthly to review and ratify guidelines with reference to the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG) and internal expertise. The committee approved tools to audit compliance with the approved guidelines.
- The hospital was a regional centre for foetal medicine and complex gynaecological services. These services had been assessed as compliant being with, or exceeding the standards of care expected of specialised services and were involved in the most recent developments of evidenced-based treatment.
- The specialised unit for foetal medicine offered an enhanced antenatal screening programme. There was routine screening for indicators of risk, such as the use of a doppler (an ultrasound device) to measure blood flow between the placenta and the foetus, with follow-up scans and other tests when this was indicated. A 36-week scan looking at foetal growth was being trialled to identify 'at risk' foetuses. There had been a reduction in the number of stillbirths over the three years prior to the inspection, and the hospital was no longer an outlier for this indicator.
- The trust was not following RCOG guidelines on antenatal tests for low-risk women and they were doing some tests that were considered unnecessary. This increased the midwives' workload. The trust had made a decision to delay the implementation of recent NICE guidance on blood sugar testing and glucose tolerance tests at early stages of pregnancy, until the service had been reorganised because of the demands this would place on the service (a high percentage of women using the service were diabetic).
- It was not clear that midwives understood how to respond to the test to identify jaundice, because we were told they routinely sent any jaundiced baby to the emergency department (ED). This was not in line with guidance on postnatal care.
- The trust contributed data to the National Neonatal Audit Programme (NNAP) and to the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK).
- Recent gap analysis of NICE quality standards for maternity included postnatal care and caesarean section. We saw examples of maternity audits that had been carried out across the trust, such as neonatal and foetal outcomes of hypertensive pregnancies.
Some audits were hospital specific, such as outpatient

induction of labour. The audits identified areas of good practice and areas for improvement, and there were further audits to check whether improvements had been implemented.

- There were no nationally required audits for gynaecology. However, the hospital contributed to the British Society of Urogynaecology (BSUG) audit database and to the British Society of Gynaecological Endoscopy, as well as national and London cancer networks.
- Some gynaecology audits were carried out trust-wide, for example, gynaecology Rapid Access Referrals and cancer outcomes, and the diagnosis and management of tubal ectopic pregnancies. We saw audits to demonstrate evidence-based practice, such as compliance with NICE guidance, and with local guidelines and action following this. For example, key improvements from the tubal ectopic pregnancy audit were to reduce the number of out-of-hours operations, and to ensure a second opinion was sought, in line with the guidelines, for all women who had pregnancy at an unknown location (where a pregnancy cannot be seen within the womb on an ultrasound scan).
- Other audits were site specific, such as early pregnancy outcomes in women with hyperemesis gravidarum, and a rolling audit of the completion of HSA1 forms (forms for recording information about abortions in England and Wales) to show compliance with the Abortion Act 1967. Audit results were presented to relevant staff and changes to policy and practice were made as appropriate.
- The hospital had formally asked for a derogation from implementing NICE guidance CG154, 'Ectopic pregnancy and miscarriage: Diagnosis and initial management in early pregnancy of ectopic pregnancy and miscarriage,' NICE CG 171, 'Urinary incontinence: The management of urinary incontinence in women,' and NICE CG122, 'Ovarian cancer: The recognition and initial management of ovarian cancer.' NICE Quality Standards gaps and baseline assessment tools had to be approved by the divisional quality governance committee. They had evidence-based derogation documentation and regular audits of practice to ensure practice was in women's best interests.

Pain relief

- Staff told us that they were able to obtain pain relief or other medication for women. All the women we spoke with told us that they had received pain relief they wanted. However, there were times when requests for an epidural were delayed when anaesthetists were attending an emergency in theatre.

Nutrition and hydration

- There was a programme to improve breastfeeding support, as part of UNICEF's Baby Friendly Initiative accreditation scheme'. Breastfeeding rates were good compared to the national average, with 80% of women breastfeeding on discharge. The service had set a goal of 85%.
- Women on the postnatal wards and gynaecology wards said they were satisfied with their meals. A kitchen on the maternity unit provided meals for women, and snacks were available from the fridge out of hours.

Patient outcomes

- The caesarean section rate was close to the national average in spite of the service seeing a high number of high risk women for whom caesarean section was indicated. The goal of reducing the caesarean section rate to 26% or lower had been met in three months in 2014; the figure was 27.6% for the year. Processes had been put in place to reduce unnecessary procedures. There was senior medical review when possible before the decision to go to theatre was made, and cases of caesarean sections were reviewed the following morning by the multidisciplinary team. Midwives discussed vaginal births after caesarean sections (VBAC) with women, including those with medical conditions, when this was appropriate. There had been improvements to the management of induction of labour, and follow up audits continued to identify further action. There was a weekly multidisciplinary review of CTGs to improve staff skills in interpretation.

- Trust maternity services had been identified as an outlier in 2012 and in 2014 in the CQC maternity outlier analysis for puerperal sepsis and other puerperal infections within 42 days of delivery. The trust had undertaken a 12-month surveillance process, which included a clinical review and a coding audit of cases. They reported to CQC that the population of women they served were at higher risk of puerperal infections than the average population. They had also identified action to lessen the risk of infections. A multidisciplinary clinical audit of best practice in infection control had

been conducted on the maternity wards in March 2015, covering hand hygiene, the number of vaginal examinations and the use of indwelling catheters. This had identified areas for improvement, for example, improved hand hygiene standards among medical staff, who had a compliance rate of less than 50%.

- The trust was within expected limits for maternal and neonatal readmissions.
- A centrally produced obstetrics dashboard reported on activity and clinical outcomes for the maternity department. A locally produced maternity birth report gave additional detail.
- There was a programme to increase the percentage of women having a normal birth (without any medical intervention) to meet the service goal of 40%. The rate in 2014 was 38%. The percentage of home births was 6%, higher than the national average of 2.3%. Further work was needed to increase understanding among some midwifery staff of how to facilitate normal birth at the Nightingale Birth Centre.
- Maternity services had identified that women were not always being assessed and managed appropriately for the risk of VTE. A trust nurse had provided additional training for midwifery staff, and the postnatal senior midwife was reviewing a further set of incidents with a pharmacist to identify underlying causes.
- There was a management performance scorecard for gynaecology, which covered key clinical effectiveness measures. The average length of stay on the ward was lower than the target, as was the readmission rate within 30 days of treatment. Emergency gynaecology care performance was good.
- Women we spoke to who had had treatment for gynaecological conditions at the hospital said they felt well informed and were pleased with the outcome. The urogynaecology service is world–renowned and all the women's services were backed by a strong research base to support developments in healthcare.
- The clinic organisation and outpatient care for the termination of pregnancy was effective in supporting women with serious medical conditions because there was access to other specialists, if necessary. Disposal of foetal tissue was in line with national guidance.

Competent staff

- There was an induction programme for new midwives and a year's preceptorship programme, supported by a midwifery practice facilitator. However, a review of the training found that training in key skills such as: suturing, cannulation, medicines management and intravenous fluids had not been delivered to all newly qualified midwives over the last two years. An audit of training needs had been undertaken and it was expected that all staff would be competent in these skills by the end of 2015.
- Student midwives and newly qualified staff were supported by a mentor, but staff told us there was an inconsistent approach to mentoring.
- Midwifery support workers said they had good support from their tutor, who promoted training opportunities for them. They were trained to take on tasks such as the observation of mothers and babies and to provide breastfeeding support. There was limited opportunity, however, for further development, except for support workers who wished to train as a midwife.
- Appraisal rates for midwives were low, with only one quarter of midwives recorded as receiving an appraisal in the last year. Senior midwives found it difficult to give time to this task.
- Midwives said they were encouraged to take up development opportunities. For example, the midwife overseeing the audit programme told us of the encouragement she had received from management to develop her skills and attend conferences. Other midwives gave examples of training they had attended, such as recognising the rapidly deteriorating woman and an FGM study day.
- Trainee doctors told us they were well supported and had the study days they needed. There were good opportunities for training on the job. There had been a visit from the deanery recently and their report had been complimentary about the support for trainees.
- Nursing and support staff in gynaecology services had the training they needed to carry out their roles safely and effectively. Staff told us there were effective induction programmes for new staff. Nursing staff on Brunel Ward, which had recently moved to its current location, and now had a different case mix, had received training in caring for other surgical cases as not all the patients on this ward were gynaecology patients.
- Clinical audit training and audit facilitation was available through a central trust team.

Maternity and gynaecology

Multidisciplinary working

- Many staff members, including the porter on the unit, praised the communication and teamwork of midwifery and support staff on the inpatient wards. Medical and midwifery staff worked well together and respected each others' skills and knowledge.
- There were team handovers on the labour ward twice daily. We observed the evening handover at 7.15pm, which was attended by 15 staff: medical staff, the coordinator from the previous shift and the doctor and midwives coming on duty. The labour ward coordinator went through each woman individually describing the current state and the plan. They then discussed the women on the antenatal/postnatal ward who may cause concern. The information was relevant and the staff attentive.
- Neonatal handover was conducted separately. Paediatric staff came to the labour ward to discuss the babies on the postnatal ward and to provide information about access to neonatal intensive care cots when this was needed. Staff reported good relations between frontline staff, but it was not clear that there was effective communication to resolve issues, such as transitional care for newborn babies.
- A multidisciplinary meeting was held every other week on the maternity unit.
- Women we spoke with in gynaecology services reported good multidisciplinary working both internally and externally. Physiotherapists and consultants worked closely with patients in urodynamics.
- There was prompt identification of women at risk and an effective care pathway, with rapid access to testing. Women could also access appointments at specialist clinics and they had access to appropriate specialists. The hospital provided specialist care for pregnant women with a variety of medical conditions, including pregnancy-related hypertension, diabetes, sickle cell and cholestasis (a liver disorder), and non-pregnancy related conditions, such as neurological diseases. There was close working between obstetricians and consultants in the hospital specialisms such as neurology, liver disease and sickle cell. Some of these clinics were supported by specialist midwives. There was a strong history of close working with psychiatrists in the neighbouring mental health trust, with access to two perinatal psychiatrists. There was a designated junior specialist trainee doctor post for perinatal psychiatry on call.

Seven-day services

- Consultants worked seven days a week until 9pm. On-site medical cover out of hours was not always easy to access.
- There was access to scanners, interventional radiology, pharmacy and the outreach services seven days a week.
- There were two dedicated obstetric theatres that were fully staffed, Monday to Friday. There were four emergency theatre teams to cover trauma, general surgery (which might include gynaecology emergencies) and the two obstetric theatres. If a second emergency team was needed for obstetrics, a support worker might have to act as the circulating nurse.
- The early pregnancy unit was open on weekday mornings. Women not seen that day were given an appointment for the following day. All women with gynaecology or early pregnancy concerns could report to the hospital in an emergency through the ED.
- Weekend cover for the gynaecology ward was on the risk register and recruitment was under way to improve junior medical staffing.

Access to information

- Midwives said, and we saw from looking at records, that information from community and clinic antenatal appointments were available to them so that they understood the needs of the women using the service. Information was also stored electronically. The women's medical and obstetric history was available electronically when there were concerns about the progress of labour.
- Postnatal booking for local women were routinely made with community midwifery services following the birth and it was very rare for the first postnatal visit to be missed. If the woman came from outside the local area, their local community midwifery team was sent information about their admission via fax.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Arrangements were in place to seek consent for surgery and other procedures. We saw that consent forms had been appropriately signed in the notes we reviewed. Women told us they had understood the risks of surgical and medical treatment and we saw leaflets explaining the risks and benefits of particular procedures.
- The trust had set procedures for assessing a patient's capacity, whether they came into hospital as an emergency or for planned surgery. We were told that

doctors were responsible for assessing a patient's capacity. The staff we spoke with talked confidently about mental capacity assessments within the remit of their role.
- Midwives had access to advice from specialist midwives when they had concerns that pregnant women might not have capacity to make specific decisions.

Are maternity and gynaecology services caring?

Good

Women said staff were caring and that they had been given information about the choices available to them. We observed woman-centred care and saw staff responding respectfully to requests for support, even when they were busy.

Specialist staff offered sensitive management of loss for women suffering miscarriages or stillbirth.

A clinic offered counselling, as required, to women with complex medical needs seeking termination of pregnancy.

Specialist staff offered to meet women who had miscarriages or stillbirth.

Compassionate care

- The women we spoke with reported that they received a good quality care and kindness from staff. We observed woman-centred care and saw staff responding respectfully to requests for support, even when they were busy.
- A woman on the postnatal ward who had attended the hypertension clinic said the care she had received was "exceptional". She saw a specialist midwife, received regular monitoring and scans and was given a phone number to call at any time if she had concerns. Another woman had been admitted early because of hypertension. She praised the clinic staff and the kindness of ward staff.
- Women using maternity services at the trust reported similar experiences to women using other trusts in the national survey of women's experiences of maternity services 2013. Most women said they were treated with kindness and understanding and that they had confidence and trust in the staff caring for them during labour and birth.

Understanding and involvement of patients and those close to them

- Three women we spoke with who were receiving antenatal care from community midwives said they felt they had been offered choices about the birth. Two of the three were from outside the catchment area and felt lucky to be booked at King's College Hospital (the Denmark Hill site). A woman we spoke with on the postnatal ward said she had received continuity of care during her pregnancy from two midwives (on the caseloading team) and had planned to have a home birth. She had decided to come to the maternity unit during labour and her midwife had accompanied her. She said she could not have had better care and that staff on the maternity unit had also been very helpful and kind.
- Women on the postnatal ward were pleased that their partners were able to stay with them overnight.

Emotional support

- A bereavement midwife contacted all women who had a stillbirth, or pregnancy loss above 14 weeks, and met those who wanted a meeting. This midwife was available during Monday to Friday, 8am to 4pm, but there was limited flexibility for a prompt appointment to see women who suffered a loss out of hours.
- Because of the demands for space on the maternity unit and ward, there was no designated room for bereaved parents. However, we observed staff taking steps to enable a woman who had a stillbirth to have time with her baby. Women who had had a previous pregnancy loss were also seen by a bereavement midwife. A plan was put in place and the women were then supported by their community midwives. Midwifery staff valued the support of the bereavement midwife and mandatory training on pregnancy loss had been introduced for staff. Midwives gave information about agencies that provide counselling support for women and their families.
- A clinic offered counselling, as required, to women with complex medical needs seeking termination of pregnancy.
- There was support for people of Muslim and Christian faiths available from a chaplaincy team who could also contact community faith leaders and the humanist association. The chaplains were assisted by a group of volunteer ward visitors.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Requires improvement

Maternity services had taken action to address the problems with capacity, but there were blockages at times of peak demand, which resulted in women sometimes not receiving care in the right place. Some facilities did not provide privacy for women using them.

There were clear pathways for access to appropriate services for pregnant women.

Gynaecology services were responsive to women's needs, particularly through one-stop and rapid access clinics. There were some delays in referral-to-treatment and some cancelled surgery, but the proportion of cancellations was relatively low. There was evidence of learning from complaints.

Service planning and delivery to meet the needs of local people

- There was high demand for maternity services at the Denmark Hill site from within the local catchment area, from women referred for specialist care, and from women outside the area who want to have their baby at the hospital. Because of the problems with capacity, the division had a goal of reducing the number of births to 5,200 a year.
- The risk of insufficient space to provide adequate care and treatment to women using inpatient maternity services had been identified in 2012. Steps had been taken to mitigate the risk by reorganising the Nightingale Birth Centre, with a five-bed recovery area and a two-bed 'transitional' care room for postnatal women, or for women who required additional observation. Dividers had been installed in two labour rooms to 'double up' women not in established labour at busy times. Senior management told us of plans to access additional space, but there had been no agreement at trust board-level at the time of our inspection.
- Women going to the triage area had to walk through the labour ward. The second triage room was used to store supplies, had no windows, and there was not enough room for a bed or trolley.
- The medial assessment unit was small, there was no privacy and it was difficult for staff to have confidential discussions with women. The two labour rooms that were divided by a screen at times of high demand were also inappropriate for confidential conversations.
- The waiting area in the labour ward was small and was at the entrance to the ward so did not provide privacy or comfort.
- There were plans to reorganise community midwifery services to provide a more efficient service. The needs of the local population were well understood, and there were services to meet particular needs, such as sickle cell services.
- Many gynaecology procedures could be done without an overnight stay in hospital, so more women now came to the day surgery unit for procedures under general anaesthetic. An ambulatory care service enabled women to have minor procedures under local anaesthetic, such as a hysteroscopy or surgical management of miscarriage. The ambulatory service also treated women with hyperemesis gravidarum (excessive vomiting in pregnancy).
- There was an integrated care pathway for termination of pregnancy. The clinic provided advice, including on contraception and sexual health, nurse consultation and counselling where women wanted this. Women saw a doctor for final consultation and consent. There were four clinical sessions and one operating list a week. Emergency referrals were seen within two weeks. This service was for women in Southwark, Lambeth or Lewisham, but the unit was also developing as a tertiary centre for women with medical conditions that had associated high risk factors. The unit was not available to teenagers. All terminations over 14 weeks were done as day surgeries.
- Plans had been developed to improve referral time for women to be seen by a senior doctor, particularly when presenting as an emergency.

Access and flow

- Women were referred to maternity services by their GP, or could self-refer. About half the bookings for local women were centralised at the antenatal clinic, close to the hospital. This enabled midwives to book high numbers of women, and to make sure blood results were sent to the women. However, the

service recognised that this did not provide continuity of care; women will have a named team and midwife for booking following the reorganisation of the community midwifery services.

- The hospital did not meet the target of booking 90% of pregnant women before 13 weeks of pregnancy, but was in line with similar services in London. Over three quarters of women were seen within the recommended time period and this rose to over 80% when it was adjusted for women who were later attenders.
- The maternity assessment unit was open from 8am to 7pm on weekdays and it provided a flexible service for women who were referred by their community midwife or GP, or who came to the hospital themselves for assessment. Women whose babies were being cared for in the neonatal unit were able to go to the unit for postnatal checks.
- When the maternity assessment unit was closed, women who needed assessment came to triage.
- Low-risk women who were past their dates and assessed as requiring induction were able to go home following treatment and returned when they were further on in labour. Women who required induction for medical reasons were admitted to the four-bed bay.
- At times of peak demand, staff were often unable to maintain the flow of women through inpatient areas. Women in labour might be referred to the antenatal area if there was no bed on the labour ward and it was sometimes impossible to move women from the labour ward to the postnatal ward because it was full. There was medical presence to facilitate the discharge of women and their babies, but if the woman or baby required additional care, discharge was not possible. Beds in the four-bed bay were often used by antenatal women with medical needs, in addition to women having induction of labour. On one of the days of our inspection, the two 'transitional' beds were being used by an antenatal woman with medical needs and a woman waiting to be discharged after the birth of her baby. We were told 'gridlock' occurred frequently, which sometimes resulted in women giving birth on the antenatal ward, or planned caesarean sections being cancelled. Staff found it difficult to provide responsive care in these circumstances.
- Midwives did not provide 'transitional care' for babies on the postnatal ward who needed antibiotics or other treatment. A support worker accompanied the mother to the special care baby unit (SCBU) to receive this care. On the day of our inspection, there were four babies on the postnatal ward who required this treatment four times a day. The support worker told us it was time-consuming to take the babies to SCUBU, wait for them to be treated, and return to the ward. When there was one or more lifts out of order, even more time was taken. The support worker was unable to carry out other tasks at these times and this meant other staff had a heavier workload, particularly at the evening meal time. We asked about plans for developing a transitional care facility, where babies could be provided with treatment by midwives, but were told there had been no formal discussions about this possibility between the maternity service and the children's service. Midwives currently had no time to provide the care, and most would require additional training in order to do so.
- We observed that midwives and support workers on the postnatal ward were very busy and found it difficult to provide responsive care. They were often carrying out essential tasks, such as monitoring women and their babies, and had to ask women who requested assistance, for example with breastfeeding, to wait.
- There was not always a cot available on the neonatal unit for babies who needed it, and the ward coordinator had to arrange for a transfer to another hospital. This was sometimes outside London.
- Maternity services had taken steps to understand the flow of women and to take steps to alleviate the blockages, for example, by discharging women directly from the labour ward. The variety and complexity of the needs of the women, however, made it difficult to find straightforward solutions. Until more capacity became available, the service focused on the mitigation of risk and the implementation of the extreme workforce policy.
- The extreme workload management policy described the escalation of concerns and the action to take when there was a shortage of beds, to make sure the safety of women and babies was maintained. There was a midwifery manager on call out of hours, who was expected to come into the hospital within 60 minutes of a 'red' alert. The unit had closed twice in 2014 in line with the policy. The unit had no beds available on one occasion in February 2015, but had not been able to close as there were no other maternity units able to take women.

Maternity and gynaecology

- Some women told us waiting times for gynaecology appointments were long. In discussion with staff we learned that the waiting times were mainly for nurse-led, or physiotherapy clinics where the wait was two months or more.
- The inpatient gynaecology ward had moved to a smaller space last summer and there were fewer beds. Complex planned gynaecology cases and emergency gynaecology patients were on this ward because most planned gynaecology surgery had been transferred to Princess Royal University Hospital. This was intended to prevent cancellation of planned surgery at the Denmark Hill site because of bed capacity. Staff reported that there were still not enough theatre slots or beds for emergency surgery for ectopic pregnancies or gynaecological emergencies. If there was no bed and women were not stable, they had to wait in the ED. Staff were encouraged to report shortage of beds as an adverse incident.
- Ninety-two per cent of patients were treated within the 18-week target. However, there were delays for patients requiring complex urogynaecology surgery because of the shortage of beds and theatre slots on this site.
- The early pregnancy unit (EPU) was open daily in the mornings as a walk-in service. Women were assessed and scanned by doctors. This was a busy clinic and if there was not time for a woman to be seen and scanned she would be offered an appointment next day. However, priority was given to any woman appearing seriously unwell.
- One-stop gynaecology clinics operated from 9am to 4pm, Monday to Friday and on Saturday mornings.
- Reductions in gynaecology operating lists at both the Denmark Hill site and Princess Royal University Hospital had led to some cancellations of surgery. There had been 176 cancellations between October 2014 and March 2014. Over half the cancellations had been made on the day.
- We saw from the risk register that there had been a concern that some day surgery patients had not been offered follow-up appointments. Staff told us a new system had been put in place as a failsafe, which would be reviewed in three months time.

Meeting people's individual needs

- Early in pregnancy, women and their partners were invited to talk to a midwife about maternity services and birth options, including: the advantages and disadvantages of home birth, the midwifery-led suite and the main delivery suite. Books and toys were provided in the antenatal waiting area for young children to use while their mothers waited for appointments.
- There was a discussion group held at a community centre, which was also run in Spanish, for women wanting a homebirth. There were antenatal classes run for women over 24 weeks into their pregnancies.
- There was information on display for women and new mothers on a wide range of topics including caesarean section and breastfeeding. There was a good selection of information leaflets in English in gynaecology clinics. Staff said they could refer people to websites for information in other languages.
- There was a robust system to ensure continuing access to appropriate services, which included following up test results and women who did not attend appointments. All community teams had a named consultant, whom they could ask for advice if they had concerns, and midwives told us they received a prompt response. There was an efficient appointment system for referral to obstetric clinics. Women told us they had no problems getting an appointment at the community midwifery clinics or the specialist clinics.
- There were specialist clinics for a variety of medical needs and access to specialist midwives working with young people, women with mental health needs, women living with HIV, or women who had experienced female genital mutilation.
- Research posters on the walls of the gynaecology clinics gave short, informative summaries of research. Opportunities to participate in research were on a noticeboard.
- We were told that women who used the service who were unable to speak English fluently could access an interpreter service if required. An interpreter could be booked to attend antenatal appointments if necessary and a telephone service was also available.

Learning from complaints and concerns

- There was information on display about the complaints process. People we spoke with knew how to raise concerns or make a complaint. There were leaflets about the Patient Advice and Liaison Service.
- Learning from complaints was integrated with clinical governance. Staff were aware of the complaints process

and were involved if a complaint related to their own actions. Forty-one complaints about maternity services had been received in 2014. About half of these were responded to within the target timescale.

- There were 18 complaints about gynaecology in the year. The main themes had been about staff attitude, delays to treatment and communication. We saw evidence of action taken in response to some complaints. For example, to minimise the admission of gynaecology patients to non-specialist wards and additional training for junior doctors on monitoring and escalating early warning scores, using Situation, Background, Assessment, Recommendation (SBAR) when a patient was becoming more unwell.

Are maternity and gynaecology services well-led?

Requires improvement

There was a clear governance structure in the women's and children's division and staff were proud to work at King's College Hospital NHS Foundation Trust. However, some staff felt that trust management were no longer responsive to frontline staff.

There were a number of services that offered innovative and ground-breaking services. There were clearly defined accountability arrangements and staff felt well-supported by their line manager.

Maternity services faced a period of change and was implementing the strategy for improving services in the context of insufficient capacity to meet demand and the merger with Princess Royal University Hospital. Gynaecology had also faced a period of change. Following the structural reorganisation, the aim was to achieve stability and deliver high quality care.

Vision and strategy for this service

- Women's services staff were proud of the pioneering work of the trust. Senior management worked with commissioning groups to plan services for the local population and meet NHS London Quality Standards, while operating as a regional centre.
- The strategy for maternity services to improve equity of access, provide continuity of care and increase normal births was being implemented in the context of insufficient capacity to meet demand. Midwifery management was also addressing the challenges of the merger with Princess Royal University Hospital, with the alignment of management and clinical governance structures. After a year of change, management were looking forward to a period of stability in which to consolidate the clinical governance arrangements, to strengthen accountability and to finalise changes to the workforce.
- The gynaecology services were being reconfigured to provide greater equity between the two hospitals in the trust, including the transfer of almost all planned surgery from the Denmark Hill site to Princess Royal University Hospital. These plans were being phased gradually, with the expectation of improvements to services to patients.

Governance, risk management and quality measurement

- There was a systematic approach to risk management and clinical governance in the women's and children division, with clear reporting lines to trust committees and the board.
- The Maternity Service Clinical Governance and Risk Management Strategy described the roles and accountabilities of committees and meetings. A joint maternity clinical governance meeting was held monthly and reviewed the reports from the maternity risk committee, the incident review meetings and the maternity dashboard meeting. The director of nursing and midwifery was the lead executive at board level.
- There was close working between the obstetric clinical lead for risk, the governance midwife, the director of nursing and midwifery, and the trust risk manager for women's services in reviewing incidents and identifying risk. The risk registers for maternity and gynaecology were dynamic documents, with risks identified from incident reports, and we noted that, if local action following an incident was not considered sufficient because there were wider system issues, the risk was added to the risk register. Each risk on the register was defined, and scored, with controls in place, a risk owner and date for review.
- Staff in women's services were aware of the risk management process and the key risks to the service, and felt they were involved in their management. The

culture of openness was evident in the high number of incidents and near misses recorded by staff and by the number of staff willing to talk openly to the inspection team.
- The maternity dashboard set challenging goals, which recognised risks (for example, the number of births not to exceed 5,200 a year (433 a month) and set high standards (caesarean section rate of 26% and breastfeeding rates on discharge of 85%).
- There was work in women's services and in the trust to improve clinical effectiveness. The King's College Hospital Clinical Guidelines System (KCGS) was available to staff.
- There was a maternity team section on the trust intranet, which provided information to staff about guidelines, audits and meetings, which we viewed during the inspection. The page included a link to the recent NICE publication on midwifery staffing, a calendar of audit meeting dates and venues, and information about conferences. The audit page stored presentations made at audit meetings. The maternity dashboard was available and updated monthly. There was a quarterly clinical effectiveness management information report.
- The Department of Health (DH) requires every provider undertaking termination of pregnancy to submit demographic data following every termination procedure performed. These contribute to a national report on the termination of pregnancy (HSA4 forms).There was a clear process for signing forms and sending them electronically to DH. The assessment process for terminations requires two doctors signatures on HSA1 forms.These were audited yearly and performance in all areas was 100%.

Leadership of service

- Women's services had clearly defined accountability structures, which were replicated across the two sites. Matrons were allocated to inpatient and community services and additional senior midwives had been appointed, who were expected to take an active role in understanding the stresses of the service and to make sure newly qualified staff were adequately supported.
- The merger with Princess Royal University Hospital had involved considerable work for the division's senior management team. The clinical director had spent three days a week during much of 2014 at Princess Royal University Hospital working with the obstetric consultant group. Her clinical duties had been covered, but medical staff at the Denmark Hill site commented on the impact on her absence. Moving elective gynaecology from the Denmark Hill site to the Princess Royal University Hospital site resulted in losing gynaecology beds as well as increasing the workload pressure on consultants and leading to revising their job plans.
- The management team had developed an organisational development paper and an associated action plan for midwifery. There had been a cultural review to understand the stress on staff and unease caused by the merger. The service was working with human resources to develop the skills and knowledge of line managers and to improve accountability.
- Some medical and midwifery staff expressed the opinion that the leadership of the trust was becoming more autocratic and was no longer responsive to the views of frontline staff. Gynaecology consultants who had been affected by the restructure of their service reported that they did not have ready access to the medical director to express their concerns. Some midwives were concerned that the trust, which had allowed flexible working hours for staff with caring responsibilities, was no longer "family friendly" and this might have an impact on retention of staff. There was anxiety about proposed changes to the community services, although midwives said there had been meetings to inform them of proposals and they had been asked to express preference for their deployment in the reconfigured service.
- Midwifery and nursing staff in women's services reported that they felt well supported by their line managers.

Culture within the service

- Staff were proud to work at the hospital and were committed to providing a good service. Many members of staff commented on good teamwork, respect for each other and shared values. However, there were concerns about the pressure of work in maternity services and the impact this would have on staff, and potentially on women using the service.
- We found processes for supporting staff were not consistent. For example, the foetal medical unit saw many women who were screened for foetal abnormality. However, in addition to the pressures of staffing on this extremely busy unit, there was no external supervision

for the midwives who had responsibility for arranging termination of pregnancies. There also was no consistent approach to debriefing maternity staff after an adverse event.

- There were regular meetings on the labour ward and of the central antenatal community midwife team. Other areas met less often and we were told it was often difficult to attend meetings because the wards were so busy. There was a feedback folder in the staff room if staff could not attend. Feedback from women, both positive and negative, was given to staff.

Public engagement

- The trust used its own system for gathering comments and suggestions, such as, 'How are we doing?' forms, which women, visitors and staff could complete online, or they could fill in comment cards in the hospital.
- The response rate to the to the NHS Friends and Family Test for women using maternity services for the six months to March 2015 was low compared to other services in the hospital and to the national average. The response rate ranged from 7% to 17% for women in labour and was usually less than 10% for antenatal and postnatal care. The women who responded were generally positive about care, but there were some comments about how busy the antenatal/postnatal ward was.
- Friends and family data for the gynaecology ward had a moderate response rate of 28%. Eighty-four per cent of responders were 'likely', or 'extremely likely' to recommend the service based on the care they received at the time of our inspection. Responses had fluctuated throughout the year.

Innovation, improvement and sustainability

- There were a number of services that offered innovative and ground-breaking services.
- The foetal medicine unit provided interventions, such as foetal blood transfusions, fetoscopic insertions of endotracheal balloons and laser separation procedures of placental circulations for complicated monochorionic twin pregnancies.
- The enhanced scanning programme included combined screening for chromosomal abnormalities at 12 weeks, with women given the results on the same day. A 36-week scan looking at foetal growth was being trialled to identify at risk foetuses.
- Specialised services, such as the hypertension pregnancy service, provided a regular review of women before and after the birth of the baby.
- The gynaecology and urogynaecology services offered a one-stop service with diagnostics carried out by a specialist doctor. The hospital was a regional training unit for this service and the unit was recognised as a gold standard unit by the British Society of Urogynaecology (BSUG).
- The urogynaecology and early pregnancy units and the Harris Birthright Research Centre for Foetal Medicine were active in research and often lead on changes to practice, such as in the expectant management of ectopic pregnancy and recommendations on hormone replacement therapy.
- The hospital offered ambulatory care for hyperemesis gravidarum, which meant women did not have to stay in hospital.

Services for children and young people

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

Information about the service

King's College Hospital NHS Foundation Trust provides a host of secondary and tertiary services for neonates, children and young people. The 35-cot neonatal intensive care unit provides level 3 surgical and medical care for babies born from 23 weeks gestation often with complex conditions. Referrals are received both locally and nationally and it is the regional centre for neonatal surgery. In addition to the neonatal intensive care unit, the trust also hosts an eight-bed paediatric intensive care unit (Thomas Cook Children's Critical Care Centre), which is equipped and staffed to provide level 3 intensive care support and is supported by an eight-bed paediatric high dependency unit.

Lion ward is a 10-bed children's ward, which provides care for children with neurosurgical conditions. Rays of Sunshine Ward is a 15-bed ward, which specialises in providing care to children with complex hepatic, gastrointestinal and nutritional disorders and diseases. Princess Elizabeth Ward is an 11-bed surgical unit and Toni and Guy Ward is a 15-bed children's ward providing care to children with a range of general and specialist medical conditions, including cystic fibrosis and sickle cell disease.

Over 2013/2014, the trust hosted 9,209 inpatient spells, with 51% of cases being emergency unplanned admissions, 33% being day case admissions and 16% being elective admissions. The children's service is a national hub providing a highly specialised service to children with liver problems.

During the inspection, we spoke with 16 parents and their children, as well as over 40 members of staff, including: nurses, student nurses, matrons, play specialists, teachers, clinical nurse specialists, doctors, consultants and support staff. We observed care and treatment being provided and also carried out an unannounced inspection of the service on 28 April 2015 when we visited Toni and Guy Ward and the paediatric short stay assessment unit.

Services for children and young people

Summary of findings

Nursing staff levels were seen to be in line with national standards in the majority of clinical areas, except for the neonatal intensive care unit where nursing levels were such that one-to-one care could not always be provided in line with national standards.

Continued increased capacity within the neonatal intensive care unit meant that the number of consultants and junior doctors employed was not sufficient to meet the needs of the unit. The existing model of medical cover was not sustainable in the long term, as there was a reliance on the good will of a small number of doctors to work additional hours.

The environment in which children and neonates were cared for was, in the main, appropriate. However, the increased capacity of the neonatal intensive care unit meant that space between cot spaces was sometimes cramped, which meant that access to cots was sometimes restricted or limited.

The uptake of mandatory training in some professions was far below the trust standard. Staff demonstrated an open and transparent culture about incident reporting. A culture of optimising patient safety was apparent amongst nursing and medical staff alike. Staff understood their roles and responsibilities in reporting incidents and described how they learnt from incidents.

Patients were safeguarded from the risk of abuse. Staff were well versed in the trust's local safeguarding policies and could describe national best practice guidance. Staff adopted a truly holistic approach to assessing, planning and delivering care. Staff developed and advocated the use of innovative and pioneering approaches to care, especially for those children with complex liver conditions and those who required surgery as neonates. Additionally, the service hosted national specialist multidisciplinary bariatric services for children with obesity issues.

Clinical teams worked collaboratively to enhance the provision of care to children. The service led on a range of national medical and surgical initiatives and worked in conjunction with a range of third party peers to drive forward advancements in paediatric surgery and medicine. Paediatric mortality rates were seen to be in line, or better than peer averages across a range of specialties. The service participated in a range of local and national audits, including clinical audits and other monitoring activities, such as reviews of services, benchmarking, peer review and service accreditation. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff. Information from local and national audit programmes was used to improve care and treatment and people's outcomes, but some work was required regarding the management of patients with asthma and diabetes. When people were due to move between services their needs were assessed early, with the involvement of all necessary staff, teams and services. People's discharges or transition plans took account of their individual needs, circumstances, ongoing care arrangements and expected outcomes.

Staff acknowledged that the demands on the service were increasing year-on-year and that capacity had proven to be difficult to manage during peak times. This was especially pertinent to the neonatal intensive care unit (NICU), whose activity had been seen to be increasing annually. The organisation recognised the need to extend children's services over the coming years to ensure that it could continue to meet the needs of the population it served. Plans had commenced to build a new children's hospital on the Denmark Hill site and local initiatives had commenced, including the opening of a paediatric short stay unit to help alleviate capacity problems in the short term.

Staff were aware of the trust vision and values. Staff had been provided with information on trust developments that had been cascaded down from their line managers. The service had a child health specific strategy, which was aligned to the trust-wide strategy. The strategy was driven by quality and safety and took into account the requirement for the service to be fiscally responsible. There were governance arrangements in place, for which a range of healthcare professionals assumed ownership. Further work was being undertaken to strengthen the governance relating to children who received care or treatment outside the auspices of child health services. There was evidence that risks were managed and escalated accordingly.

Services for children and young people

Nursing staff reported good management support from their line managers. Changes to the management team within the NICU was said to have a had a positive impact on the service. Innovation and long-term sustainability were seen as key priorities for the leaders of the service. Participation in national and international research was a driving motivation for clinical staff in order that the wellbeing and clinical outcomes of children could be enhanced.

Are services for children and young people safe?

Requires improvement

Nursing staff levels were seen to be in line with national standards in the majority of clinical areas except for the NICU, where nursing levels were such that one-to-one care could not always be provided in line with national standards.

Continued increased capacity within the neonatal intensive care unit meant that the number of consultants and junior doctors employed was not sufficient to meet the needs of the unit. The existing model of medical cover was not sustainable in the long term, as there was a reliance on the good will of a small number of doctors to work additional hours.

The environment in which children and neonates was cared for was, in the main, provided in appropriate environments. The increased capacity of the NICU meant that space between cot spaces was sometimes cramped, which meant that access to cots was sometimes restricted or limited.

The uptake of mandatory training in some professions was far below the trust standard. Staff demonstrated an open and transparent culture about incident reporting. A culture of optimising patient safety was apparent amongst nursing and medical staff alike. Staff understood their roles and responsibilities in reporting incidents and described how they learnt from incidents.

Patients were safeguarded from the risk of abuse; staff were well versed in the trust's local safeguarding policies and could describe national best practice guidance.

Incidents

- No never events had been reported by the hospital for the children's and young people's service in the period February 2014 to January 2015.
- Learning from incidents was disseminated to staff through the 'Child Health Safety' newsletter. The newsletter included trends from incidents, as well as describing the lessons that had been learnt and actions that staff should consider to help reduce the risk to patients. For example, the Spring 2015 newsletter listed medication incidents as the most common form of

incident report across both sites within the child health division. There was considerable focus on the reduction of incidents, which had resulted in patients receiving medication dosages which were ten times the recommend amount. Nursing staff were aware of the newsletter and were aware of the recommendations that had been made as a result of the incidents that had occurred over the previous year.

- Nursing and support staff on the wards and within paediatric intensive care said they had been encouraged to report incidents by members of the senior nursing team.
- Regular incident trend reports used red, amber, yellow and green indicators. Those that were yellow or green were investigated by the ward managers. The incidents that were marked with red or amber were passed to the clinical governance and risk management team for investigation and would be investigated by a consultant and a senior nursing staff member. We saw a breakdown of incidents by category and date that allowed trends to be identified and action taken to address any concerns in a timely manner.
- Between September 2014 and December 2014 a total of 449 incidents had been reported which were attributed to incidents occurring within the children's division at the Denmark Hill site. There were 211 incidents that were graded as having caused no harm, four having caused moderate harm or illness, 50 caused minor injury or illness and 183 were ungraded. One incident resulted in the death of a patient. We spoke with staff and considered a range of documents, which demonstrated that a significant number of learning points had occurred as a result of the patient's death, including the enhancement of communication between parents and clinical and nursing staff. Staff had been provided with opportunities to discuss the incident and to review the management of the child, in order that lessons could be learnt, so as to reduce the likelihood of another incident happening again in the future.
- Incidents that had been rated as 'amber' or 'red' were discussed at the local child health divisional quality and governance committee, which was attended by the senior divisional team. Root causes were considered, actions generated and named allied health professionals assigned to incidents to aid in consistency in ensuring that actions were resolved against timelines.
- There were arrangements in place for ensuring that mortality and morbidity meetings took place on a regular basis. In addition to local mortality review meetings, members of the surgical team also participated in a review programme, which included representation of surgeons from two neighbouring trusts in order that clinical outcomes could be considered and learning shared across the three trusts to help enhance patient care and clinical outcomes. Additionally, the neonatal intensive care team also held mortality monitoring committees every two months and surgical neonatal mortality and morbidity meetings every six months, which included representation from the neonatal medical team, the surgical team, the foetal medicine team and anaesthetic teams. Every perinatal death was reported to the Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP).
- Consultants and nursing staff were well versed in the concept of their responsibilities regarding the Duty of Candour. There were local arrangements in place for ensuring that patients and their carers were kept informed of incidents and were provided with the necessary support as well as being kept informed of any investigations and their outcomes.

Cleanliness, infection control and hygiene

- All the ward areas were visibly clean. Appropriate colour-coded equipment was used for the respective areas.
- There were arrangements in place for ensuring that toys and play equipment was appropriately decontaminated between uses.
- Hand wash basins were available on the entrance to each of the clinical areas, including the paediatric and neonatal intensive care units. We observed visitors using these facilities and staff were observed to challenge visitors when they did not wash their hands on arrival to the clinical area.
- We observed staff complying with the trust's policies for infection prevention and control. This included wearing personal protective equipment, such as aprons and gloves, following the 'bare below the elbows' policy and frequently decontaminating hands both before and after patient contacts.
- An infection control scorecard dated September 2014 indicated that there had been no reported cases of MRSA bacteraemia within the child health division (April -September 2014). During this same period, there had

been a total of 59 hospital-acquired alert organism confirmations within the child health directorate, of which five were MRSA colonisation cases and one was a C. difficile case.
- The infection control scorecard reported 76.1% compliance against the Hand Hygiene Audit. This was worse than the trust target of 95%, although the performance trend was noted to be improving.
- The service reported 97.2% MRSA screening for the trust target, which was for 100% of cases to be screened in line with trust policy.
- Sixty-eight per cent of nursing and midwifery staff and 47% of medical and dental staff working within the women's and children's directorate had completed training in infection control. This was below the trust standard of 80%.
- Where outbreaks of hospital-acquired infections had taken place, there was evidence that staff had learnt from these incidents and had taken action to reduce the risk of similar incidents happening again in the future.
- The child health directorate had an established antimicrobial stewardship programme, which was supported by a multidisciplinary team.
- The neonatal team had taken a range of actions to ensure that the risk of pseudomonas infection (gram-negative rod bacteria commonly found in soil, ground water, plants and animals) to babies was reduced. This included ensuring that babies were only bathed in bottled, sterile water and ensuring that in line water filters were attached to the taps. Additionally, staff reported that the issue formed a standing agenda item with the infection control meetings and routine testing of the water supply also having taken place.

Environment and equipment

- Each of the clinical areas where children were inpatients were locked, preventing unauthorised access. Parents/ carers and visitors were able to gain access to the clinical areas by using a buzzer system, which was monitored by nursing staff. We saw that members of the nursing or administrative team greeted each visitor as they entered each of the clinical areas.
- The trust had a child abduction policy, which had been rehearsed prior to our inspection to ensure that staff were appraised of the action to take in the event of a child abduction incident.
- Members of the clinical team raised some concerns regarding the temperature of the Thomas Cook Children's Critical Care Centre. The issue was listed as a risk on the divisional risk register as the cold conditions on the unit had impacted on the welfare of some patients. There were arrangements in place for ensuring that when the environment became too cold and all incidents associated with the cold temperatures were reported as incidents. While there were processes in place for mitigating the impact of the cold environment on the newborn, and while there was evidence that the issue had been discussed at the local governance group and escalated internally, there was little evidence to demonstrate that robust action was being taken to resolve the issue in the long term.
- The department had a range of equipment that was cleaned and checked regularly and was sent for routine maintenance. Staff were aware of who to contact or alert if they identified faulty equipment or environmental issues that needed attention.
- We checked resuscitation trolleys on the NICU, PICU, Toni and Guy Ward, Princess Elizabeth Ward and the paediatric short stay unit and found that they had been regularly checked by staff and were ready for use.
- On the neonatal intensive care unit there were limited facilities available to enable staff to nurse infants in individual cubicles if there were concerns about infectious diseases. Staff were, however, able to describe the actions they would take in the event that they were required to barrier nurse an infant. This included nursing babies in incubators and increasing nursing levels so that babies were cared for on a one-to-one basis.
- Staff working on the neonatal and special care unit reported that, during periods when there was increased occupancy within the unit, space between cots and incubators was reduced and so conditions became cramped. Staff considered that this posed a potential risk to the welfare of babies, especially in the event of an emergency situation. We noted that the conditions within the neonatal intensive care rooms was cramped, due to the high usage of multiple medical devices including ventilators, as well as a presence of chairs for visitors and family members.

Medicines

- It was noted that a risk relating to the management of medicines on the Thomas Cook Children's Critical Care Centre was rated as having a severity risk of 25 (which was high). The risks related to an increased frequency of

medicine administration errors (including incorrect dose calculations and shortfalls in the second checking process amongst nurses). We found that changes to practice had been made including the increase in supervision of junior nursing staff and improved communication amongst staff to share outcomes from previous incidents. However, what was not apparent was whether changes to systems and processes had been considered to reduce systemic failings. Discussions with the consultant pharmacist provided us with some assurance that action was being taken to address the risk of overdose of injectable medicines across all child health wards (the Rule of One project).

- Staff were observed to be preparing intravenous medications in line with the local trust policy. Staff reported that they received daily advice and support from a pharmacist who we observed to be screening drug charts for inaccuracies and prescribing errors so as to reduce the possible risk of harm to patients through drug errors.
- There were processes for ensuring medications were kept securely. Medication fridges were routinely checked to ensure they were operating correctly in order that medicines were stored in in line with manufacturer recommendations.
- We reviewed four drug charts, patient details were appropriately recorded, the allergy status of the patient was documented, medications had been prescribed by registered medical practitioners and each chart was found to be legible.
- Staff had access to policies and supporting information, including intravenous drug preparation guidance, British National Formulary (BNF) for Children and pharmacist support.

Records

- An electronic patient system ran alongside paper records and allowed staff to quickly access patients' previous medical history without delay. This was especially important for patients who had complex medical histories, including those with cystic fibrosis, liver disorders and cancer.
- We randomly checked ten observation records and case-tracked five patients' records, which included reviewing electronic records for completeness and to ensure that patient-specific treatment plans had been recorded. Records were found to be contemporaneous and staff were able to accurately describe the individual treatment plans for patients.
- We saw that the observation records had included a detailed bedside paediatric early warning score (BPEWS) chart, which had been kept up to date.
- Seventy per cent of administrative staff, 39% of medical and dental staff, and 74% of nursing staff had completed mandatory training in health record keeping. This was below the trust standard of 80%.

Safeguarding

- Ninety-three per cent of nursing staff and 74% of medical staff had completed child safeguarding (level 2) training; the trust target was 80%.
- Eighty-eight per cent of nursing staff had completed child safeguarding (level 3) training. These figures were better the trust standard of 80%. However, only 60% of medical and dental staff working within the women's and children's directorate had completed the same level of training.
- Staff could describe the referral process for alleged or suspected child abuse and knew the names of the lead staff member for safeguarding. While there was no formal clinical safeguarding supervision available for staff, staff said they were well supported by the safeguarding team and could access them for advice and support on an 'as required' basis.
- A policy relating to safeguarding children and young people was readily available and accessible and had last been reviewed in August 2014, making reference to national guidance and best practice processes. Staff were able to locate the policy with ease using the trust intranet system.
- Staff working on the NICU were able to describe the arrangements they had in place for being informed of safeguarding concerns, which were likely to have impact on babies who were scheduled to be admitted to the unit. There was close working relations between the names of midwife for safeguarding and the nursing and medical staff working on the NICU.

Mandatory training

- Eighty-two per cent of nursing staff had completed their mandatory training in clinical moving and handling. This was above the trust standard of 80%.

- Eighty-seven per cent of nursing staff and 42% of medical staff had completed resuscitation training. The trust target was 80%.
- Thirty per cent of nursing staff and 9% of medical staff had completed their mandatory training relating to the Mental Capacity Act 2005.

Assessing and responding to patient risk

- The service used a bedside paediatric early warning scoring (BPEWS) system to help them to recognise the deteriorating patient. BPEWS charts were in use, which gave staff directions for escalation. There were BPEWS monitoring charts for different age groups, namely ages zero to three months, three to 12 months, one to five years, five to 12 years and from 12 years upwards. We saw that the BPEW recording charts were found to be completed on admission and then at planned frequencies during the patient's stay.
- We looked at completed charts and saw that repeat observations had been taken within the necessary time frame. Audit data provided by the trust demonstrated that there had been consistent improvements in the completeness of the BPEW scoring chart with the most recent results demonstrating that 97% of charts had been completed correctly.
- Staff explained how they used the BPEWS chart and how they matched the score to care recommendations. Staff had knowledge of the appropriate action to be taken if a patient's BPEWS was elevated. There was documentary evidence of when patients had triggered the BPEWS escalation protocol. Staff reported that medical staff responded within set timescales, which ensured that patients were assessed in a timely manner.
- Nursing staff were able to describe the process for escalating emergency issues, such as violence, absconders, safeguarding, Child and Adolescent Mental Health Services (CAMHS) issues, non-accidental injury (NAI) and bed management issues. The flowchart provided emergency numbers for staff to page or phone the relevant team, such as: consultants, resuscitation team, security and safeguarding leads.
- Paediatric site practitioners were available to review patients out of hours, especially when nursing staff were concerned about the clinical condition of patients. We spoke with two site practitioners who were both aware of two patients who were acutely unwell on Toni and Guy Ward at the time of our inspection. This demonstrated that staff were communicating the condition of acutely unwell patients to the relevant individuals within the hospital.

Nursing staffing

- Nursing staff turnover within the women's and children's directorate was reported as being at 12.5% between April 2013 and March 2014. Data demonstrated that nursing staff turnover was at 3.4% between July 2014 and September 2014.
- The overall nursing vacancy rate for women's and children's services was reported as being at 1.82%.
- Sickness rates within the women's and children's rate was seen to be increasing between July and September 2014, and was at 3.83% in July 2014, 4.35% in August 2014 and 4.6% in September 2014.
- The NICU was reported as having insufficient numbers of substantive nursing staff to meet the demands of the unit. Cot occupancy had been seen to be increasing over the previous three years and was reported as consistently operating above it's funded capacity. Nursing staff deficits had triggered the senior management team to submit a business case in order to increase funding to recruit additional nursing staff and to reduce the over-reliance on agency staff. At the time of the inspection, the service was not able to meet the nurse-to-patient ratio for babies who required intensive care treatment. Current ratio's allowed for a nurse-to-patient ratio of 1:2 as compared to the national standard of 1:1 care – as per the British Association of Perinatal Medicine (BAPM) standards. In addition to the reliance on agency staff to support the neonatal intensive care unit, the sickness rate amongst staff within the unit was reported as being above 5% for 2014/15, with many nursing staff telling us that they felt additional pressure and increased stress levels as a result of the increased demand on the service.
- The Thomas Cook Children's Critical Care Centre reported that there were sufficient numbers of nursing staff available to meet the nurse-to-patient ratio as set by the Paediatric Intensive Care Society (PICS). Data from the Paediatric Intensive Care Audit Network (October 2014) demonstrated that the overall nursing establishment for the Thomas Cook Children's Critical Care Centre was below that of the national standards, with five whole time equivalent (WTE) nurses per bed space employed. This fell below the national standard

of 7.01 WTE nurses per funded bed space. While the budgeted establishment was below the minimum recommended paediatric intensive care standard, staff reported that bank and agency staff could be accessed to support the unit.
- There were systems in place for ensuring that the clinical needs of patients were assessed and staffing levels adjusted accordingly. Paediatric Site Practitioners were responsible for assessing staffing levels out of hours and for ensuring that wards were suitably staffed with appropriately skilled individuals.

Medical staffing

- Child Health employed a total of 108 medical staff, 57 of whom were employed at consultant level. Sixty-three per cent of doctors were employed at specialist registrar (year 1-6) level, which was higher than the national average of 51%. Two per cent of doctors were employed as foundation year 1 or 2 trainees. This was below the national average of 7%.
- The NICU was supported by eight WTE consultant neonatologists who provided cover to the unit 24 hours per day. A business case had been submitted to the executive team to increase the number of consultants available to support the NICU. This was in response to the recognition that the unit was consistently running above it's funded capacity.
- Doctors for a range of specialties were available 24 hours a day. There was general medical and paediatric intensive care consultant cover seven days a week, including a consultant on call at night. There was cover from junior and middle grade (specialist trainee) doctors on the wards day and night.
- Handovers on the neonatal intensive care unit took place daily between the day and night medical teams. We noted that, while the majority of cases were handed over at the cot side as part of a formal ward-round basis, due to the number of babies within the unit, some babies were not formally handed over. This was especially applicable to those babies who were clinically stable, were well known to the medical staff and had generally been inpatients for a long period of time.
- Consultants led on a range of ward rounds on the various wards. We noted that specialty doctors, including those from the respiratory team conducted regular, twice daily ward rounds.

Major incident awareness and training

- Senior nursing and clinical staff reported that they had received major incident awareness training. Senior staff were aware of the location of the major incident plan and were well versed in it's contents.

Are services for children and young people effective?

Good

Staff adopted a holistic approach to assessing, planning and delivering care. Staff developed and advocated the use of innovative and pioneering approaches to care, especially for those children with complex liver conditions and those who required surgery as neonates. Additionally, the service hosted a national specialist multidisciplinary bariatric service to children with obesity issues.

Clinical teams worked collaboratively to enhance the provision of care to children. The service led on a range of national medical and surgical initiatives and worked in conjunction with a range of third party peers to drive forward advancements in paediatric surgery and medicine.

Paediatric mortality rates were seen to be in line with, or better than, peer averages across a range of specialties.

The service participated in a range of local and national audits, including clinical audits and other monitoring activities, such as reviews of services, benchmarking, peer review and service accreditation. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff. Information from local and national audit programmes was used to improve care and treatment and people's outcomes. Performance against a range of national audits was seen to be in line with, or better than, national averages although some work was required regarding the management of asthma patients and those with diabetes.

When people were due to move between services, their needs were assessed early, with the involvement of all necessary staff, teams and services.

Evidence-based care and treatment

- The trust's hospital protocols were based on the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health

(RCPCH) guidelines. Local policies were written in line with this. Staff knew where to find policies and local guidelines, which were available on the intranet. There were systems in place for ensuring that policies were reviewed following changes to national guidance.

- Consultants and nursing staff from a range of specialties were engaged in the development of national and international treatment guidelines as well as engaging in international research programmes.
- There were a range of clinical pathways and protocols for the management and care of various medical and surgical conditions which had been developed in conjunction with healthcare professionals from a range of specialties.
- Nursing staff confirmed clinical governance information and changes to policies and procedures and guidance had been cascaded down by the matron and ward manager via emails, special meetings and discussion at team meetings, which were held monthly.

Pain relief

- We observed that a variety of tools were used to assess pain, depending on the age of the child and their ability to understand information. The pain assessment chart was embedded in the BPEWS chart. For a younger child, we noted that a pain assessment tool using 'smiley faces' had been used. The child had been asked to choose a face that best described their own pain. In the case of a child living with a learning disability, a Face, Legs, Activity, Cry, Consolability (FLACC) behavioural tool was used.
- Condition-specific guidance was available to staff to help them to manage cases, for example, those presenting to the hospital in sickle-cell crises.
- We saw that the special care baby unit (SCBU) and NICU used kangaroo care (a technique where the baby is held skin-to-skin with the parent) as a means of helping to stabilise neonates. We observed that parents were encouraged to engage in skin-to-skin care as frequently as the condition of the baby permitted.
- Advanced pain management services were available through a dedicated pain management team. The paediatric site practitioners had undertaken additional training to enable them to provide second and third stage pain management services out of hours, a consultant anaesthetist was available 24 hours per day to assist with patients who presented in severe pain or who required additional intervention.

Nutrition and hydration

- Patient records included an assessment of each patient's nutritional requirements. The service used the adapted Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) to assess nutritional risk for all patients.
- Patients with poor food and hydration intake were observed closely. The care pathway observation chart included a section for nurses to monitor the food and fluid intake of these patients. This ensured patients' nutritional and hydration needs had been monitored and maintained.
- Parents and children commented that there were choices in the menu offered each day and that the food provided was 'good'. The menu card was given to patients to select their menu in the morning and hot meals were served twice a day. Sandwiches and snack boxes were available throughout the day.
- We saw that children had drinks readily available by their bedsides.
- Specialist paediatric dieticians were available to support the wider multidisciplinary team.
- A multidisciplinary bariatric clinic which provided national services to obese children had been established. At the time of inspection, eight patients had been operated on, in line with strict selection criteria. National bariatric symposiums had been facilitated by the service.
- There were policies in place to support staff to ensure that patients were starved preoperatively, in line with national recommendations. Three parents told us that they had not received any preoperative information regarding the starving times for their child. On two occasions, parents had not sufficiently starved their children and so the children were delayed in going to theatre. Staff were well versed in the requirements and acknowledged that further work was required to ensure that the local policy was communicated to parents and carers to educate them so as to reduce the likelihood of delays in future cases.
- A joint working collaboration had been established between King's College Hospital NHS Foundation Trust and South London and Maudsley NHS Foundation Trust

to establish a child and adolescent eating disorder service, which was hosted at The Maudsley Hospital, London. Changes to treatment pathways, including the introduction of family therapy and integrated outpatient and inpatient therapies was seen to lead to medical stabilisation and more cost-effective care in the long term.

Patient outcomes

- The service participated in a range of national audit programmes in order that benchmarking and measuring of clinical effectiveness could take place. Audits participated in included the Childhood Epilepsy Audit, the British Thoracic Society Paediatric Asthma Audit, the National Paediatric Diabetes Audit (NPDA), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK) and the National Neonatal Audit Programme (NNAP).
- Summary Hospital-level Mortality Indicators (SHMIs) across a range of specialties were seen to be better when compared to peer services for neonatology, paediatric gastroenterology and paediatric transplantation services.

National Paediatric Diabetes Audit

- The glycosylated haemoglobin (HbA1c) measurement is recognised as being the best indicator for long-term diabetes control. Because red blood cells in the human body survive for eight to 12 weeks before renewal, measuring glycated haemoglobin (or HbA1c) can be used to reflect average blood glucose levels over that duration, providing a useful longer-term gauge of blood glucose control. Data from the 2013 NPDA demonstrated that King's College Hospital (the Denmark Hill site) paediatric diabetes service performed worse than the national average with regards to Hba1c ratios being below 58mmol/mol, in that 11.6% of the hospital case mix had a Hba1c below this level. This compared with a national case mix mean of 17.1% and a regional caseload mix of 17.6%.

British Thoracic Society Paediatric Asthma Audit

- Performance against the national clinical audit for paediatric asthma was varied. A higher proportion of patients could expect to receive a chest X-ray and antibiotics when compared nationally (78% of children had a chest X-ray versus 26% nationally and 50% of children received antibiotics versus 26% nationally). Ninety-three point eight per cent of children who were administered steroids to help manage their condition had received a dose prior to admission versus 18.6% nationally. The service had acknowledged that further work was necessary to ensure that patients were managed appropriately and in line with national standards. A local audit had subsequently been commissioned.
- It was reported that no children received information leaflets, peak flow meters or a store of steroids prior to discharge. This compared negatively against national performance, where 47% of children were given information, 4% were given a peak flow meter and 11% were given a store of steroids. Further, the number of children who had their technique for using an inhaler device assessed prior to discharge was reported as 59% locally versus a national average of 44%.

National Neonatal Audit Programme (NNAP)

- Performance against the NNAP (2013) was positive . The NICU performed better in each of the five key indicators, including: recording of temperature within one hour (97% versus 93% nationally), administration of antenatal steroids (87% locally versus 85% nationally), the number of eligible babies screened for retinopathy of prematurity (RoP) – 100% locally versus 95% nationally, the number of babies discharged home receiving some or all of their mother's breast milk (52% locally versus 35% nationally) and the number of parents who received a consultation from a senior member of the team within 24 hours of admission to the unit (94% versus 84% nationally).

Paediatric Intensive Care Society Audit Network (PICANet)

- Risk adjusted standard morality rates for the paediatric intensive care unit (PICU) over the previous three years had consistently been better than expected (2011 – 0.86, 2012 – 0.96 and 2013 – 0.83).
- Emergency readmission rates within 48 hours of discharge was better than the national average with a readmission rate of 0.8% versus 1.8% nationally.

Competent staff

- Staff reported that they had attended induction on starting employment and had attended mandatory training, including basic life support. All nursing staff working on the special care baby unit had completed their newborn life support training.

- There were arrangements in place for ensuring that newly qualified nurses were orientated across both of the hospitals (King's College Hospital and Princess Royal University Hospital). Newly qualified nurses were also supported by way of undertaking a preceptorship programme, as well as receiving support from a practice educator. However, some junior nursing staff reported that their individual preceptorship programme had not been as effective as it could have been, due to the infrequency with which they were worked with their preceptors. The ward managers that we spoke with acknowledged that further work was required to enhance the preceptorship programme, so that newly qualified staff were sufficiently supported.
- There were systems in place for monitoring training for new staff, through the training department. Practice development nurses worked in a range of specialities and oversaw newly qualified nurses and those going through their induction period to ensure appropriate training had been arranged for them. This included mandatory training, mentorship training and competency assessments, such as for the administration of oral and intravenous medication.

Multidisciplinary working

- Overall, staff reported good multidisciplinary working across the children's division, with other services within the trust and with external organisations, such as local authorities and general practitioners, who had made referrals. There were good shared care arrangements with surgeons, and other services, such as theatres, orthopaedics and psychiatry.
- We found that the pathway for emergency patients requiring treatment from the maxillofacial surgical team was disjointed and poor communication existed between the surgical team and the paediatric site practitioner team. For example, we found two cases where beds were required for patients, and for whom both parents reported that the admission process had been convoluted and had led to some delays.
- Several multidisciplinary team meetings were held monthly, including serious case reviews, a safeguarding steering group meeting and a weekly psychosocial meeting. The care and treatment of each patient was discussed and different views were listened to before making decisions in the best interests of the child.
- While multidisciplinary working existed within the NICU, with multiple specialties providing input into the clinical care and support of complex cases, we found the organisation of such working to be disjointed. A range of weekly meetings took place with varying specialties attending the meetings, where decisions were made about treatment plans. However, it was noted that at no time, complex case meetings were held, where all specialties were in attendance at the same time. There was, therefore, a risk of some disjointed working and delays in decisions being made regarding treatment plans.
- The arrangements for the transitioning of patients with chronic health conditions, especially for those with liver conditions was exceptionally robust. The service was leading on national and international transitional care programmes and research to enhance the transition programme for adolescents undergoing liver transplantation, in order to improve mortality rates amongst 20 to 30 year olds. The service had a liver adolescent strategy, which was supported by clinical nurse specialists, paediatric and adult hepatologists, clinical psychiatrists, specialist social workers, liver transplant surgeons and sexual health consultants. Specialist adolescent liver outpatient clinics operated twice a month to support this age group. Eighty-eight per cent of patients reported that their overall experience of the transitional care service was "very good" or "excellent". Due to the success of the adolescent service, it was noted that the age of referral to the clinic had progressively reduced between 2008 and 2013 from a median age of 17.4 years to 16.1 years, meaning that more patients were being offered additional support over a longer period of time.
- Play specialists were available each day and provided a service to children accessing clinical services in inpatients, outpatients, PSSU and paediatric intensive care. Staff reported that some infants on the SCBU would have benefited from input from play specialists, especially for those infants who had been on the unit for some months.

Seven-day services

- There was a 24 hour consultant-led service, with medical and nursing cover for each of the clinical areas. There was support from diagnostic services, including: radiology, physiotherapy and speech and language services.

Services for children and young people

Consent

- Parents on the wards confirmed that their consent had been sought prior to treatment of their child. They described how the procedures had been explained to them by both doctors and nurses. They felt they had been given very clear information and were well informed before they signed the consent form for surgery and treatment.
- Staff were able to describe the legislative requirements regarding consent and confirmed that policies and procedures were available to ensure that informed consent was obtained from the appropriate individual. Staff were able to describe the concept of Gillick competencies and the arrangements for seeking consent from children and young people where they had been assessed as being competent to make decisions regarding their care and treatment.
- Although the uptake for training of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was low across the directorate, staff were able to describe the arrangements that were in place should the legislation need to be applied. Staff reported that the least restrictive form of deprivation would be used and decisions were made in conjunction with the wider family unit, specialist social workers, clinicians and nurse specialists.

Are services for children and young people caring?

Good

Parents were complimentary about the medical and nursing staff and they felt their child was in safe hands. Parents felt involved in the care of their child and participated in the decisions regarding their child's treatment.

There was good staff interaction with patients and parents. Both children and parents were treated with compassion, dignity and respect, although some additional work was required to ensure that patients who accessed the diabetes service had their views heard and were respected and understood by all members of the team.

Compassionate care

- Response rates against the service's 'How are we doing' survey were seen to be consistently better than the trust benchmark of 86%.
- Performance against a range of Commissioning for Quality and Innovation (CQUIN) payment framework measures regarding patient experience consistently exceeded benchmarks:
- Throughout our inspection, we witnessed good staff interaction with patients and parents. We observed good, friendly and appropriate communication by nursing and medical staff with parents and their child. We observed how the nurses assisted parents and children during recovery from a surgical operation.
- Parents were all complimentary about the care and the staff who cared for their child. Both children and parents were treated with compassion, dignity and respect.
- One parent commented, "Very good service, although the ward can be a little noisy at night. The staff offered me a tour and have been very supportive". Another parent said, "I received information before we arrived for our surgery. The staff have been very informative. They have been compassionate and have demonstrated a high level of understanding about how we, as a family, are feeling. We are all extremely anxious and both the doctors and nurses have moved mountains to reassure us."

1. Ninety per cent of responders stated that that they were able to find someone on the hospital staff to talk about their worries or fears.
2. Over 92% said that when they had important questions they got answers that they could understand.
3. Response rates regarding questions at night, nurse response time to call bells and support on discharge was consistently above, or better than, the trust benchmark.

- Parents were all complimentary about the care and the staff who cared for their child. Both children and parents were treated with compassion, dignity and respect.

Understanding and involvement of patients and those close to them

- Parents felt well informed before they signed the consent form for surgery and other treatment. They felt involved in the care and in the decisions regarding their child's treatment. One parent said, "I was able to meet

with the surgeon on two occasions before signing the consent form. I was given sufficient information in order that I could make an informed decision. As a family, we have all been involved in planning the care for our child."

- Patient and parent satisfaction survey questionnaires were available and the results were published on the dashboard, together with the action taken to improve the service.
- Within the NPDA experience survey for children and young people (2013/2014), 100% of patients reported that they either 'agreed' or 'strongly agreed' that they received useful information from members of the clinical team. While the majority of patients either 'agreed' or 'strongly agreed' that clinical appointments were well organised and gave them sufficient time to discuss everything that they would like to discuss, 8.3% of patients disagreed. This was worse than the national average of 3%.
- Parents reported they were given appropriate information and the proposed treatment was explained to them by both doctors and nurses.

Emotional support

- A range of healthcare specialists were available to provide emotional support to the family and to the child. Bereavement nurse specialists, clinical psychologists and psychiatry services were available to families who were grieving the loss of a child or sibling.
- Psychological support could be offered to patients with complex health needs. The paediatric bariatric service referred all patients to a psychologist whose role it was to help support the adolescent in the lead up to, and following, their surgery in order to enhance recovery and to adjust to physical body changes, as well as to support the emotional wellbeing of the individual.
- While 88.6% of patients in the NPDA patient experience survey 'agreed' or 'strongly agreed' that they felt heard, respected and understood by all members of the team, 11.4% disagreed. This was worse than the national average of 3.2%.

Are services for children and young people responsive?

Good

Staff acknowledged that the demands on the service were increasing year on year and that capacity had proven to be difficult to manage during peak times. This was especially pertinent to the NICU whose activity had been seen to be increasing annually. The organisation recognised the need to extend children's services over the coming years to ensure that it could continue to meet the needs of the population it served.

People's discharge or transition plans took account of their individual needs, circumstances, ongoing care arrangements and expected outcomes.

Service planning and delivery to meet the needs of local people

- Paediatric site practitioners had been employed to oversee the day-to-day operation of the service, having input into the admissions and discharges of each clinical area. Also, the site practitioners were available to assess the clinical condition of patients about whom staff were concerned and were also available to provide second line pain management services out of hours.
- Daily unit meetings took place, allowing the nurse in charge from each clinical area to discuss their bed occupancy, upcoming discharges, elective and emergency admissions.
- We noted that young people up to the age of 18 were cared for within the children's and young people's service and saw evidence that their transition into adult services was managed effectively. This was especially noted for young people with complex liver disorders, where an extensive transitional care service had been developed to help support young people's move from the paediatric liver service to the adult team.
- The service employed a range of clinical nurse specialists to ensure that patients with specific health conditions and their families received expert care and support. These included those for liver disease, sickle cell disease and respiratory conditions.

Access and flow

- The total number of cot days within the NICU and SCBU was seen to have peaked in 2010 when 12,499 days were

reported. While there had been a marginal decrease in cot days through the following two years, cot days were noted to have slowly increased and were reported as 12,253 cot days in 2013. While there had been a decrease in the number of special care cot days (from a reduction of 6,927 in 2010 to 6,155 in 2013), there had been an increase in the number of cot days for babies requiring high dependency or intensive care support (5,572 in 2010 and 6,098 in 2013). It was widely accepted by the senior management team and those working within the NICU that it did not have a sufficient number of cots to ensure that it could meet the needs of the local and regional population. Staff reported that poor discharge planning had impacted on the ability of some babies to be repatriated to local neonatal units to enable their care to be continued. Further, the acuity and complex clinical conditions of some babies had led to significant increases in their length of stay. While there was some action being taken, including improving the working relationships between the NICU and the paediatric intensive and high dependency care teams to facilitate the transfer of babies to more age-appropriate environments, the increased occupancy in the PICU and HDU had meant that transfers could not always take place. There was also concern amongst the clinical staff that the skill set of ward-based nursing staff meant that they were anxious to transfer babies to the children's ward for continued care.

- Staff reported that the occupancy on the neonatal unit consistently fluctuated and at times was reported to have peaked at 40 babies. The week prior to our inspection we found this to be the case. During the inspection, occupancy of the unit fluctuated between 34 and 36 babies. Nursing staff reported that, while best practice was for there to be a cot available at all times, in order that an emergency admission could be accepted, this was often not the case. Nursing staff said that the service adopted a more responsive approach to managing emergencies instead of it being proactive, and that this was attributed to an overall lack of capacity within the unit. Data provided by the trust demonstrated that cot availability on the NICU at the Denmark Hill site was a continuous problem. Daily reports to the 'Emergency Bed Service' between September 2014 and January 2015 demonstrated that cots were only available on 12 out of a possible 153 days. This meant that 36 mothers were transferred outside of the South East Neonatal Network and 16 transferred within the network, during that time period.
- Occupancy difficulties within the NICU were listed as a risk on the divisional risk register and had a residual severity risk score of 16. In order to enhance the discharge process of babies, a nurse had been appointed to work as a special care discharge coordinator, as well as establishing a more robust in reach service, which intended to help facilitate the early discharge of infants, while dedicated nursing staff were available to support parents in the lead up to, and subsequent discharge from, the unit.
- The paediatric surgical team had access to one dedicated theatre, which some surgeons felt was insufficient to meet the growing demands of the service. There were, however, arrangements in place for ensuring that the surgical team had access to the emergency theatre and were able to discuss with colleagues on a daily basis any surgical cases, which should be prioritised in order that the needs of the most critically-ill patient be put first.
- As a means of trying to resolve ongoing capacity issues within the children's service and to help enhance the pathways for children, a paediatric short stay unit was opened in July 2014 and was designed to treat patients who required inpatient care of less than 48 hours. We saw evidence that the introduction of the paediatric short stay unit had led to a reduction in the cancellation of elective surgical cases and also an increase in the number of specialty patients being able to be admitted to Toni and Guy Ward as a result of improved bed management. Inpatient cancellations was seen to have peaked at 12 in November 2014, but had since reverted to zero for January and February 2015. Overall, surgical cancellations had reduced from 54 prior to the opening of the paediatric short stay unit (PSSU) to 34 (37% reduction) following its inception. Further, there had been a marked reduction in the number of paediatric medical outliers admitted to non-medical wards after the opening of the PSSU.
- The outpatient 'did not attend' (DNA) rate was seen to be worsening month on month and was significantly above the trust target of 8% (as of February 2015 the DNA rate was reported as being at 16.6%).

Services for children and young people

- The scorecard for the service, which was provided to us lacked any data regarding emergency readmission rates and diagnostic waits of more than four weeks.

Meeting people's individual needs

- There were information leaflets available for many medical conditions, including child-friendly leaflets on diabetes, asthma and sickle cell anaemia.
- The menus included cultural dishes reflecting the local community.
- Activity facilities were provided with toys, colouring books and games to entertain children on the ward. Play activity specialists covered the ward to assist inpatients.
- Children were given educational support five days a week. The teacher gave a choice of subjects for the children to choose, depending on their age group. All activities were documented in accordance with education guidelines. The education team were able to provide specialist support to children living with learning and complex physical disabilities. This included the use of pictorial and electronic communication tools.
- The wards operated flexible visiting times to enable parents to visit or to stay with their child at all times.
- Translation services were available to those patients and families for whom English was not their first language.
- The liver team raised concerns that there was limited bed capacity to provide care and support to adolescents in an appropriate environment.
- Parents whose children were receiving long-term care were provided with accommodation local to the hospital.
- Children who required support for mental health conditions were routinely nursed on a one-to-one basis. Staff told us that, while the service did not employ specialist mental health nurses, shifts could be covered with bank and agency staff.
- While the service employed a range of clinical nurse specialists, there was some concerns raised that, due to the complexities of some children's conditions and the increased workload of the specialist team, some patients may not always have sufficient time to speak with the nurse specialists at length.
- The clinical nurse specialists provided a range of outreach clinics in other hospitals in order that patients were not required to travel to the Denmark Hill site for clinic appointments.
- Information leaflets for parents was also on display on the noticeboard in the children's wards, Thomas Cook Children's Critical Care Centre and the NICU.

Learning from complaints and concerns

- Information was available for patients to access on how to make a complaint and how to access the Patient Advice and Liaison Service. A dedicated member of staff within each of the clinical areas, including the matron, reviewed all formal complaints received and concerns were raised with the Patient Advice and Liaison Service. All concerns raised were investigated and there was a centralised recording tool to identify any trends emerging. Learning from complaints was disseminated to the whole team to improve the patient experience within the department.
- Information was readily available for patients who wished to make a complaint, but who may have needed support to do so.
- Complaint levels within the child health directorate were seen to be generally low. Staff reported that they always tried to resolve issues in the first instance by speaking with family members. In response to a recent serious incident, staff had produced a new leaflet, which was aimed at supporting parents to escalate their concerns to senior members of the clinical and nursing team if they felt they were not being heard by members of the team and were concerned about the clinical condition of their child.

Are services for children and young people well-led?

Good

Staff were aware of the trust vision and values. Staff had been provided with information on trust developments that had been cascaded down from their line managers. The service had a child health specific strategy, which was aligned to the trust-wide strategy. The strategy was driven by quality and safety and took into account the requirement for the service to be fiscally responsible.

There were governance arrangements in place for which a range of healthcare professionals assumed ownership. Further, work was being undertaken to strengthen the

governance relating to children who received care or treatment outside the auspices of child health services. There was evidence that risks were managed and escalated accordingly.

Nursing staff reported good management support from their line managers. Changes to the management team within the NICU was said to have a had a positive impact on the service.

Innovation and long-term sustainability were seen as key priorities for the leaders of the service. Participation in national and international research was a driving motivation for clinical staff in order that the wellbeing and clinical outcomes of children could be enhanced.

Vision and strategy for the service

- There was a service-level clinical strategy for child health, which was aligned to the trust strategy. The strategic vision included both short and long-term priorities for the next one to two years and three to five years respectively and included developments regarding the environment, finance, service provision and governance arrangements.

Governance, risk management and quality measurement

- Governance arrangements at the King's College Hospital (Denmark Hill site) were underpinned by a documented risk management process, which senior staff were well versed in and they reported that its overall effectiveness was good. There was engagement from a range of healthcare professionals regarding the clinical governance and risk management process.
- Regular child health divisional quality and governance meetings, chaired by the clinical director were held and attended by a range of health professionals, including nursing staff and the divisional quality and risk lead.
- Standing agenda items at the divisional governance meeting included a review of actions from previous meetings, reviews of the divisional risk register, reviews of recent incidents, consideration given to recent safety alerts and infection control issues. Patient experience, clinical effectiveness and self assessment against the trust risk management strategy were also considered.
- It was evident that some issues, which had impacted on the clinical effectiveness of the service, including the escalation of the deteriorating child, had been escalated to the divisional risk register and there was evidence that action was being taken to address the issues.
- While the service had introduced a child health scorecard in order that the quality of the service provided could be monitored, we found that a proportion of metrics contained no information. It was, therefore, not possible to take complete assurance from the scorecard that all components of quality measurement were being effectively undertaken.
- Participation in a host of national and local audits meant that the service could measure their clinical effectiveness and performance against a range of peers and national outcomes. Presentations and assurance to the board meant that there was transparency within the service and there was evidence that where improvements were required, action plans were developed and further assurances offered to commissioners and patient groups alike.
- The senior team acknowledged that further work was necessary to ensure that the governance arrangements for all children who received care and treatment at King's College Hospital NHS Foundation Trust was strengthened. The introduction of a child health board had received executive approval and while it was yet to be formally established, it had been designed to ensure that the skills and training of all staff who provide care and treatment was sufficient and that clinical areas were appropriate to meet the needs of children.

Leadership and culture of the service

- Leadership of the service was by way of a triumvirate with a clinical director, head of nursing and general manager. It was noted that the operational management of the service was provided by way of the general manager's deputy, who was well versed in the operational strategy and vision of the service. The clinical director had delegated responsibility to specialty leads and the head of nursing had delegated some responsibility to her deputies. Development of the matrons and ward managers was seen as a key priority and empowerment of the role of the paediatric site practitioner was seen as key to ensuring the service was well-led.
- The leadership of the neonatal intensive care service had undergone change in recent months and was reported by staff to have been a positive change. There had been significant shortfalls identified by the new team regarding the management of the NICU. We found that the shortfalls had been identified and were being resolved, including the lack of nursing, medical and

therapy support staff to support the growing service. Additionally, the ongoing capacity issues caused by poor discharge planning had been identified and new roles had been created as a means to resolve the issues. Morale within the NICU was reported to be improving among both the medical and nursing staff since there had been a change in medical and nursing leadership.

- Staff were highly complimentary about the frontline management team. Junior doctors felt the consultants were very approachable and supportive.
- Ward managers and matrons reported that having supernumerary status allowed them the time to develop their workforce and to address quality and patient safety issues. The head of nursing was an advocate of ensuring that the ward managers were visible to their staff and, therefore, promoted the concept of the management team undertaking regular clinical shifts.
- The staff that we spoke too were extremely proud to work for King's College Hospital NHS Foundation Trust and felt that the care they provided was excellent.
- There was an open culture amongst the staff group. Staff felt confident to report incidents and concerns in the majority of clinical settings, although it was noted that the culture within the NICU was one in which personal issues that impacted on the workforce would try to be resolved among staff, as compared to sharing those concerns with the management team. Again, this had been identified by the management team and work was being undertaken to ensure that personal differences were resolved in a professional and timely manner.

Public and staff engagement

- Specialty services invited feedback from a range of service user groups and families in order that services could be developed and reconfigured to ensure they met the needs of the population. The liver service hosted annual functions, which allowed patients to meet with each other in order to allow peer relationships to develop as well as to allow staff to seek feedback from patients.
- Patient feedback was widely disseminated across each of the clinical settings and included initiatives including 'You said, we did' noticeboards, as an example. As of April 2015, the service was said to be introducing a new system to seek feedback from children aged eight years and above.

Innovation, improvement and sustainability

- The introduction of the paediatric short stay unit was seen to have enhanced the patient pathway for those who required treatment for acute illnesses, as well as impacting positively on those patients who required rapid, open access to the children's wards. Engagement with local general practitioners (GPs) had led to them providing positive feedback about making referrals to the acute medical team at the hospitals. There had been a significant reduction in the number of patients who presented to the ED who were seen for 'treat and transfer'. There had been two reported treat and transfer cases up to April 2015, as compared to 43 during the same period the previous year.
- The adolescent liver transition service was seen as a gold standard service. Year-on-year, increases in the number of referrals to the service, as well as a reduction in the age of referral, meant that young people were receiving support and advice at a much earlier stage and for longer durations. We reviewed information, which indicated that drug compliance had improved as a result of the initiative, as well as increases in patient experience.
- While only a small service, the paediatric bariatric service was seen as providing a holistic, multidisciplinary-led service to children across the country. The lead clinician had identified the importance of maintaining their specialist surgical skills and assisted with adult surgical cases. There was engagement with the adult surgical team for each of the paediatric cases, so as to ensure the service remained safe.
- As a result of a five-year paediatric and mental health joint working collaboration programme relating to the management of children with eating disorders, the local clinical team had presented nationally as well as advising government officials on the structure and treatment pathways for those with eating disorders.

End of life care

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

Information about the service

King's College Hospital NHS Foundation Trust provides integrated end of life care across King's College Hospital (the Denmark Hill site) and Princess Royal University Hospital. End of life care was not seen as the sole responsibility of the specialist palliative care team (SPCT). End of life care at King's College Hospital (Denmark Hill site) consisted of an SPCT who worked in partnership with the local voluntary sector provider, St Christopher's Hospice, providing support to patients with complex symptoms at the end of life. A practice development nurse (PDN) and clinical nurse specialists (CNS) support the generalist staff in the delivery of end of life care, as well as training and education of nursing and medical staff.

The SPCT was led by the lead palliative care consultant and a nursing matron. The team consisted of social workers, a service manager and team administrator. In addition, the bereavement office staff provided bereavement support after death and the chaplaincy team provided multi-faith support.

The core SPCT were available five days per week, Monday to Friday, 9am to 5pm. At weekends and bank holidays, specialist registrars (StRs) provide a first on-call visiting and a telephone advice service via the King's Health Partnership (KHP), King's College Hospital NHS Foundation Trust and Guy's and St Thomas' Hospital, supported by the on-call consultant.

During the inspection, we visited a variety of wards across the trust, including: Lonsdale Ward, Howard Ward, Oliver Ward, Annie Zunz Ward, Mary Ray Ward, Donne Ward, Todd Ward, Katherine Monk Ward, Lister Ward, Davidson Ward, Fisk Ward and Cheere Ward, the emergency department (ED), the neurological intensive therapy unit (NITU), the chemotherapy day unit, Bereavement Centre, the mortuary and the Macmillan Information and Support Centre.

We spoke with palliative care medical consultants, registrars and junior ward doctors, clinical nurse specialists, registered nurses, a practice development nurse (PDN), bereavement staff, ward matrons, head and assistant heads of nursing, porters, mortuary staff, Specialist Nurse in Organ Donation (SNOD) and the hospital chaplain in order to assess how end of life care was delivered.

We reviewed documents relating to the end of life care provided by the trust and the medical records of ten patients receiving end of life care. We observed the care provided by medical and nursing staff on the wards and spoke with four patients receiving end of life care and four family members of patients receiving end of life care.

We received comments from our public listening event and from people who contacted us separately to tell us about their experiences. We reviewed performance information held about the trust.

End of life care

Summary of findings

Current trust policy around syringe drivers was inconsistent across the sites and did not protect patients from adverse incidents. The cover for the concealment trolley was in poor repair and was an infection control risk. We saw little evidence of the documentation of preferred place of care/preferred place of death or the wishes and preferences of patients and their families. Although there was a unified do not attempt cardio-pulmonary resuscitation (DNA CPR) policy, orders were not consistently completed in accordance with the policy. There were also no standardised processes for completing mental capacity assessments.

Staff at King's College Hospital (the Denmark Hill site) provided compassionate end of life care to patients. The specialist palliative care team (SPCT) provided face-to-face support, seven days a week, with a palliative care consultant providing out-of-hours cover. There was strong clinical leadership of the SPCT and chaplaincy team resulting in well-developed, strong and motivated teams. Bereavement support was available from the social workers, chaplaincy and bereavement office staff, who were able to provide support for carers and their families following the death of their relative. The teams worked well together to ensure that end of life policies were based on individual need and that all people were fully involved in every part of the end of life pathway. However, we did not see any evidence of a long-term vision around end of life care across the trust.

Relatives of patients receiving end of life care were provided with open visiting hours and were also offered 'keepsakes' from the deceased patient. There was excellent spiritual/religious awareness by staff across the hospital and facilities were in place to support the different cultures and religions of the local population.

End of life care was embedded in all the clinical areas and staff we spoke with were passionate about end of life care and the need to ensure that the wishes and preferences of their patients and families were met as they entered the last stage of their life.

There was a multidisciplinary team approach to facilitate the rapid discharge of patients to their preferred place of care or preferred place of death. Patients were cared for with dignity and respect and received compassionate care. Medicines were provided in line with guidelines for end of life care.

End of life care

Are end of life care services safe?

Requires improvement

A syringe driver was used in the wards to deliver consistent infusions of medication to support end of life patients with complex symptoms. Patients being discharged with a syringe driver in place required the specialist palliative care team (SPCT) to connect a different syringe driver for discharge. However, nursing staff on the wards had not been trained in the use of the syringes used on discharge and, as a consequence, clinical issues had developed, including blocked pumps, resulting in pain medication not being delivered to patients. The current trust policy around syringe drivers used with end of life care patients did not afford optimum protection against the risk of adverse incidents.

An X-ray trolley was being used as the hospitals concealment trolley because the actual trolley was being repaired. The cover for the concealment trolley was in poor repair and was an infection control risk. Medical staff were not based on the chemotherapy day unit. This could be an issue if medical support was required by patients immediately and doctors unavailable.

The mortuary provided data about incidents with summaries of actions taken to mitigate the risk of reccurrence. A total of 59 incidents had been reported in the last 15 months. Of these, three were classed as serious incidents.

Incidents

- All the staff we spoke with told us they were encouraged to report incidents using the electronic reporting system. A senior nursing staff on Todd Ward told us that feedback from incidents was given at the staff meetings that took place monthly. Minutes of the most recent staff meeting showed that areas discussed included incident reporting.
- Incidents that related to end of life care were discussed at the palliative care governance meeting. To monitor adverse incidents, the SPCT had set up a 'governance action tracker'. We reviewed the action tracker for January/February 2015 and noted that seven incidents were logged for both the Denmark Hill site and Princess Royal University Hospital sites. There were clear descriptions of the incidents recorded and the actions taken following the incidents. The majority of incidents were around medication errors. By monitoring the incidents related to end of life care, the SPCT were able to monitor themes and influence training and policy to improve the quality of end of life care across the trust. Learning from incidents was shared through regular staff meetings, the daily bulletin to staff, emails from consultants and the setting up of a web page. Ward meetings were held monthly and minutes from the meeting were available on the ward. On Lonsdale Ward, one nurse told us that the feedback received regarding incidents was good.
- The mortuary provided data about incidents across both sites reported from 1 January 2014, with summaries of action taken to mitigate the risk of reccurrence. Fifty-nine incidents had been reported in the past year and of these, three were classed as serious incidents (red), five as moderate (amber) and all the rest were low risk incidents. We reviewed how the red risks were managed and noted that the appropriate procedures were followed, including a root cause analysis and discussion with families. We noted that one of the red risks was due to be discussed at the April 2015 serious untoward incident meeting by the palliative care consultant. We were shown by the mortuary staff that systems had been introduced in the mortuary to prevent similar incidents happening in the future.
- The chemotherapy outpatients senior nurse told us that adverse incidents were recorded in the electronic reporting system, as well as informing the unit manager and lead chemotherapy nurse. In the 12 months prior to the inspection, incidents had included medication not prescribed on time and chemotherapy drugs omitted from the prescription, thus delaying patient treatments. Incidents reported also included blood spillages, extravasations and medication errors.

Cleanliness, infection control and hygiene

- The wards, mortuary and viewing areas we visited were clean, bright and well maintained. In all clinical areas, the surfaces and floors were covered in easy-to-clean materials allowing hygiene to be maintained throughout the working day.
- Ward and departmental staff wore clean uniforms and observed the trust's 'bare below the elbows' policy. Personal protective equipment (PPE) was available for use by staff in all clinical areas. In the mortuary, we

observed adequate supplies of PPE for use by visiting undertakers and porters. However, the cover for the concealment trolley was in poor repair and was an infection control risk.

- Draft guidance was available for staff to follow to reduce the risk of infection when providing care for people after death in the trust's 'Care of the Body After Death – Last Offices Policy 2015'. The approved policy was due to be introduced across all areas in the hospital soon. The policy included the wearing of gloves, aprons and the use of body bags. A red dot was placed on the death certificate to highlight to all staff that may come into contact with the deceased person that they had had an infection. However, we noted that in the incidents, which had occurred in the mortuary, mortuary staff did not always learn on time that a deceased patient had had an infection.

Environment and equipment

- People reaching the end of their life were nursed on the main wards in the hospital. The bereavement policy suggests that whenever possible, patients were to be cared for in side rooms on wards in order to offer quiet and private surroundings for the patient and their families. We observed this in practice when we visited the wards.
- A syringe driver was used to deliver consistent infusions of medication to support end of life patients with complex symptoms. Patients to be discharged with a syringe driver in place required the SPCT to change it to another type of syringe driver prior to discharge. A senior nurse on Donne Ward told us that they did not discharge patients home at the weekend, because they did not have access to the SPCT to change the syringe drivers.
- Staff told us that acutely-ill patients were sometimes admitted with a particular syringe driver in situ. Nursing staff on the wards had not been trained in the use of these syringe drivers. As a consequence, clinical issues had developed, including blocked pumps resulting in pain medication not being delivered to patients. We were told by the SPCT that staff in the ED were trained to disconnect the syringe driver. However, during the inspection, we spoke to two patients who had been admitted to the wards with the particular syringe driver in place, which later resulted in poor pain management because the syringe driver had become blocked.
- The use of two types of syringe drivers across the trust increased the risk of potentially harmful errors and incidents. We therefore noted that the current trust policy around syringe drivers used with end of life care patients did not afford optimum protection against the risk of adverse incidents.
- Syringe drivers were available across the trust, on request from the equipment library. On Katherine Monk Ward a nurse told us that the syringe drivers were routinely cleaned by ward staff and a date was put on them stating when they were due for annual maintenance. The monitoring requirements for the syringe drivers were on the electronic prescribing system in the patients' electronic records.
- Pressure-relieving equipment, including mattresses, was available for patients requiring them. We saw these mattresses in use on Katherine Monk Ward where an end of life patient was being nursed on an air mattress.
- The mortuary was secured to prevent inadvertent or inappropriate admission to the area. CCTV was evident in four areas in the mortuary. Freezers were lockable to reduce the risk of unauthorised access and the potential for cross infection.
- Equipment was maintained by the estates department. However, we saw that an x-ray trolley was being used as the hospitals concealment trolley as the actual trolley was being repaired. Staff told us the trolley had been away for a week and they were unsure when it would be returned.
- The mortuary was due to be refurbished, but we observed chalk being used to write people's names on the fridge doors. This was a risk with this that names could be wiped off easily.

Medicines

- The SPCT had introduced the 'Management of the Dying Patient – Clinical Guidelines for the Control of Symptoms', which set out the management of patients who had been recognised as dying. The guidelines gave good, easy to follow instructions, including: signs commonly seen in the last few days of life, common symptoms and essential components of care.
- Clear guidelines set out the drug management of symptoms in the dying patient and included reducing medication to a minimum, the route of administration, 'as required' medication and the medication necessary to support the management of the five symptoms experienced by patients at end of life: pain, nausea and

vomiting, breathlessness, agitation and respiratory secretions. Symptom control algorithms had been agreed and implemented to support the management of dying patients.

- Medical teams were asked to contact the SPCT if patient symptoms persisted, or the patient had a complex medical condition, such as Parkinson's Disease, or diabetes. We saw that a second set of guidance had been developed to support patients with end stage renal failure. On Lonsdale Ward the foundation year 2 (FY2) doctor told us that they were happy to prescribe end of life anticipatory drugs, but they would not start a syringe driver unless they had senior guidance.
- The trust undertook an audit of the NICE clinical guideline CG140, 'Opioids in palliative care: safe and effective prescribing of strong opioids for pain in palliative care of adults'. Specific challenges identified included leadership, generalists versus specialist and monitoring outcomes. The King's Opioid Safety Group (KOSG) meeting was developed to provide leadership. The terms of reference clearly set out the purpose of the committee, which included: monitoring adverse incidents and any action plan developed, reviewing the pain and palliative care register, reviewing safety alerts and cascading via the risk management department. The responsibilities of the KOSG also included reviewing serious complaints and approving local guidelines.
- We reviewed the minutes of March 2015 KOSG meeting. We noted that adverse incidents were discussed and a new KOSG action tracker was set up. Safety alerts were in place, which included discussions around high strength opioids that must not remain on the wards and needed to be returned to pharmacy within seven days. Patient information was discussed as to whether there was a need to improve these. The trust had responded proactively by establishing this group to provide leadership in the management of opioids in order to improve patient safety. This was demonstrated by the new 'opioid patch monitoring chart', approved by the group in February 2015. This chart was secured in the patient's paper prescription chart. We noted a poster alerting staff around the prescribing of oral opioids sent out by the group.
- We were told by staff on the wards we visited that medication for end of life care was available on the ward and was easily accessible. We observed that locks were installed on all store rooms, cupboards and fridges containing medicines and intravenous fluids on the wards we visited. Keys for cupboards were held by nursing staff.
- Medicine administration records were completed accurately in the patient records we looked at.
- On Todd Ward and Lonsdale Ward, as well as the liver ITU, we were shown that controlled drugs were handled appropriately and stored securely, demonstrating compliance with relevant legislation. Controlled drugs were regularly checked by staff working on the wards we visited. We checked the contents of the CD cupboard against the controlled drug register on two wards and found they were correct.
- On Mary Ray Ward, we reviewed a patient's electronic patient record (EPR). We saw evidence of good team work with the SPCT for the control of pain and discussions with the patient and the family.

Records

- The EPR allowed staff to identify patients at the end of their lives, which then initiated an assessment of the patients' individual needs and facilitated the development of individualised care plans. However, during the inspection we noted that there was still a mixture of paper and EPR across the critical wards, which introduced a level of risk as information/ instructions could be missed.
- The palliative care consultant told us that all face-to-face and telephone activity outside of core working hours was recorded using a standardised contact sheet across KHP and Lewisham Hospital. This improved patient safety by passing clinical information between teams, along with a permanent record of the conversation, which could be placed in the patient's records to ensure continuity of care between care providers. At the end of an evening or weekend, handover sheets around the care delivered were emailed to the handover consultant.
- The chaplaincy service used a database to enter minimal data about their consultations. This included the patient's name, date of birth, episode of care and any particular requirements. This allowed the chaplaincy to deliver streamlined care if the patient was readmitted to the hospital over a period of time.
- In the chemotherapy day unit, several forms of documentation were completed by the nursing staff.

These included: a nursing update on the EPR, the completion of paper notes that included a safety questionnaire and the e-prescribing chemotherapy system.

- We reviewed the EPRs of ten patients receiving end of life care. These demonstrated the SPCT had supported and provided evidence-based advice, for example, on complex symptom control and support for the patients and families as they traverse the care pathway. This specialist input by the SPCT ensured that a high level of expertise was used to ensure the best possible care was delivered to end of life care patients so that people had a positive experience of healthcare.
- The end of life policy stated that patients at the end of life were assessed by the medical and nursing teams so that individualised care plans could be developed to meet the patient's needs. In the EPR records we reviewed, we observed documentation was poor around the wishes and preferences of the patient.
- Patients receiving end of life care were placed on the 'generic medical pathway'. However, within the renal database, we observed the storage of patients' demographics, symptom control needs, quality of life measurement and patients' preferences.
- The hospital had recently introduced an electronic version of the do not attempt cardio-pulmonary resuscitation (DNA CPR) orders. The resuscitation officer told us that, as part of the admissions process, a box in the EPR was completed with the status of the patient. This would be completed on admission or during the ward round (by a consultant within 24 hours). A treatment escalation plan was being piloted that would specify the ceiling of care. On Oliver Ward, the senior nurse told us that DNA CPR orders were monitored twice daily during multidisciplinary handover rounds. A registrar showed us the electronic process, including the making of an electronic treatment escalation plan. The doctor demonstrated a high level of understanding of the principles, especially best interests and the role of family.
- A daily DNA CPR list was distributed to the resuscitation team, critical care outreach team and the clinical site managers, which identified the patients across the hospital that had a DNA CPR order. The resuscitation officer told us that this had improved the management of deteriorating patients.
- The DNA CPR policy had been developed separately from the resuscitation policy by the SPCT. In March 2015, a snapshot audit was undertaken of 30 patients. Out of the 12 patients who had a DNA CPR in place, only three had explanatory forms completed on EPR. Six had paper DNA CPR orders, with only two completed correctly. Of the 12 orders, six had recorded discussions with the patient and six with the family. The conclusion was that there was current confusion with a mix of paper and electronic records. Furthermore, there were three patients who were not for DNA CPR, however, there were no electronic or paper DNA CPR forms, which represented a clinical risk.
- We looked at a sample of 12 DNA CPR forms across a number of wards and found the same issues as the audit throughout the hospital. We found a mixture of paper and electronic DNA CPR orders. On Mary Ray Ward, we reviewed two EPRs and found old style DNA CPR forms, which were raised on the 4 April 2015. The change from paper orders to electronic began on 1 April 2015, so there seemed to be a lack of clarity as to how DNA CPR orders should be completed. We reviewed a third order written on EPR, but there was no explanation on how the decision was made.

Safeguarding

- We reviewed the training records on Annie Zunz Ward and noted that 24 of 33 staff had completed their safeguarding training.

Mandatory training

- We reviewed the end of life training programme, which was last updated on 6 April 2015. An end of life e-training module was developed in 2012, with mandatory training for nurses introduced in 2013. The trust had set an 80% compliance target, however, across the trust they were achieving 60%. The wards that were achieving above the 80% target included Cheere Ward (94.4%), Fisk Ward (95.65%), Dawson Ward (100%), Annie Zunz Ward (90%) and the liver ITU (92.59%). Wards that were not reaching the 80% target included Donne Ward (66.67%), Lonsdale Ward (58.33%) and Oliver Ward (65.79%).
- We noted that other staff across the trust, where end of life training was not mandatory had also completed the training module. These included a variety of healthcare professionals, including: managers, consultants, helper/assistants, trainee practitioners, occupational therapists, physiotherapists, healthcare scientists,

clinical psychologists and social workers. This highlighted that staff were interested in ensuring that good end of life care was delivered by all healthcare professionals to all relevant patients.

- The mandatory training records of the SPCT were up to date. We saw the team had completed their training in line with trust policy.
- Minutes of the most recent staff meeting showed that areas discussed included mandatory training.

Assessing and responding to patient risk

- Patients that were recognised as deteriorating or dying were commenced on the end of life care plan. We were told by staff that this would be commenced after discussion with the consultant, the multi-professional team, as well as patients and relatives. An end of life care identification order was raised by the ward, which alerted the SPCT and they visited the ward the following day to review the care plan with the nursing staff.
- The trust had a project to develop 'Treatment Escalation Plans' (TEPs). The plans would help to ensure consistent consideration of treatment and care needs and support the timely decisions on the 'ceiling of care' and resuscitation status for patients who were moving towards the end of their life. The aim of the 'ceiling of care' is to provide guidance to admitting staff who do not know the patient, so that there is continuity with the patients' previously expressed wishes, and/or limitations to their treatment are clear.These plans were drawn up with the involvement of the patients and family. The TEPs were launched in February 2015 on Oliver Ward and RD Lawrence Ward and provided medical and nursing teams with clear guidance on the treatment management of patients who were deteriorating in order to prevent inappropriate care/ treatment being delivered.
- The trust used the early warning score (EWS) system for monitoring acutely-ill patients, to alert staff of deterioration in their condition. The tool allowed staff to monitor patient functions, such as their heart rate, blood pressure, temperature and oxygen levels. On Twining Ward, the sister told us that patients were observed every four to six hours, but if there was an increase in the score (five and above) the patient would be reviewed. A senior nurse told us that, as patients approached the end of their life, they were reviewed hourly and a senior nurse reviewed the patient at the beginning and end of the shift.
- The senior nurse on RD Lawrence Ward told us that, on admission, risk assessments were completed for each patient to ensure their needs were identified and the optimum care was delivered. Risk assessments were included on moving and handling, pressure area and nutrition.
- The ward manager on the chemotherapy day unit told us that there was no medical support on the unit, which can be an issue if medical support was required immediately and doctors were unavailable. We were told that, on some occasions, there was only one doctor covering the three haematology specialties and, therefore, the unit had to call the inpatient registrar or consultant.
- Where the progression of a patient's illness was clear, the amount of intervention was reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible at all times. When patients were identified as being at the end of their lives, monitoring was modified to ensure an emphasis on comfort. Staff told us that any changes to the frequency of monitoring were discussed with patients and their families to ensure they understood the plan of care. This was confirmed on Annie Zunz Ward, where we observed nursing reviews taking place ever four hours in the last 48 hours of the patient's life, which included: mouth care, comfort and positioning.
- On Davidson Ward, the ward manager told us that 'huddles' took place at 10.30am each morning to discuss any issues related to patients. A weekly meeting took place with occupational therapists (OTs), physiotherapists and social workers to discuss the patient's management. If patient incidents had occurred, the nursing staff were encouraged to reflect these within the 'huddle'.

Nursing staffing

- There were palliative care 'link' nurses on a number of the wards we visited including Oliver Ward, Davidson Ward and the Jack Steinberg Ward (ICU). However, we were unable to establish the exact number of palliative care link nurses across the wards. The Specialist Nurse in Organ Donation (SNOD) told us organ donation link nurses worked across the wards.

End of life care

- The SPCT consisted of four clinical nurse specialists (3.6 WTE) and one WTE practice development nurse. The nursing team was managed by a 0.2 WTE matron.
- Nursing staff on the wards told us there was enough staff on duty to ensure the needs of patients at the end of their lives were met. Staff said patients who were very close to the end of life would have a dedicated member of staff with them whenever possible. On Davidson Ward, a nurse told us that staffing levels were short some days, which made delivering appropriate levels of care difficult.
- On the chemotherapy day unit, there was a vacancy for a band 6 nurse. The unit had two long-term agency nurses who supported the service.

Medical staffing

- The hospital was well established, with five consultants in palliative medicine (3.4 WTE), two of whom were employed full-time, delivering hospital-based care and outpatient clinics. The consultants work plans were a mixture of clinical and academic sessions.
- The consultants were supported by two specialist registrars and a FY2 junior doctor who was shared with oncology. The registrars supported the delivery of a seven-day, face-to-face service and were part of the King's Health Partnership.
- Specialist palliative care consultants provided Monday to Friday, face-to-face reviews and provided specialist advice out of hours. Two of the palliative care consultants were assistant medical directors and played a senior role in the running of the trust.

Duty of Candour

- The senior nurse on the chemotherapy day unit told us that, when mistakes were made, the patient was informed immediately and details of the incident were put in writing to the patient. We were told that, after the investigation, feedback was given to the patient. However, we were unable to see evidence of this during the inspection.

Major incident awareness and training

- We looked at the mortuary's storage contingency plans. The mortuary had the capacity to store 64 deceased patients. We noted that, when four fridge spaces were left, the contingency plans were put into play, with mortuary staff or clinical site managers organising extra storage spaces at a local undertaker's premises. The policy also stated that, in extenuating circumstances, there could be a need for the trust to hire a refrigerated container. However, we noted that this plan had not been followed in January 2015 when the mortuary had reached capacity. We were told that staff involved informed mortuary staff that they were unaware of the storage contingency plans. This incident was reviewed at the local risk meeting. No deceased patient remains were disturbed, so it was rated as an 'amber' incident.

Are end of life care services effective?

Requires improvement

The do not attempt cardio-pulmonary resuscitation (DNA CPR) policy had been developed separately from the resuscitation policy by the SPCT. A snapshot audit of 30 patients in March 2015 concluded that there was confusion with a mix of paper and electronic records. The audit found that, although three patients had DNA CPR orders, there were no electronic or paper forms for these patients, which represented a clinical risk. There also seemed to be a lack of clarity as to how DNA CPR orders should be completed.

We found no documented evidence that mental capacity assessments and best interest decisions were appropriately undertaken and discussions with the patient and family had take place. However, we were told that if a procedure needed to be done and the patient could not consent, a best interest decision would be made with the involvement of the family where possible.

Limited advanced care planning (ACP) was undertaken across the hospital. The only ACP undertaken was the Proactive Elderly Advance Care Planning (PEACE) planning tool. This was for patients being discharged to a nursing home who did not have mental capacity and was developed in conjunction with the family to establish care in the patient's best interests. The trust was also over dependent on the SPCT for the delivery of good end of life care.

The hospital had access to an electronic palliative care coordination system (EPaCCS), which was called 'Coordinate My Care'. This system alerted healthcare professionals across care providers of the wishes and preferences of the end of life patient. The SPCT had access to this system but the ED team did not.

End of life care

There had been ten mortuary incidents reported in the 15 months prior to our inspection relating to poor portering practices, which suggested that further training was required in the working practices of the mortuary.

The trust had responded to concerns regarding the Liverpool Care Pathway (LCP) and informed staff of the replacement guidance to ensure patients were treated safely and in line with national guidance. The SPCT practice development nurse (PDN) visited the wards daily to support the nurses and doctors with documentation.

Use of national guidelines

- King's College Hospital (Denmark Hill site) had responded to the National Recommendations of the Liverpool Care Pathway (LCP) review, 'More Care, Less Pathway' (2013) by removing the LCP from the trust. From 12 November 2013, the hospital agreed to stop using the LCP to support the care of the dying patient. On Oliver Ward, the ward sister confirmed that the trust was not continuing to use the LCP. This showed that the trust had responded to concerns regarding the LCP and informed staff of the replacement guidance to ensure patients were treated safely and in line with national guidance. A nurse on Davidson Ward told us, "When the LCP was withdrawn there was not a lot of support with what to do, but the SPCT was always helpful."
- To maintain standards and ensure consistent care for patients approaching the end of their life, staff were asked to continue to regularly assess the needs of all patients and clearly identify patients who appeared to be dying. The decision to place patients on end of life treatment was a multi-professional one led by the consultant in charge. On Oliver Ward, the sister and junior doctor told us that placing a patient on the end of life care plan was a multidisciplinary decision made after the patient had received active treatments.
- The SPCT PDN told us that they reviewed patients who were flagged as requiring end of life care. Since the removal of the LCP, an end of life notification order was completed by the wards. We reviewed data submitted and saw that a snapshot audit took place between the 16 and 22 March 2015. Nine notifications were received by the SPCT and this suggested that ward teams were alerting the SPCT when the decision was made that a patient was dying. Depending on whether the patient was regarded as routine, urgent or an emergency, the SPCT PDN or matron visited the wards and reviewed the patient with ward staff around the five priorities of care.
- Through the clinical effectiveness group, the SPCT monitored compliance to the NICE guidelines (QS13 and CG140). Gaps in compliance with standards were placed on an action plan and were monitored through the group.
- After communicating to the patient and family that their relative was dying, an individualised end of life care plan was developed that included regular assessments and the management of symptoms. On Mary Ray Ward, we saw evidence of good individualised care, including: symptom control, anticipatory medication, a review of interventions and discussions with the family. A King's College Hospital web page (KWIKI) was set up to guide staff, covering the key areas of an individualised end of life care plan, ongoing care and care after death.
- The SPCT PDN told us that they visited the wards daily to support the nurses and doctors with documentation. We were told there were no standard care plans for end of life care, however, this was work in progress. One staff member told us, "We need to be careful we don't develop another LCP." Nursing notes we reviewed confirmed that there was no standardised personalised end of life care plans. Nevertheless, we saw that care was delivered and recorded.
- A 'Care of the dying: questions and prompts for all professionals' leaflet and an 'end of life care identification' order were introduced to the workforce in August 2013 in preparation for the removal of the LCP. These listed a number of core principles, which were felt to be crucial to good care in the last few days of life incorporating a number of the NICE quality standard 13 ('End of life care for adults') statements. The flowchart was a checklist, which aimed to support healthcare workers as an aid to the memory.
- The end of life care policy was published on the 1 January 2015 after being approved by the End of Life Strategy Group and ratified by the King's College Hospital executive/board of directors. The policy, which sets out the trust's response to the withdrawal of the LCP and the systems in place to support identification and care for people that are dying and their families. This policy compliments 'The management of the dying patient: clinical guidelines for control of symptoms' (September 2014), the Bereavement Policy (2007) and the Do Not Attempt Cardio-Pulmonary Resuscitation Policy (2014).

End of life care

- The advanced renal care programme had good processes in place to identify and support the palliative care needs of patients with end stage renal disease who were not suitable for renal replacement therapy.
- The hospital took part in the National Care of the Dying Audit of Hospitals (NCDAH) round four, in 2014. The information gathered offered insight into the clinical practices at that time and areas that would benefit from improvement strategies as well as aspects of care the clinical teams were delivering well. The audit highlighted three areas where the organisational key performance indicators (KPIs) were not achieved.
- In order to address the organisational KPIs not achieved and to improve compliance in two clinical KPIs, a NCDAH detailed action plan was developed (dated 23 September 2014) around the key findings. We saw evidence during the inspection that the action plan was in the process of being actioned. We observed that a trust board executive for end of life care had been appointed and this was the chief nurse.
- The SPCT completed a scorecard each month that covered the key performance indicators set by the trust. We reviewed the data submitted in December 2014 and February 2015. The data confirmed that, in December 2014, 216 referrals were received and of these, 179 patients were reviewed by the SPCT. Sixty-eight patients had a cancer diagnosis (38%) and 109 patients did not (60.9%). In February 2015, 204 referrals were made and of these, 174 referrals were reviewed. Of the referrals, 64 patients had a cancer diagnosis (36.7%) and 114 patients had a non-cancer diagnosis (65.5%). Across the year, a palliative care consultant told us that 65% of their patients had a non-cancer diagnosis and 34% had a cancer diagnosis. This demonstrated that the SPCT actively supported a high number of non-cancer patients. This was above the national average of 28% of patients with non-cancer diagnosis who were supported by an SPCT.
- Although there was no electronic system that flagged up if a palliative care or end of life patient had been admitted, the introduction of an end of life care identification order raised by the ward staff, highlighted to the SPCT, patients who might require specialist SPCT input. When an order was received, the SPCT reviewed the patient with the ward staff the following day. On Lonsdale Ward, two FY2 doctors confirmed that they sent an electronic identification order when it was expected that the patient could die after they had been identified by a senior doctor.
- A palliative care consultant told us that the only advanced care planning undertaken was the PEACE document.

Pain relief

- Effective pain control was an integral part of the delivery of effective end of life care. On RD Lawrence Ward, a senior nurse told us that pain would be reviewed as part of the "essential care review". This highlighted how often a patient's pain needs would need to be reviewed.
- On Annie Zunz Ward, we reviewed an EPR and found that anticipatory medicines were prescribed and appropriately used. In the Quality Sampling Audit (October 2014 to December 2014), it was found that 11 out of 15 patients had their anticipatory medication appropriately prescribed.
- The SPCT were involved in advising and reviewing the medication of patients approaching the end of life. On Donne Ward, a nurse told us that the SPCT were "excellent" and came quickly to support complex symptom management including advice on the medication required to manage pain effectively as well as advising the medical and nursing teams around the medication that the patient no longer required. We were told by staff on the wards we visited that all patients who needed a continuous subcutaneous infusion of opioid analgesia or sedation, received one promptly.
- On RD Lawrence Ward a senior nurse told us that, for patients suffering from dementia and learning disabilities, their pain would be assessed by clinical observations, including: facial, vocal, behavioural and physical signs.

Nutrition and hydration

- In the 'Management of the Dying Patient' guidance and in the end of life care policy, multi-professional teams were encouraged to pay specific attention to the patient's nutritional and fluid requirements. The guidance said that, "Oral fluid and nutrition must always be offered provided this was not causing any harm or distress to the patient." In the daily care plan review, staff were encouraged to maintain basic, excellent care,

which included encouragement and support and ensured the patient's and family's views and preferences around nutrition and hydration at the end of life were explored and addressed.

- On Lonsdale Ward, a FY2 doctor told us they prescribed intravenous fluids to support the hydration of patients as they approached the end of their lives. On Annie Zunz Ward, we reviewed a patient's EPR and noted repeated assessments of their hydration and nutritional needs.
- On RD Lawrence Ward, the senior nurse told us that, on admission, the patient underwent risk assessments, which included a malnutrition universal screening tool (MUST) assessment. This tool identifies patients who are at risk of poor nutrition, dehydration and who have swallowing difficulties. Patients identified as high risk were referred to the dietician, who developed a food plan. The ward staff developed a food record chart that was completed daily.
- On Twining Ward and RD Lawrence Ward, we observed that the coloured (red) tray scheme was being used to indicate patients who needed additional help at meal times. Meal times were protected, which meant staff ensured people could eat uninterrupted except for urgent clinical care. We were told that staff encouraged relatives to support family members who were receiving end of life care. On reviewing the quality sampling conducted in the trust between October 2014 and December 2015, the 15 cases audited found that seven out of 15 had a review of their nutritional needs assessed, of which, only two were conducted by a senior clinician. Only five cases had their hydration needs assessed, of which, only three were conducted by a senior clinician. This suggested that further work was required to become compliant to trust policy.
- To improve patient's quality of life, a mouth care policy was in place across the trust. This was available on the KWIKI page. The senior nurse on Katherine Monk Ward told us mouth care was regularly performed on patients who were entering the final stages of their life. We observed this taking place and it included using soft children's tooth brushes to clean their teeth, Vaseline or lip salve to soften the lips and gauze swabs with water to hydrate the mouth. In the quality sampling audit (October to December 2014), it was found that mouth care was being undertaken in eight out of 15 patients and four did not require it. This suggested that three patients were not receiving mouth care.

Patient outcomes

- The SPCT had introduced 'quality sampling' to monitor the quality of care delivered to end of life patients against the five priorities of care. This sampling supported the development of a training and education programme. The sampling took place at the beginning of each month and the first five deaths, each month, were audited.
- The 'quality sampling' included assessing if a senior doctor responsible for the patient care identified that the patient was dying, the diagnosis that the patient was at the end of their life was communicated and the risks and benefits of nutrition/hydration. The audit was undertaken by two palliative care doctors. Fifteen deaths were audited between October and December 2014. Areas where it was felt compliance needed to be improved across the five priorities included documentation that the patient was dying (seven out of 15 had no senior documentation), communicated to the patient that they were at end of life (only two out of 15 cases discussed this) and there was no information in any of the 15 cases given to patients or their families around organ donation. Recommendations from the audit were: ongoing education via the road shows, ward end of life champions, updating the ward teams about the results of the audit and more education of junior doctors. These would ensure all patients were receiving consistent, safe care no matter where they were receiving their care across the wards.

Competent staff

- The palliative care PDN facilitated trust-wide programmes, such as preceptorship study days, all nursing and midwifery induction, clinical support workers training, transforming end of life care study days and the ward road show schedules. We reviewed the palliative and end of life care educational plan, which showed that training days at the Denmark Hill site and Princess Royal University Hospital had been scheduled in for 2015/16.
- Transforming end of life care courses were planned as part of the KHP. We observed that the next study days were at King's College Hospital (Denmark Hill site) on 11 and 12 May 2015. Ward road shows had been planned, with training being delivered on Katherine Monk Ward on 25 May 2015 and Lonsdale Ward on 1 June 2015.
- The SPCT were actively involved in the training and teaching of medical and nursing staff. In February 2015,

we noted that 13 hours were allocated to the training of doctors, 35 hours for teaching doctors and 13 hours for teaching nurses. A total of 61 hours of the team's time in February 2015 was allocated to training and teaching.

- We were shown the medical training records that demonstrated that junior doctors had regular training with the palliative care consultants, with FY2 doctors receiving opioid prescribing training.
- One of the palliative care consultants supported undergraduate training, including loss and grief. This demonstrated the commitment of the team to improve the quality of care delivered on the wards.
- We reviewed the SPCT operational policy 2014/15 and this demonstrated that all team members had undertaken national advanced communication skills training, which gave the team the necessary skills to communicate appropriately in difficult situations they may come across.
- The SPCT had two social workers who worked within the palliative care multidisciplinary team. The social workers supported the psychosocial needs of patients/families and provided integrated bereavement follow ups. A psychosocial worker was based in critical care to support the complex needs of patients and their families receiving intensive care.
- On the chemotherapy day unit, the senior nurse told us that all staff were trained in the N59 Care of the Patient having Cytotoxic Chemotherapy course. However, the unit had no training posts and, therefore, succession planning did not take place.
- Palliative care link nurses were on some of the wards we visited. The palliative care matron told us that that there was no structured education programme for link nurses, however, the team recognised there was a need for consistency. Feedback to the link nurses was through the End of Life Care Quality and Implementation Group, where, through training and education, they were able to cascade the latest information down to all staff groups within the ward to support the delivery of good end of life care. However, attendance at the End of Life Care Quality and Implementation Group had been poor, with no one attending the group in March 2015. The palliative consultant told us that a new way to provide feedback was being discussed.
- The portering manager told us that they had received training to support the movement of deceased patients to the mortuary. The training included access to the mortuary, use of the hoist, fridge spaces paperwork and use of PPE. However, when we reviewed the mortuary incidents, there had been ten incidents reported in the last 15 months related to poor portering practices, which suggested that further training was required in the working practices of the mortuary.
- The chaplain was a 'SAGE & THYME' trainer ('SAGE & THYME' is a mnemonic which guides healthcare professional/care workers into and out of a conversation with someone who is distressed or concerned).
- The chaplain told us that this involved training nurses and midwifes to give them the necessary skills to manage difficult situations. Other training provided by the chaplain included talks on 'Spirituality and religion', which we were told had been recently given to a group of healthcare assistants (HCA).
- The CNSs in the SPCT were line managed by the palliative care matron. One CNS who told us that appraisals were undertaken and were up to date. This ensured that staff were adequately supported to develop their skills to support the delivery of high quality care.
- All palliative care CNSs had completed the training necessary to enable them to practice at level 2 psychological support for patients and carers.
- Minutes of the most recent staff meeting showed that areas discussed included staff appraisals.

Multidisciplinary team working

- The SPCT undertook morning meetings, where there was handover and update on any issues that had developed overnight with any of the patients. The team also discussed all referrals and hospice notifications received the day before. A clinician triaged the requests received and decided on the urgency of the request. All requests were allocated a key worker. We observed the handover during the inspection.
- Weekly multidisciplinary team meetings included: an inpatient multidisciplinary team review (on Tuesday evenings), a death/bereavement weekly review (on Thursday mornings) and a discharge weekly review (on Friday mornings). During the inpatient multidisciplinary team meeting, we observed discussions taking place around all new referrals, complex patients and those who had been on the caseload for three weeks. We observed that all discussions were minuted in the teams specialty database and that Patient Content Stores (PCS) and attendance sheets were completed.

End of life care

- We were told that the SPCT attended the thoracic, hepatopancreatic, biliary oncology, colorectal, neuro-oncology and the haemato-oncology multidisciplinary teams. The SPCT supported joint clinics with their medical colleagues, including: weekly palliative care/lung cancer clinics, monthly neurology/ respiratory palliative care clinics and complex neurology clinics every three months.
- The team leader in the Jack Steinberg Ward (ICU) told us that multidisciplinary meetings took place with family members. The meeting included: consultants, nursing staff caring for the patients, psychosocial workers and the SNOD. Discussions around the management of the patients took place with any concerns raised and whether the needs of the family were meet. For relatives who wished to discuss organ donation, the SNOD discussed the options. Relatives of patients who were brain stem dead were given a leaflet called 'Understanding brain stem death: A guide for relatives,' which allowed families to review the information given and make the most appropriate decision.
- The SNOD told us that, after families had had a conversation around organ donation, they were given time to make a decision. If the family could make an immediate decision, the process was slowed down. If a decision could not be made, no further pressure was placed on the family and the process was stopped.
- A SPCT CNS told us that close working relationships were in place with other clinical nurse specialists across the hospital, including cancer and non-cancer specialists. The SPCT CNS was able to describe the joint work undertaken to support the complex symptom management at the end of a patient's life.

Seven- day services

- The SPC core team provided a Monday-Friday, 9am to 5pm service. At weekends and bank holidays, specialist registrars (StRs) provided a first on-call visiting and telephone advice service to the KHP acute hospitals (King's College Hospital and Guy's and St Thomas' Hospital), supported by the consultant on-call.
- Out of hours (after 5pm and before 9am), a consultant provided telephone cover for health professionals across the local cancer centre. Monday to Friday, the consultant was first on-call for telephone advice. The consultant rota comprised all specialist palliative medicine consultants working across Guy's Hospital, King's College Hospital, St Thomas' Hospital and University Hospital Lewisham. On Mary Ray Ward, we reviewed an end of life EPR and observed good, valued input from the SPCT. We saw evidence of face-to-face, out-of-hours support and telephone support from the SPCT.
- The NHS Blood and Transplant organ donation service, led by the SNODs, were available across the hospital, Monday to Friday, 9am to 5pm. Outside these times an on-call service was provided.
- The chaplaincy service was available Monday to Friday, 9am to 5pm. Outside these hours, the chaplaincy provided an on-call service.

Access to information

- The hospital used 'Coordinate my Care', (London electronic palliative care coordination system (EPaCCS), which would alert healthcare professionals across care providers of the wishes and preferences of the end of life patient. However, the ED team had no access to this. We were told by the SPCT this was being reviewed at present.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- The trust had a Mental Capacity Act 2005 policy, which included guidelines about patients with advance decisions to refuse treatment. A nurse on Todd Ward told us they were aware of the existence of the Mental Capacity Act 2005 and when it would be used. However, they were less clear of the Mental Capacity Act 2005 process. The nurse felt they were a 'patient advocate' and would speak to the matron or the ward manager if something was being done to the patient without their consent.
- The senior nurse on Todd Ward told us that many patients on the wards were confused. We were told that Mental Capacity Act 2005 assessments were undertaken by the doctors. However, we saw no evidence of this during the inspection. If a procedure needed to be done and the patient could not consent, a best interest decision would be made with the involvement of the family where possible.
- Mental capacity assessments and best interest decisions were not always appropriately undertaken or documented and discussions with the patient and family did not always take place.
- On Annie Zunz Ward we reviewed the training records. We noted that five out of 10 staff had completed Mental Capacity Act 2005 training.

End of life care

Are end of life care services caring?

Good

Staff at King's College Hospital (the Denmark Hill site) provided compassionate end of life care to patients. The palliative care PDN performed patient reviews in a sensitive, caring and professional manner, engaging well with the patient. The patient's complex symptom control needs were being met and the supportive needs of both the patient and relative were being addressed. The trust's homeless team got involved if patients were homeless.

The SNOD told us that families whose relative donated organs would receive a phone call after the retrieval to let the families know the process has been completed. Families would be invited to receive the St John Ambulance's award.

In the ED, the breaking of bad news was led by a consultant and a senior nurse.

On the Jack Steinberg Ward (ICU), the team leader told us that the psychosocial workers play a crucial role in supporting families whose relatives were extremely unwell. The psychosocial worker attended the meetings with families where bad news was broken.

The SPCT conducted a patient satisfaction survey for patients who had been treated by the SPCT during their admission to hospital as well as a bereaved carer survey. Staff demonstrated a positive and proactive attitude towards caring for dying people.

Compassionate Care

- During the inspection, we were able to observe several end of life care patients being reviewed by the palliative care PDN. The PDN performed the reviews in a sensitive, caring and professional manner, engaging well with the patient. During a holistic assessment on Howard Ward, the PDN went through the patient's pain management, medication prescribed, if the patient felt sick and if the patient had any emotional needs.
- We observed that staff demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service. On Davidson Ward a nurse told us that the ward was 'open and honest' and was committed to providing good patient care.
- A family member told us that the SPCT "pull[ed] things together". We observed the SPCT CNS responding to the patient in a holistic manner. We observed that the patient's complex symptom control needs were being met and the supportive needs of both the patient and relative were being addressed with the involvement of the trust's homeless team, when necessary. The family member told us that they were able to stay overnight on the ward to support their relative.
- We observed, from the palliative care dashboard, that in December 2014, the team had 615 hours of contact with patients, relatives and hospital staff. Of this, 267.3 hours were spent with patients and 107.6 hours with families. This increased in February 2015 to 656 hours of contact, with 311.7 hours of contact with patients and 119.8 hours with families. This demonstrated the patient and family focus of the SPCT.
- The SNOD told us that, after families had had a conversation around organ donation, families were given time to make a decision. If a family could not make an immediate decision, the process was slowed down. If a final decision could not be made by the family, no further pressure was placed on them and the process was stopped.
- One patient and their relative on Lonsdale Ward told us that they were very happy with the care they received and that prompt pain relief was offered. The nurses listened to them and call bells were always answered promptly. However, they were unhappy that they had been moved three times since being admitted to the hospital.
- Several patients also told us that, after leaving the ED, they were moved around the wards. Two patients told us they were on their third ward since being admitted. Relatives told us that handovers and information sharing from the ED to the wards and between the wards were poor.
- The SNOD told us that families whose relatives donated organs would receive a phone call after the retrieval to let the families know the process has been completed. Families were then contacted two to three weeks later and given an update on how the recipients were doing. This was repeated a year after the retrieval to give the families an update on the recipient. Families were

invited to receive the St Johns Ambulance award. This was offered by invitation to all families whose loved one donated an organ in the UK and was given posthumously to the donor, accepted on their behalf by a relative at a regional ceremony.

- The chaplain told us that they visited the wards to support patients and relatives when requested. This could include bedside rituals, bible readings or providing a listening ear. We spoke to a chaplaincy volunteer who told us that they visited the elderly care wards on Tuesday afternoons to spend time listening to patients and greeting them.
- In the ED, the assistant head of nursing told us that the breaking of bad news was led by a consultant and a senior nurse. Consultants were available between 8am and 2am daily. Nursing staff had not received training in breaking bad news, but could be involved in the consultations as part of the development. This was confirmed by a junior doctor who told us that they never broke bad news themselves, but that they were often present when senior doctors did.
- In the chemotherapy day unit, the senior nurse told us that, when patients received chemotherapy that required the removal of any of their clothing, the curtains could be drawn to maintain the patient's dignity and respect.
- The SPCT conducted a patient satisfaction survey for patients who had been treated by the SPCT during their admission to hospital. This was part of the KHP. The survey takes place annually and was sent to patients who met the selection criteria to ensure no distress was caused to those completing the survey. We reviewed the 2014 survey, which had a response rate of 21%. Feedback from the survey was that the quality of care provided was very high, especially in relation to information and support while in hospital, with only two respondents stating that the team were unhelpful.
- A bereavement carer's survey was also undertaken. We reviewed the findings from the 2014 survey and saw that the comments were positive, apart from raising concerns around a delay in death certificates, the lack of facilities when families needed privacy and the fact that the bereavement office did not have seven-day opening. We saw that the SPCT were addressing the issues raised and had placed these on the team's action plan.
- The mortuary APT told us that patients that arrived at the mortuary were prepared by the nursing staff in the majority of cases as stated in the 'Care of the Body After Death – Last Offices Policy 2015'. We were told that an audit was being undertaken at the time of the inspection to monitor compliance. We were able to review the audits from the three months prior to the inspection and saw that, in the majority of cases, deceased patients were being cared for in a respectful way. We were told that the audit would remain in place until the new 'last offices' policy, which was in the draft stage at the time of the inspection, was ratified. Mortuary staff were feeding the audit findings back to the SPCT matron.

Understanding and involvement of patients and those close to them

- We observed the palliative care consultant undertake a holistic patient assessment and plan of care on Katherine Monk Ward. The patient had no family present. The consultant discussed the plan of care with the patient followed by a discussion with the staff nurse and junior doctor who prescribed the medication on the EPR immediately.
- On the Jack Steinberg Ward (ICU) the team leader told us that families were always informed of decisions and were included in decision making, as appropriate. This involvement started when the patient was admitted. In the liver ITU, we reviewed the EPR of a patient receiving end of life care. We found good documentation with lots of entries regarding decisions with relatives from both the medical and nursing teams.
- We reviewed 10 EPRs, and noted that patients referred to the SPCT were kept actively involved in their own care and relatives were kept involved in the management of the patient with the patient's consent. On Twining Ward, we were told that, when a patient's condition deteriorated, a discussion took place with the family. If the patient wished to go home, a team discussion then took place and all efforts were made to get the patient home to their preferred place of death.
- The ward manager on Twining Ward told us that they liked to include families as much as possible in caring for their relative, but only as much as they wanted to be involved. Areas where relatives supported their relatives included mouth care and making sure the patients were supported to lie comfortably. Relatives were also sometimes asked by staff to support their relatives at meal times.

End of life care

- The trust's bereavement policy states that families should be given the opportunity to help in the care after death. On the wards we visited, ward managers told us that, while some families wished to be involved in care after death, not many families did.
- The SNOD told us that three to four months after a donation has taken place, the family were sent a questionnaire regarding their experience. We were told that feedback was good. However, we were unable to review the questionnaire during the inspection.

Emotional support

- All the palliative care CNSs had completed the training necessary to enable them to provide level 2 psychological support to patients and carers. One CNS told us that they all received monthly one-to-one clinical supervision from a trained level 4 supervisor.
- The SPCT had two social workers that were level 3 practitioners who were able to support the psychosocial needs of patients/families and carers, providing an integrated bereavement follow up and assessing and coordinating the ongoing needs of patients/families and carers to ensure their needs were met. On the Jack Steinberg Ward (ICU) the team leader told us that the psychosocial workers played a crucial role in supporting families whose relatives were extremely unwell. The psychosocial worker attended the meetings with families, where bad news was broken and attended the multidisciplinary team meetings to ensure that they were equipped to provide the necessary support required to facilitate the needs of the patients and families before and after death.
- The team leader on ICU told us that, if a young parent was critically ill, the team would contact the paediatric psychosocial worker to support their children through the distressing situation. We were told that a book was available, which tells the story of a dying parent in a child-friendly way.
- If a young parent died suddenly in the ED, a paediatric nurse was called to support their children. The 'red thread' (for children and young people from ages 13 to 19) team would be called in to support the children and organise counselling if necessary.
- Support to families whose relatives became organ donors was available through the SNOD. As information came to light that a patient could die, or active treatment could be stopped in the next few days, the SNOD would become actively involved in their care and support the family by being a point of contact for questions and concerns which could arise through the process.
- Bereavement Centre staff undertook interviews with families after the deaths of their relatives. Staff told us that, after meeting the families, they were the point of contact if they need to speak to anyone in the next year following the death. Staff told us that if they had any concerns about the welfare of relatives they would contact the family's GP, where support could be accessed.
- On the chemotherapy day unit, the ward manager told us that systems were in place to support patients during their palliative chemotherapy. If patients required support, mechanisms in place, including a referral being made to the cancer and haematology councillor, or a visit organised to a Macmillan information centre. The cancer and haematology nurse specialists were also available to offer emotional support.
- The chaplain was available to provide spiritual and religious support when asked by the patient/families and medical and nursing staff. On the ICU, a nurse told us that they would call the chaplaincy, when requested, to support families.

Are end of life care services responsive?

Requires improvement

Patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available. Open visiting hours for families whose relatives were receiving end of life care was available on the wards we visited. Information leaflets for families whose relatives were receiving end of life care were available.

The Bereavement Centre contained a quiet room, which meant that interviews of the bereaved relatives took place with the upmost privacy. The hospital had a multi-denominational Christian chapel, which was opened 7am to 10pm daily. A multi-faith room called The Sanctuary was available for people of all faiths, or none. A Hindu shrine was being developed with support from one of the hospital consultants. A Muslim prayer room was available, with two carpeted prayer rooms and washing facilities.

End of life care

Memorial services called 'A time to remember' took place in the chapel. Relatives from all faiths or no faith were invited. The SPCT aimed to see the majority of patients on the same day as the referral. For urgent referrals, a target of 100% was set and this was continuously achieved.

Complaints were reviewed by the End of Life Strategy Group. Following complaints being investigated, actions were in place to mitigate the same incidents happening again, including more staff training and the attendance of the ward manager at the End of Life Strategy Group.

Service planning and delivery to meet the needs of local people

- As part of the end of life care policy, patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available. However, patients that had infections took priority over an end of life patient.
- If a patient was nursed in a bay on the ward, privacy was maintained by keeping the curtains drawn, if requested, by the patient or family. The team leader on the Jack Steinberg ICU told us that there were only two side rooms available to support end of life patients and it was, therefore, not always possible to nurse end of life patients in a side room. Patients that may be in the last days of life would be found a room on a ward where the environment will be more appropriate as the noise in ICU could be an issue.
- On Katherine Monk Ward, we observed a patient receiving end of life care. The patient was being nursed in a single room. Curtains were around the inside of the door to protect the patient's dignity and privacy. On Mary Ray Ward, we were told by the matron that patients receiving end of life care were nursed in a single room. However, no 'Z' beds or reclining chairs were available on the ward. Some staff we spoke to told us that 'Z' beds were available from paediatric wards, however, other staff were not aware of this. A palliative care consultant told us that 'Z' beds were available from the Macmillian information centre. However, no ward-based staff told us about this.
- We found little evidence of family rooms on the wards. However, staff would use the day room or nursing/ doctor's room to provide a quiet place for relatives. The SPCT had recognised the shortage of quiet places for families and had conducted a facilities audit. A list of available spaces had been placed in the 'end of life folders' we saw on the wards, so staff could signpost relatives to the nearest quiet room. In the minutes of the End of Life strategy Group, there was reference to a facilities leaflet, which was in the process of being developed. Although the trust had recognised the lack of quiet areas for families, we saw no evidence of how the trust planned to take this forward.
- On all the wards we visited, staff spoke of the need for opening visiting hours for families whose relatives were receiving end of life care. On Mary Ray Ward, Twining Ward and the liver ITU, staff confirmed that open visiting hours were available on the wards. The ward manager on Mary Ray Ward told us that tea and toast was available to relatives.
- The SPCT told us that only a one car parking permit was available for families whose relatives were receiving end of life care. We saw that, in the End of Life Strategy Group meeting in March 2015, this was being reviewed.
- In the ED, we were shown Room 10, which could be used to care for seriously-ill patients and those who were dying, so that they could be cared for in privacy. Double doors allowed the patient to be taken to the last offices room after their death. We were also shown the relatives room, which was next to the last offices room. The senior nurse told us that, if a death had occurred, other relatives were asked to wait in the waiting room while the grieving family used the relative's room. The family could then be moved into the last offices room to spend time with the deceased patient.
- On Fisk Ward, relatives wishing to stay overnight with their relatives had the option of staying and having a 'Z' bed or reclining chair to spend the night on. However, we were told that the environment was not good, as cubicles were small and the air conditioning was not working.
- The SPCT CNS reviewed patients depending on their needs, offering them support and reviewing their care needs. Patient contacts ranged from 15 to 60 minutes depending on the need of the patient and their families, with many end of life patients requiring more than one contact in a day. Palliative care medicine consultants reviewed complex cases and spoke to medical teams and carers.

Meeting people's individual needs

- On the Jack Steinberg ICU, the team leader told us that visiting hours on the unit were between 1.30pm and 7.30 pm daily. However, the team leader told us that, in

exceptional circumstances, such as patients receiving end of life care and those in the last 24 hours of life, relatives were able to stay with their loved ones day and night.

- Information leaflets for families whose relatives were receiving end of life care were available and they were given out by SPCT CNSs when ward reviews took place. The information leaflet 'Coping with dying' covered areas such as the patients reduced need for food and drink, withdrawing from the world and changes in breathing. The CNS told us that the leaflet had just been introduced and that, at present, the SPCT gave out the leaflet with a brief overview of the information and made themselves available for any questions relatives may wish to ask. A second leaflet given out was called 'The Palliative Care Team – information for patients and relatives', which described what palliative care is, the members of the team and their contact numbers.
- The advanced renal team provided clinics locally and, if the patient became too frail, home visits could be arranged. Links with the hospice and primary care through the 'Coordinate My Care' system ensured that patients and their families were supported and their wishes and preferences were met.
- We noted that the trust had a lone working policy and staff had identification badges with pull pins, which alerted the police in an emergency.
- For patients and relatives of patients affected by cancer, the Macmillan information centre, which was opened Monday to Friday, 10am to 4pm (except Bank Holidays), offered emotional, financial and practical support and information. The centre was able to direct patients/ carers to local and national support services and signpost them to self help and support groups. The centre provided support in a quiet and calm environment, with a full range of patient support information both online and in paper format. Staff told us that feedback was good around the service they provided, however, we were unable to see evidence of this during the inspection.
- The SNOD told us that families whose relatives were classed as brain stem dead and had consented to donate their relative's organs, said goodbye in the ITU prior to their relative going to theatre. Care after death took place in theatre. For patients that were non-heart beating donors, their families escorted them to the theatre anaesthetic room, where the life support machine was turned off. The family stayed with their relative as their life came to an end. The team leader told us that cultural needs were guided by the family and any faith leaders.
- In the ED, after a death has occurred, relatives were given a bereavement leaflet and the number of the nurse in charge as they left the hospital. The department's clerk contacted the bereavement office, who in turn contacted the relatives the following day.
- The Bereavement Centre carried out the administration of a deceased patient's documents including the Medical Certificate of Cause of Death (MCCD) and their belongings, as well as providing practical advice and signposting relatives to registering the death and planning a funeral. The centre contained a quiet room, which meant that interviews of the bereaved relatives took place with the upmost privacy.
- The SPCT had a bereavement multidisciplinary team, where patients who died were discussed and any concerns around their families were highlighted and actions put in place to support the families. Contact with the family was made two to three weeks after the death of their relative, followed by a bereavement letter eight weeks later offering follow-up bereavement support, including the need to discuss feelings or the need to have questions answered. Families were offered immediate support and future support as well.
- The Bereavement Centre staff told us that systems were in place for the quick release of deceased patients, if required, for religious reasons. Out of hours, the site practitioner was able to release the MCCD. We were told that the MCCD was available for relatives ideally within the next 24 hours, or the next working day, if the death happened over the weekend, except for those patients who were referred to the coroner. However, we were told this did not always happen and there had been delays in releasing the MCCD. We reviewed the actions from the End of Life Strategy Group meeting (March 2015) and saw that actions had been put in place to prevent delays in this process. No audit information was available to see how long, on average, the MCCD took to be released.
- The team leader in the Jack Steinberg ICU told us that relatives could stay on the unit after a patient died to help with the after care of the deceased patient. However, we were told that this rarely happened. Relatives were offered a lock of hair as a 'keepsake' if the

requested it. On leaving the unit, a bereavement leaflet was given to the relatives and the necessary phone numbers to call if a family member wished to talk to a member of the multidisciplinary team.

- We visited the mortuary and observed the viewing suite where families came to spend time with their relatives after their death. Appointments could be organised through the bereavement office or mortuary and was available Monday to Friday throughout the day. The viewing suites were decorated in neutral colours, with no religious symbols in place, however, staff were able to show us symbols of different cultures and religions that they had. We were told that the viewing area was due to be refurbished.
- The anatomical pathology technologist (APT) told us that effective systems were in place to log patients into the mortuary. We were walked through the process and were shown the ledger type book that contained the required information. We observed that the book was completed appropriately and neatly and was completed in a respectful way. Confidentiality was maintained at all times.
- Mortuary staff told us that they were unable to provide an area for religious washings.
- Staff in the bereavement office told us that, if an appointment was required to view a relative in the viewing suite, they could arrange this. A convenient time for the viewing was organised with the family. When the family arrived in the hospital bereavement office, staff escorted the family to the viewing suite and ensured the environment and the deceased patient was ready for viewing.
- Patients who died where it was unknown whether they had family or friends, required bereavement staff to search for any relatives with the help of the local council. In such circumstances, the hospital arranged the funeral, with support from the chaplaincy.
- Next to the chapel a multi-faith room called The Sanctuary was available for people of all faiths or none. The room was open until 10pm each night, but access could be given at other times, if requested. The chaplain told us that a Hindu shrine was being developed with support from one of the hospital consultants. Two weeks ago prior to the inspection, a Buddhist chanting took place in The Sanctuary.
- The hospital had a multi-denominational Christian chapel, which was opened 7am to 10pm daily, but can be opened at other times, by request. The chapel could accommodate patients in beds for services. The chaplain told us that all inpatients attending the chapel must have an escort with them.
- Memorial books were available in the chapel. There were separate books for adults, children, haematology patients, staff and volunteers.
- The trust did not have a separate religious or spiritual policy, but the remit fell within other policies, for example, the bereavement policy. Chaplaincy staff told us they followed national guidelines for chaplaincy.
- A Muslim prayer room was available, with two carpeted prayer rooms with washing facilities. Friday prayers were led by two medical consultants. The chaplain told us that plans were being drawn up to upgrade the prayer room. Prayer mats and a Quran were also available.
- Sacred texts were available through the chaplaincy, if required, on the wards. These included sacred texts for the Jewish, Buddhist, Hindu, Muslim, Sikh and Christian faiths.
- Memorial services called 'A time to remember' took place in the chapel. Relatives from all faiths or no faith were invited. The service for children took place on the first Saturday in December and the adult service took place on the first Saturday in November.
- The chaplaincy was served by 7.3 WTE (11 people) chaplains representing the Christian faiths. An imam visited the hospital one afternoon a week and two Muslim volunteers were available. A Jewish visitor visited the hospital on a Thursday. The chaplain told us that a Buddhist volunteer was interested in supporting the hospital.
- Chaplains were available 24 hours a day and easily contactable through the hospital switchboard for out-of-hours visits. Staff could contact the chaplains by telephone or in person to refer patients or ask them to visit.
- The chaplaincy had 23 regular volunteers who visited the wards. Volunteers identified and offered initial pastoral support to end of life care patients. However, if more complex needs were expressed they would refer the patient to the chaplaincy.
- A range of services took place in the chapel daily, including lunchtime prayers for the Christian community (Tuesday) and Roman Catholic mass (Friday). Written information about chaplaincy services was available in leaflet form for patients and relatives to access and on the KWIKI page for staff to access.

End of life care

- The chaplain told us they were involved in the development of the end of life care, the bereavement and the 'Care of the Body After Death – Last Offices Policy 2015'. The chaplain attended the Tuesday palliative care multidisciplinary team meeting where all patients on the end of life care pathway were discussed. If any areas of concern were highlighted, the chaplain visited the patient.
- Chaplains were involved in delivering regular training to staff at induction training where they signposted staff to all the materials available and explained to staff about the individualised spiritual care assessment. We saw that spiritual guidelines were evident in the bereavement policy to inform staff of the importance of these to an individual.
- The chaplaincy provided services tailored to patients' individual needs. For example, they had conducted blessings and contract funerals of deceased patients who had no relatives.
- Access to information had been addressed with the introduction of the 'Coping with dying' leaflet. However, the facilities leaflet was still in development. Spiritual care guidance was in place with one other policy in development.
- In the bereavement policy, guidance was available for ward staff to provide care in accordance with people's religious and cultural preferences. The guidance gave information on care of the dying, post mortems, organ donation and funerals for patients of different faiths. In the chapel, we were shown a calendar, which had all the religious festivals and important days highlighted. All staff told us they had access to specialist advice from the chaplaincy where clarification was needed.

Access and flow

- We were told that systems were in place to facilitate the fast-tracked discharge of patients to their preferred place of care or preferred place of death, although, most of these were not documented. The SPCT facilitated 95% of the fast-tracked discharges. The SPCT CNS explained that a multi-professional approach was in place, which could involve a discharge liaison nurse, physiotherapist and an occupational therapist to ensure that patients were discharged in a timely manner, with all the necessary support and equipment in place. We were told that ordering a hospital bed could take 24 hours and oxygen could be secured within four hours. We were told that Lambeth and Southwark local authorities ensured that equipment was in place the following day after discharge. However, we were unable to substantiate this during the inspection. The trust did not audit the responsiveness of the fast-tracked process.
- We were told that two-thirds of patients were local. However, with multiple clinical commissioning groups to engage with, the process was not standardised.
- The team's standards stipulated that routine referrals should be seen within 2 working days, urgent ones within 1 (often the same day) and emergencies within 4 hours on the day of referral. For February 2015, the palliative care scorecard showed that the team had achieved 92.3% against a target of 90% for routine referrals, and 93.9% for urgent referrals against a target of 97%.
- It had received 1,100 requests in 2014/15; 53% of these patients had a cancer diagnosis and 47% a non-cancer diagnosis. The team told us that recently they had received 15 referrals in one day; however, many referrals were received too late.
- The SPC team completed a scorecard each month that covered the key performance indicators set by the trust. The data submitted in December 2014 and February 2015 confirmed that in December 2014 179 of 216 referrals received had been reviewed by the SPC team. Sixty-eight of those patients had cancer (38%) and 109 had not had a cancer diagnosis (60.9%.). In February 2015, 174 of 204 referrals had been reviewed. Sixty-four of these patients had a cancer diagnosis (31%) and 114 patients had a non-cancer diagnosis (65%).
- The trust did not audit the percentage of patients that achieve their preferred place of care/preferred place of death. Patients were discharged to their home, hospice or nursing home. We were told that two thirds of patients were local, but with multiple clinical commissioning groups to engage with, the process was not standardised. A palliative care consultant told us that there were delays in securing nursing home places, which could be lengthy. An outsource team came to the trust to support families in nursing home choices.
- We reviewed the quality sampling data provided and found that, between September 2014 and February 2015, out of 30 patients, 12 had no preferred place of care/preferred place of death written in their notes, 13 were too ill and five had had their preferred place of

care/death documented. This demonstrated that ward-based teams needed to improve the way in which the asking and recording of the wishes and preferences of the patients was done.

- As part of the 'Care of the Body After Death – Last Offices Policy 2015', deceased patients were expected to be transferred to the mortuary within a four-hour window. Staff on the wards we visited told us that deceased patients left within this timeframe. However, we were unable to review this during the inspection, as the wards do not audit this.
- The SPCT aimed to see the majority of referrals on the day of referral. Referrals to the SPCT could be by self-referral or by referral by professional groups, via EPR. Referrals to the team were classified as 'routine, urgent or emergency'. A senior clinician would triage all the requests daily to ensure all were appropriate and the urgency of the requests were acted on in an appropriate timeframe. The team standards stipulated that routine referrals were seen within one working day, that urgent referrals were seen within a day of referral, often the same day, and emergencies were seen on the day of referral. We reviewed the palliative care scorecard and saw that, for February 2015, a target of 90% was set for routine referrals. The team were achieving 92.3%. For urgent referrals, a target of 97% was set, but the team were achieving slightly below this at 93.9%. For urgent referrals a target of 100% was set and this was continuously achieved.
- To support the transfer of patients from the hospital to the community teams, the SPCT CNSs and the discharge liaison nurse were able to describe the communication flows and systems that were in place, including the engagement with the district nursing team, GPs and the community palliative care team to ensure that the community teams were well placed to deliver continuous end of life care. If specialist palliative care was required at home, the SPCT CNS made a referral to the community palliative care team.
- We noted that documentation was in place to support the discharge of patients, including a standard discharge summary and gold discharge summary. This ensured that streamline care was communicated across care providers.
- Minutes of the most recent staff meeting showed that areas discussed included discharge planning.

Learning from complaints and concerns

- Any complaints around the delivery of end of life care were reviewed by the End of Life Strategy Group. We were told by a palliative care consultant that, in the last year, only one complaint had been made about the SPCT. The process undertaken when the complaint was made demonstrated that systems were in place to respond to complaints in a timely manner. We saw a good governance structure and learning from complaints.
- Ward-based complaints about end of life care were also discussed at the End of Life Strategy Group. In the minutes of the March 2015 meeting, the group recognised that the discussion about complaints had slipped. Four complaints had been submitted across the hospital about end of life care in the last three months. We reviewed the complaints and saw that actions were in place to mitigate the same incidents happening again, including more staff training and the attendance of the ward manager at the End of Life Strategy Group.
- Bereavement centre staff undertook interviews with families after the death of their relatives. Staff told us that, when meeting families, if any issues arose around the care of their relatives, the staff will contact the medical team involved and try and resolve the issue for the family.
- We reviewed the clinical effectiveness programme and saw that an audit was undertaken to ensure that patients that received palliative care were coded properly to ensure that any complaints about their care could be monitored appropriately. The audit tested that the palliative care code (z51) was being used appropriately. Slight discrepancies were highlighted, but generally patients were being coded correctly.
- Minutes of the most recent staff meeting showed that areas discussed included complaints.

Are end of life care services well-led?

Requires improvement

The 'End of life Strategy Group' took place every two months, chaired by the director of nursing, with attendees from palliative care and consultants from elderly care and ITU. The director of nursing was appointed as the

nominated board lead for the development of end of life care and provided representation at trust board-level for care of the dying. However, we did not see any evidence of a long-term vision around end of life care across the trust.

Monthly palliative care service development meetings took place, which fed into the integrated bi-monthly 'Palliative Care Governance Group', which discussed areas including: adverse incidents, risk register and patient satisfaction feedback. The SPCT were visible, responsive and were active in policy development and audit. Outside the trust, the team were involved in regional and national groups.

The chaplaincy service was led by the hospital chaplain. The lead chaplain was an integral member of the End of Life Strategy Group, the Pan London Clinical Strategic Network for end of life care and chaired the organ donation committee.

Two members of the palliative care team led on the implementation of the 'Schwartz Rounds' (Schwartz Rounds are meetings which provide an opportunity for staff from all disciplines, across the organization, to reflect on the emotional aspects of their work), which had been established for staff. The partnership working with the King's Health Partners to provide access to face-to-face, seven-day specialist palliative care was established. The trust had participated in all four rounds of the NCDAH, which allowed scrutiny of the trust's end of life care strategy and encouraged improvements in the care delivered.

The SPCT were actively involved in undergraduate and postgraduate education and the training of generalist staff across the trust.

Vision and strategy for this service

- We did not see any evidence of a long-term vision around end of life care across the trust. However, we were able to review the 2014/15 action plan, which set out the work of the SPCT. This covered areas, such as: the introduction of a system for the identification of dying patients, the development and implementation of a treatment escalation plan, quality sampling of the trust's deaths, a bereavement survey and a review of the facilities for families. During the inspection, we were able to observe the above workstreams in place at varying levels of completion.
- The End of Life Strategy Group had set out a draft proposal around their work plan for 2015/16. The workstreams the group were proposing to cover included the development of a five-year strategy for end of life care in Lambeth and Southwark, a review of the commissioning intentions for 2016/17, support for local care networks and the setting of local priorities, as well as establishing systems to oversee and measure progress. Local priorities were due to be set by May 2015 and were reviewed in September 2015.
- We reviewed an action plan in response to the NCDAH, 2014 .This set out the key areas the trust could improve around the delivery of end of life care in 2014/15. The action plan covered the areas where the organisational and clinical KPIs were not compliant. A work programme to achieve compliance was in place, which we were able to review. We noted that areas of non-compliance had been addressed and actions were being taken illustrating that teams involved were addressing areas for improvement in a timely, cohesive manner. We were told by the palliative care consultant that feedback to the ward-based medical teams was via the "grand rounds", where issues could be flagged and awareness raised. We reviewed the 'grand round' timetable and saw that palliative care was due to be discussed in June 2015.
- A palliative care consultant told us that the trust's response to the independent review of the Liverpool Care Pathway (LCP): 'More Care, Less Pathway' (2013) and 'One chance to get it right' (2014) was to withdraw the LCP from the trust and to introduce the 'Five priorities of care' when caring for patients as they approached the end of their life. The introduction of 'quality sampling' had been used to monitor the implementation of the 'Five priorities of care' across all the wards.

Governance, risk management and quality measurement

- An 'End of life Strategy Group' took place every two months chaired by the director of nursing, with attendees from palliative care and consultants from elderly care and ITU. Agenda items discussed included monitoring performance, such as complaints, a bereaved carers survey, a bereavement and DNA CPR policy, spiritual care, mortuary services, education and training and a review of the action tracker. The wide agenda covered by the group demonstrated the importance of all areas in care of the dying patients.
- An end of life care 'Quality and Implementation Group' was established to discuss end of life care with other

divisions across the hospital and to be a forum for the feedback to end of life champions. We were told by the palliative care consultant that attendance at the meetings was poor and that was confirmed in the minutes of the March 2015 'End of Life Strategy Group', where discussions took place on the best way to feed back on issues relating to end of life care. Suggestions had been made to re-launch the group as a workshop four times a year.

- We were told by a palliative care consultant that separate monthly service development meetings took place at the Denmark Hill site and the Princess Royal University Hospital. These groups fed into the integrated bimonthly 'Palliative Care Governance Group', which discussed areas, including: adverse incidents, risk register, patient satisfaction feedback, clinical effectiveness, which included team audits, quality sampling feedback, research and infection control updates.
- We saw that the SPCT multidisciplinary team undertook a variety of roles, which included: continuously updating its clinical governance programme, regularly reviewing and updating guidelines, protocols and patient pathways for all key service areas, ensuring regular appraisals, continuous professional development and compliance, with mandatory training for all staff and making regular external clinical supervision available. The team considered reports on patient experience, clinical effectiveness and risk management and ensured appropriate action plans were developed and implemented. We noted that the SPCT was effective in those roles and responsibilities, as we were able to review action plans, palliative care meetings minutes and training records.
- The director of nursing had been appointed as the nominated board lead for the development of end of life care and provided representation at trust board-level for care of the dying. This appointment was made as part of the NCDAH 2014 action plan.
- The specialist palliative care team had a risk register. In March 2015, four risks associated with the Denmark Hill site were on the register, one of which was rated as a 'major' risk. The prescribing and administration of opioids to end of life care patients had been highlighted as a risk for 11 months. To mitigate this risk, a trust Opioids Safety Group was established in October 2014 and objectives set were due to be completed by December 2015. The risk register was reviewed at the Palliative Care Clinical Governance Group.

Leadership of service

- There was good leadership of the SPCT, led by the palliative care consultants and the nursing matrons. However, the cross-site integration of the teams was still a work in progress. We observed that the SPCT were visible, responsive and were active in policy and audit. Outside the trust, the team were involved in regional and national groups, including London Cancer Alliance Palliative Care Group, Clinical Research Network South London and The National Association for Specialist Palliative Care Social Workers.
- The chaplaincy service was well-led by the hospital chaplain. We observed that the chaplaincy team were visible, responsive and were involved in policy and auditing. The lead chaplain was an integral member of the End of Life Strategy Group, the Pan London Clinical Strategic Network for end of life care and chaired the organ donation committee. They were also involved in other groups, including the patient issues committee and the Volunteer's Steering Group. This highlighted the trust recognition that religious/spiritual input was an essential part in the delivery of end of life care and the development of its policy.
- King's College London University, King's College Hospital (Denmark Hill site), Guy's and St Thomas' Hospital and South London and Maudsley NHS Foundation Trusts were part of King's Health Partners. King's Health Partners had a five-year plan (2014/19) in place, which sets out how they will work together. The aim is to focus on seven key clinical areas – cancer, cardiac, child health, dental, diabetes/obesity, mental health/ neurosciences and transplantation/regenerative medicine and will drive better understanding and improved treatments in these fields through research and education. King's Health Partners provide a seven-day, face-to-face on-call service for palliative care patients, across the trusts. This represented good partnership working across care providers ensuring that patient's complex needs were met during the weekend and evenings up until 10pm.
- Two members of the palliative care team led on the implementation of the 'Schwartz Rounds', which had been established for staff to regularly come together to

discuss the non-clinical aspect of caring for patients, including: psychological, emotional and social challenges associated with their work and help staff deliver compassionate care. Schwartz Rounds had been running since October 2013 and, as a result, the end of life strategy group members secured funding, these will continue in 2015.The group were in the process of identifying people to become facilitators and support the Schwartz Rounds.

- The SNOD told us that the organ donation committee took place every three months. A palliative care consultant was a member of the group with the chaplain being the chair. The SNOD told us that data was reviewed and discussed and the action plan was updated.

Culture within the service

- SPCT members we spoke with were passionate about supporting both families and staff in end of life care. This was confirmed when we spoke to staff on Davidson Ward. One nurse told us that SPCT staff were excellent in helping with "discharge and complex symptom control" and another nurse told us how helpful and supportive the SPCT CNSs were.
- All staff we spoke with demonstrated a positive and proactive attitude towards caring for dying people. They described how important end of life care was and how their work impacted on the overall service. On Davidson Ward, a nurse told us that the ward was "open and honest and was committed to good patient care". Staff felt they could speak out and felt "listened to". This was confirmed on Lonsdale Ward when a nurse told us that there was "an open culture on the ward where everyone felt they could speak out and would be listened to".
- SPCT staff told us that they felt supported in their roles and told us how approachable there managers were. On Davidson Ward, a nurse told us they felt well supported by the line manager and the matron. They were always around and were "very approachable". In the bereavement office, staff told us they felt supported by their line manager and appraisals were undertaken.
- The chaplain we spoke to told us that everyone tried to do their best around end of life care. They said, "Patient's safety and quality were a priority here as it's a very human place. People want to get it right."
- Mortuary staff told us that they had lots of contact with non-mortuary staff and contributed to the development of the end of life policies, including the 'Care of the Body After Death – Last Offices Policy 2015' that was being developed. Chaplains, porters and undertakers were frequent visitors to the mortuary and were able to see where their work fitted into the provision of end of life care services.
- Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone's responsibility and this was evident in the SPCT in their patient-centred approach to care.
- Across the wards we visited we saw that the SPCT was integrated well with nursing and medical staff and there was obvious respect between specialties and disciplines. On Fisk Ward, a nurse told us that the SPCT was "very supportive" and this was also expressed by a FY2 doctor we spoke to on Lonsdale Ward.

Public and staff engagement

- To ensure public and patient representation was established and maintained within the trust, a layperson was appointed as part of the board to champion end of life care.
- Staff awareness of the SPCT was raised by the annual 'Dying Matters' at King's College Hospital, a stall at the King's College Hospital. Open day and road shows across the trust to raise awareness around the care of the dying amongst staff. A palliative care consultant told us that public awareness around end of life care was undertaken by St Christopher's Hospice.
- The chaplaincy organised an annual remembrance service for adults, children, staff and haematology patients. A book of remembrance was available in the chapel where the name of the deceased could be placed. Remembrance services took place in November and December each year. Bereaved relatives were invited to the services via a card that was handed out when the family attended the bereavement office after their relative had died.

Innovation, learning and improvement

- We were told the trust implements end of life care planning using the 'Coordinate my Care' system. This enabled the trust to share the care plan electronically internally and with external care providers in Southwark, Lambeth, Lewisham and Greenwich, Bexley and Bromley Cluster.

End of life care

- The SPCT were actively involved in service improvement projects and undertook audits to monitor the quality of end of life care across the trust. Audits undertaken included diabetes at end of life, palliative care on-call rota and acute palliative care treatment.
- Innovative work undertaken included the partnership working with the KHP to provide access to face-to-face, seven-day specialist palliative care (only 21% of trusts deliver this nationally). The trust had participated in all four rounds of the NCDAH, which allows scrutiny of the trust's end of life care strategy and encouraged improvements in the care delivered.
- The palliative care team members were heavily involved in contributing to the MSc in palliative care, were actively involved in module teaching, including: palliative care in multiple sclerosis, ethics and palliative care and palliative care for patients with renal disease.
- The improvement in end of life care in 2014/15 was via a locally agreed Commissioning for Quality and Innovation (CQUIN) payment framework. The CQUIN was for the turnaround time of the end of life care patient's discharge letters. A target has been set of 92% for the letters to be completed within 24 hours. The SPCT had performed above that set target, with the team achieving 96.9%.
- The palliative care matron told us that the hospital had undertaken a pilot around the use of amber care bundles (assessment management best practice engagement recovery uncertain), which were used to support patients that were assessed as being acutely unwell and deteriorating, with limited reversibility and where recovery was uncertain. The end of life strategy meeting in October 2014 made the decision to no longer use the amber care bundles. However, wards that wished to continue using the amber care bundles would be supported. During the inspection, staff on Twining Ward told us they continued to use the amber care bundles.
- The SPCT submitted data to the National Minimum Data Set, which allowed the team to benchmark their service nationally and could be used as a service improvement tool.

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

Information about the service

King's College Hospital, Denmark Hill site provided 735,148 outpatient appointments in 2014/15. A number of different specialties are covered by the outpatient department, including: liver, renal, breast, fracture and orthopaedic, dental, dermatology, ear, nose and throat, ophthalmology, general medicine, cardiology, oncology, diabetic medicine, endocrinology, gastroenterology, general surgery and other clinics. The outpatients and diagnostic imaging department is open on Monday to Friday from 9am to 5pm.

As part of the inspection, we visited the outpatients and diagnostic imaging department and spoke with 28 members of staff, including: nurses, healthcare assistants, receptionists, the head of operations, departmental managers and medical staff. We spoke with 45 patients and relatives attending the hospital for a variety of outpatients and diagnostic imaging procedures. Additionally, we visited breast radiology, X-ray and imaging departments, including: nuclear medicine, magnetic resonance imaging (MRI) and computerised tomography (CT) scanning. We also visited the outpatient booking office.

Before the inspection, we reviewed information about the trust's performance sent to us by the trust, information from clinical commissioning groups (CCG) and other stakeholders and information from the listening event. We observed interactions between patients and staff and inspected the environment where services were provided.

Phlebotomy and pathology services were provided privately at the hospital by an independent contractor and were, therefore, not visited during this inspection.

Summary of findings

Patients received a caring service, as staff treated them with compassion, kindness and respect. Positive feedback had been received by the trust from patients using the outpatients and diagnostic and imaging departments. The service was delivered by trained and competent staff who had been provided with an induction as well as mandatory and additional training specific for their roles.

The leadership, governance and culture with the outpatient and diagnostic imaging services promoted the delivery of person-centred care. Staff were supported by their local and divisional managers. Risks were identified and addressed at local level or escalated to divisional or board-level if necessary. The trust promoted a good working culture. However, some clinical staff we spoke with did not feel supported by their line managers.

Many patients complained about the waiting times in the outpatient clinics. They said they had little information about the waiting times and staff were not always open with them about it. There was no systematic template of clinic schedules for the hospital. Different clinics used different templates and some templates allowed for the over booking of clinics and multiple bookings of appointments under one time slot.

Outpatient services were not organised in a manner that responded promptly to ensure patients' needs were met. Some patients experienced long delays in waiting

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times to their first outpatient appointment. The booking team were taking action to address waiting times and monitored patients who did not attend for appointments.

The liver clinic environment presented challenges for staff and patients, particularly in relation to the space required for patients to sit comfortably while waiting for their appointments. Seating areas were cramped and, throughout our inspection, we saw patients standing in areas of the clinic, who were unable to find a seat. Access for patients and visitors with mobility issues was challenging, due to tight spaces in corridors and seating areas in some areas of the clinic.

Are outpatient and diagnostic imaging services safe?

Good

There were systems in place, supported by adequate resources to enable the department to provide good quality for care to patients attending for appointments. We spoke with staff of all grades and disciplines across the outpatient areas and were told that the majority felt the department was adequately staffed to meet patients' needs.

We found that the environment was safe and the required safety checks were being completed and recorded. The department was clean and well maintained. Equipment was readily available and staff were trained to use it safely. There were no hand gel dispensers at the main entrances of some clinics however they were available in all clinics and other areas of the clinics we visited. Although the clinics were busy, nursing staff provided good and safe care to patients. Treatment records were informative and showed a clear pathway of the care and treatment patients received at the hospital.

Incidents

- During the last year there had been eight serious incidents reported between February 2014 to January 2015 and two Never Events reported between the same periods. We were told that all incidents were investigated, including the Never Events, and we were given evidence of that including action plans and learning from incidents.
- The Never Events were discussed at the departmental levels and action taken to ensure that the incident is never repeated. We were told by the Head of Ophthalmology that all the never events were thoroughly investigated and lessons learnt were shared with all staff concerned. However there was no closer working relation with the other trust location; for example the never events at the ophthalmology department at this hospital was not shared with the ophthalmology department at the Princess Royal University Hospital.
- Nursing managers told us they received regular reports of incidents and this enabled them to identify themes and trends and take corrective actions accordingly.

- Incidents were reported as per trust policy via the Datix electronic incident reporting system. They were reviewed at the clinical risk meeting and clinical governance meetings in the medical directorate, and also at departmental-level. Incidents were also documented in the annual clinical governance report. Nursing staff informed us they were encouraged to report incidents, which occurred in their working area. All of the staff we spoke with were confident to report incidents via Datix.
- We were given examples of incidents that had been reported by various outpatient clinics and diagnostic and imaging departments. For some of these, staff were able to inform us of changes that had happened as a result of their report. Although staff understood incidents were monitored, some of them felt they did not consistently receive feedback on the outcomes and action taken as a result of their report. We were shown the evidence of learning as a result of the incident that was reported and investigated by the department.
- In the ophthalmology department, there was a checklist developed to prevent surgeons from using incorrect data on the Medisoft system (Medisoft is the software system that is used for assessments, investigations and ophthalmic procedures) and inserting an incorrect implant into a patient's eyes. This action took place as a result of learning from Never Events. There was evidence that the trust learnt from incidents and that action plans were developed to address any issues identified.
- We saw a breakdown of incidents by category and date that allowed trends to be identified and action taken to address any concerns in a timely manner.
- All staff we spoke with in the diagnostic imaging department understood their responsibilities when it came to raising concerns and recording safety incidents and near-misses. Staff felt confident that they could discuss incidents with their direct line manager and that their concerns were listened to and acted on. Senior managers met regularly to discuss compliments, complaints, concerns and incidents. Themes from incidents were discussed at the senior manager's meetings and minutes of the meetings confirmed this was the case.
- We were given an example of an incident regarding a patient being given the wrong testing equipment at the sexual health clinic and staff described the action that had been taken as a result. We saw that changes to practice had been made and that this had been discussed during team meetings to ensure that male and female testing kits were appropriately marked during storage. We saw that actions had been completed within the given timescale.
- Safety alerts were received by managers and cascaded to all staff, displayed in the staff office and discussed at team meetings. Minutes of staff meetings confirmed that safety alerts were being discussed and it was a standing agenda of the meeting.

Duty of Candour

- Information regarding Duty of Candour had been cascaded from the divisional managers to all staff teams. Staff told us information had also been made available on the trust intranet regarding Duty of Candour and the responsibilities for being open and transparent with patients. One member of staff we spoke with demonstrated they were aware of this information and how to access it.
- We saw evidence of Duty of Candour in action when the consultant in the ophthalmology department gave us the example of letters being sent to patients offering apology and inviting them for a meeting to discuss the incident. This was one thing the department did when dealing with the Never Event incident.

Cleanliness, infection control and hygiene

- The overwhelming majority of staff we observed in the outpatient clinics and diagnostic imaging department were complying with the trust policies and guidance on the use of personal protective equipment (PPE) and were seen to be 'bare below the elbows'. We observed staff in the outpatient clinics undertaking hand washing when attending to patients and in-between patients. Staff working in the outpatient clinics had a good understanding of their responsibilities in relation to cleaning and infection prevention and control.
- The clinic areas and imaging department were visibly clean and tidy. We saw staff cleaning the areas between use by patients using appropriate wipes, thus reducing the risk of cross-infection or cross-contamination between patients. Within the imaging department, staff took active measures to ensure that infection control issues were appropriately dealt with.
- Toilet facilities were located throughout the outpatient and diagnostic imaging departments and these were clearly signposted. We looked at a sample of these and

saw they were regularly cleaned, with records showing when they were last cleaned. Clinical areas were monitored for cleanliness by the facilities team. Housekeeping staff could be called to carry out additional cleaning, where staff felt it was necessary.

- Nursing staff were responsible for cleaning clinical equipment. We saw that there were checklists in place in each clinic room and observed that these had been completed to provide assurance that equipment and rooms had been cleaned. The equipment that we saw was in good repair and we noted that green labels were placed on the equipment that had been cleaned.

Environment and equipment

- We found that the outpatient and diagnostic imaging department had resuscitation equipment, with appropriate signage directing staff to its location. All resuscitation equipment was checked during our inspection and found to contain an automated external defibrillator, suction equipment, and oxygen along with the appropriate emergency drugs and medical supplies. Other equipment was visibly clean, regularly checked and ready for use.
- The main outpatient department was located in the Golden Jubilee Wing of the hospital and it is divided into various numbered suites for ease of access and patient convenience.
- From observation in the outpatient clinic, we noted that there was adequate equipment. Staff told us that there was not a problem with the quantity or quality of equipment that was needed at the clinic.
- Equipment was maintained, checked regularly and given a portable appliance test (PAT) in line with the trust's policy. Labels on equipment stated when the equipment was last checked. All equipment we saw had been checked within the last year.
- Within the imaging department, we looked at the treatment rooms and found that they complied with the safety guidance on radiology. Personal protective equipment, such as goggles and tabards were available the machines were locked when not in use and access to the room was restricted when treatment was taking place. Local rules drawn up by the radiation protection advisor was in place and a laser protection supervisor was appointed by the department.

Medicines

- Staff we spoke with were aware of medicines management policies for reference purposes. Medicines administration records we checked were completed appropriately. There was a medicines information leaflet for patients. We saw medication audits had been undertaken with minutes seen of staff meetings to address any issues that arose from the audits.
- Medicines were stored in locked cupboards in the outpatients department. Nursing staff ordered all medicines through the hospital pharmacy.
- We found that controlled drugs and fridge temperatures were regularly checked by staff working in the outpatients and diagnostic imaging department. The nurse in charge carried the keys to the controlled drugs cupboard at all times. Two nurses checked controlled drugs taken from the locked medicines cupboards for administration. A lockable medicines fridge was in place, and daily temperature checks were recorded by staff. Temperature records that we looked at were completed and contained minimum and maximum temperatures to alert staff when they were not within the required range. We also found evidence in the dermatology outpatients department of prompt and appropriate action that had been taken when a fridge had been found to be outside of the recommended temperature range.
- Prescription pads were stored in a locked cabinet. When clinicians wrote patient prescriptions, the clinic kept a log which identified the patient, the doctor prescribing and the serial number of the prescription sheet used. This ensured the safe use of prescription pads.
- There were standard operating procedures in place at the sexual health clinic for vaccinations and vaccination reactions.
- Medications and contrast media required during diagnostic imaging procedures were administered appropriately using approved patient group directions (PGDs). The use of PGDs enables the registered health professionals other than doctors to supply and/or administer medicines to patients. PGD was a written instruction for the supply and/or administration of a named, licensed medicine for a defined clinical condition by specific healthcare professionals to improve patient care by enabling healthcare professionals to administer medication without individual prescriptions.

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Records

- All nursing and diagnostic imaging records were electronic and stored on the hospital's computer system, which were accessible to clinical staff using individually issued secure passwords.
- Information governance training was mandatory for all staff to ensure compliance with the Data Protection Act 1998. The mandatory training records we saw showed that all staff had completed Data Protection Act 1998 training.
- The records management policy stated that any breaches of data protection would be discussed at the senior manager's meeting and actions taken to remind staff of the importance of data protection. We were not provided with evidence to demonstrate that there had been any breaches of data protection in the 12 months prior to the inspection.
- Staff we spoke with could not recall an occasion where medical records had not been available for a clinic, or when a patient could not be seen because their records were not available, because all records were held electronically with a secure backup in the event of system failure.
- All patients attending the outpatient appointment for consultation, radiological examination, or treatment were risk assessed in areas of mental capacity before undergoing their treatment or other invasive procedures.

Safeguarding

- Staff we spoke with were aware of their responsibilities and understood their role in protecting children and vulnerable adults. They demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. The trust had a whistleblowing and safeguarding policy that was known to staff working in the outpatient and diagnostic imaging department. They told us that they would feel happy using this policy to raise concerns if they felt it was necessary.
- There was a safeguarding lead at the hospital and the outpatient and diagnostic imaging staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff assured us they knew who the trust's safeguarding lead was and how to contact them. We were told that the trust was represented at both adult and children's safeguarding strategy meetings at the local council.
- Staff in the outpatient and diagnostic imaging department had completed mandatory safeguarding training to level 2, and child protection level 2 training. They were able to talk to us about the insight and knowledge gained from this training. An outpatient nurse was able to give us an example of when staff in the department had followed the trust safeguarding policy and made an appropriate referral.
- In the sexual health outpatient clinic, we were shown how all safeguarding referrals were identified, monitored and updated. Staff described how each referral was recorded and reviewed at monthly meetings and how the lead clinician managed these patients around the service.
- We were told the hospital had a robust system for monitoring female genital mutilation (FGM). The system involved monitoring and providing support to patients experiencing or under threat of experiencing this abuse. We saw examples of information given to patients when referring them to other services within the hospital. For example, for corrective surgery. Records confirmed that all cases of FGM were recorded and discussed with the safeguarding lead.

Mandatory training

- Corporate induction training was provided for all staff and was compulsory for all staff to attend. There was also a service specific induction. This was specific to the department where staff worked and their role. We saw records held within the outpatients and diagnostic imaging department, which showed the induction records for new staff were comprehensive and up to date. All of the staff we spoke with confirmed that they had received their mandatory training in line with the trust's policy.
- Staff told us they were given time to undertake mandatory training, which was offered in a format of two days' worth of face-to-face training, augmented with e-learning. Some staff told us that accessing e-learning had practical difficulties, as it was located on the rust intranet, which meant access through some computers in some departments was not always possible.
- The completion of mandatory training varied between different departments and clinics, with an average

completion ranging between 70% to 90%. Staff knew how their training was monitored and confirmed that managers reminded them when training was overdue and needed to be completed.

- We saw examples of staff training records showing completed training. We also saw examples of the monitoring that showed staff had undertaken all mandatory training, such as health and safety, infection prevention and control, moving and handling, safeguarding and basic life support.
- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if they requested it.

Assessing and responding to patient risk

- The hospital had systems and processes in place for responding to patient risk. Staff were noted to be available in all the waiting areas of the clinics so that they would notice patients who appeared to be unwell and needed assistance. Staff we spoke with demonstrated knowledge and understanding of patient risk, particularly for people living with dementia or learning disability, and elderly or frail patients with more than one medical condition.
- There were clear procedures in place for the care of patients who became unwell. Staff we spoke with told us about emergency procedures and escalation process for unwell patients. However, they stated these had not been used often, as the department did not often have acutely-unwell patients.
- In the diagnostic imaging department, staff we spoke with knew who their radiation protection adviser and radiation protection supervisor were for their clinical area. Staff explained how they would report any concerns about safety to their line manager. We saw local rules and copies of the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) in place.
- There were emergency assistance call bells in all patient areas, including consultation rooms, treatment rooms and the x-ray suite. Staff we spoke with told us when the call bells were used they were answered immediately. Staff we spoke with were aware of their role in a medical emergency. Staff provided an example of a patient who had become acutely unwell during a clinic appointment where a cardio-respiratory resuscitation (CPR) team had been called to assist the patient.

Nursing staffing

- The outpatient clinics were staffed by registered nurses and health care assistants. Each clinic was run by registered nurses and was supported by health care assistants.
- The outpatients and diagnostic imaging department used a staffing contingency plan to assess daily whether they had sufficient numbers of nursing staff in the department. The plan included a staff escalation protocol, which instructed staff on procedures to follow when staffing levels fell below the level required to run the department safely.
- All of the staff that we spoke with felt that there were enough staff of a suitable skill mix to manage the workload. Where areas required a trained nurse to be available for clinics, for example breast clinics, they would be provided.
- Nursing staff told us that, although they were busy, they thought they provided good and safe patient care.

Medical staffing

- Medical staffing was provided by the relevant specialty running the clinics in the outpatient department. Medical staff were of mixed grades, from consultants to junior doctors. There was always a consultant to oversee the clinics, and junior doctors felt supported by the consultants.
- Doctors we spoke with thought they had a good relationship with outpatient nursing and clerical staff. They said they felt well supported and could discuss issues with them.
- Trust policy stated that medical staff must give six weeks notice of any leave in order that clinics could be adjusted in a timely manner. However, records showed that the outpatient department was not compliant with this policy. We were told that where the policy was not met, staff escalated this to divisional or deputy divisional managers to be challenged, investigated and approved.
- Consultants and registrars provided cover for each other at times of annual leave or sickness whenever possible. All medical staff we spoke with confirmed that cancellation of a clinic was a last resort.

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Major incident awareness and training

- The trust had a business continuity management plan, which had been approved by the management team. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The hospital major incident plan covered major incidents, such as: winter pressures, fire safety, loss of electricity, loss of the frontline system for patient information, loss of information technology systems and internet access, loss of staffing, and loss of the water supply.
- Staff we spoke with were aware of the hospital's major incident plan, such as winter pressures and fire safety incidents, and they understood what actions to take in the event of an incident such as a fire. Most staff we spoke with had attended major incident awareness training within the last three years and were able to describe the outpatient department's role in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence-based assessments, care and treatment was delivered in line with National Institute for Health and Care Excellence (NICE) guidelines, by appropriately trained and qualified staff. Radiation guidelines, local rules and national diagnostic reference levels (DRLs) were available for staff references. There was an assigned radiology protection adviser and an radiology protection supervisor.

A multidisciplinary team approach was evident across all the services provided by the outpatients and diagnostic imaging department. We observed a shared responsibility for care and treatment delivery. Patients were provided with sufficient information about their treatments and had the opportunity to discuss any concerns. Staff working in the clinic told us their managers encouraged their professional development and supported them to complete training. However, completion of training had not always been possible, due to staff shortages that made it very difficult to undertake study leave. Appraisals were undertaken annually, but staff had no other form of formal supervision on a regular basis.

The diagnostic imaging service manager monitored the radiology turnaround times for reports, which were shared with all staff during staff meetings. The diagnostic imaging department had effective systems in place for monitoring radiation levels administered for diagnostic treatments, interventions and patient outcomes.

Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance and the trust's treatment protocols and guidelines were available on the trust's intranet. Staff told us that guidance was easily accessible and was clear and comprehensive. We saw that the outpatients and diagnostic imaging department was operating to NICE guidance standards and local protocols and procedures. Staff we spoke with were aware of how this guidance had an impact on the care they delivered.
- We noted that NICE guidelines were in use in most clinics. Staff we spoke with described how they ensured that the care they provided was in line with best practice and national guidance. Adherence with NICE guidelines was monitored by the relevant directorates' clinical governance committees.
- There were clear standard operating procedures (SOPs) for the imaging department, as required under IRMER 2000 regulations. These addressed patient identification and responsibilities of individual members of staff, and also set training requirements for staff working at the imaging department.
- We were told by the diagnostic imaging lead that the radiation protection monitoring at the hospital was satisfactory and in line with IRMER 2000 requirements. We saw evidence through audits which showed that radiation exposure monitoring was up to date. There was no IRMER 2000 report submitted to the Care Quality Commission (CQC) in the last year.

Pain relief

- The imaging department had a stock of pain relief and local anaesthetic medication for use when invasive procedures were being carried out. We saw that pain relief was discussed with patients during their consultation or treatment and analgesia was prescribed as necessary and dispensed by the hospital pharmacy.
- Patients at the outpatients department had access to pain relief when it was needed. Clinical staff reported that patients' pain was assessed and monitored to ensure they received the appropriate amount of pain

relief when in clinic. Staff told us that they could give paracetamol to patients if they were in pain, but all other analgesics had to be prescribed before being administered to patients.

- Staff in the pain clinic told us that prescribed pain relief was monitored for efficacy and, where necessary, they changed to meet patients' needs. This was discussed with patients as part of their ongoing management of pain.

Patient outcomes

- National guidelines for radiological reporting and the clinic's own quality standards for radiology practice were followed regarding radiology activity and reporting. This included all images being quality checked by radiographers before the patient left the department.

Competent staff

- Patients who attended outpatient clinics and the diagnostic and imaging department were very positive about the clinical staff and the care and treatment they had been given.
- In the diagnostic imaging department, there were protocols, policies and procedures in place for the use of equipment and these served as a reference manual for staff. All staff had undergone local training in the use of all equipment in the diagnostic imaging department. We were shown a record of training completed by staff as part of their professional development.
- We spoke with a selection of staff in all departments, who told us they had participated in the annual trust appraisal system. The neurology clinic manager told us they had attained a 90% appraisal rate of staff. However, there was no data or record to corroborate this figure. While some staff said they had formal supervision meetings with their managers, others said they did not. All staff we spoke with told us they were well supported by colleagues and by their managers.
- We were shown how individual managers recorded and accessed information regarding line management responsibilities for staff appraisals. Staff in the cardiac clinic told us how they took responsibility for initiating the appraisal process and showed us using the intranet online system. They reported that they found this helpful in ensuring that the appraisal process was fully inclusive and not just a task that had to be completed.
- Staff were provided with training relevant to their specialty, such as general surgery, orthopaedics and cardiology. Staff told us they were trained in the care of patients living with dementia or who had a learning disability. We saw evidence of this through the mandatory training data submitted by the trust.
- We spoke with staff throughout the outpatients and diagnostic imaging departments, who told us there were many development opportunities available for them and that the trust supported staff to broaden their competencies. We spoke with healthcare assistants, ward managers, link nurses, and nursing staff, who described how the intranet published courses available and contained good information for them to access. The practice development nurse told us how they attended study days every three months, which ensured they were updated and remained current. We spoke with a range of link nurses, including the dignity champion and the diabetes lead. They described a culture of developing individuals and sharing best practice.
- We were told that the diagnostic imaging department had a departmental induction programme for radiologists, radiographers and other staff working in the department that included orientation on the department's equipment. We were told that each new staff member was assigned a mentor. A member of staff told us that a colleague would go through the controls with them when a piece of equipment was new to them. However, they said that this was not recorded formally. We reviewed more recent induction and training records and these were found to be up to date.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatients department. We were told about a number of examples of where joint clinics were provided, for example: the breast clinic, the dermatology clinic, the ophthalmology clinic, the older person's clinic and the oncology clinics.
- Many clinics had multidisciplinary meetings, particularly the cancer related specialties, where the team agreed and planned the care for patients and decided which clinician would be seeing the patient in the clinic to explain the plan to them. We saw, for example, that a member of staff from the outpatient's clinic and breast radiology team attended the breast care multidisciplinary team meeting.

Outpatients and diagnostic imaging

- Specialist nurses ran clinics for some specialties, such as: a pain clinic, a breast clinic, a heart failure clinic and a diabetic clinic, among others. We spoke with some of the specialist nurses, who described how their clinics fitted into patient treatment pathways. Nursing staff and healthcare assistants we spoke with in clinics, such as orthopaedic and gynaecology clinics told us that teamwork and multidisciplinary working were effective and professional.
- We saw that patients were regularly referred to community-based services, such as community nursing services and GP services.

Seven-day services

- The outpatient department service ran from Monday to Friday, from 8.30am to 5.30pm. We were told there were mostly no evening or weekend clinics, but the fracture and orthopaedic clinic provided Sunday services from 8:30am to 1pm.
- The diagnostic and imaging department offered seven-day services for inpatients and those who attended the ED.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence from staff training records that clinical staff had completed training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff we spoke with confirmed they had completed training and undertaken regular updates. However, we noted that their knowledge of Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was variable, with some staff demonstrating clear knowledge of the act and its implications and others not being as clear.
- Patients we spoke with said that they completed consent forms before their treatment, when this had been appropriate. We were told that clinicians asked for consent before commencing any examination and explained the procedure that was to take place. Staff undertaking procedures were aware of the need to obtain patients' consent and completed appropriate consent documentation.

Are outpatient and diagnostic imaging services caring?

Good

We saw that caring and compassionate care was delivered by all staff working at outpatients and diagnostic imaging department. We observed, throughout the outpatients department, that staff treated patients, relatives and visitors in a respectful manner. Staff offered assistance without waiting to be asked.

Clinical room doors were kept closed, and staff knocked before entering clinic rooms to maintain patients' privacy. Patients and relatives commented positively about the care provided to them by the staff from all the clinics visited. Staff ensured that patients understood what their appointment and treatment involved.

Patients told us they felt involved in their care and treatment, and they thought that staff supported them in making difficult decisions. Patients told us they were given sufficient information about their care and treatment and were fully involved in making decisions about their care and treatment. All the patients we spoke with told us the staff were caring and polite. Patients we spoke with were satisfied with the services provided and stated that doctors and nurses had time to discuss with them their care and treatment plan.

The liver clinic was cramped, which meant there was no privacy for patients. We could hear the conversations taking place between patients and staff. We observed patients having their vital signs taken on the corridor of the clinic.

Compassionate care

- We observed most staff interactions with patients as being friendly and welcoming. We observed some instances where patients that attended the clinic regularly had built relationships with the staff that worked there. We saw examples of caring interactions by healthcare assistants. For example, friendly greetings getting down to a patient level to interact with them and maintaining eye contact.

Outpatients and diagnostic imaging

- We saw that staff always knocked and waited for permission before entering clinic rooms. We also saw that clinic rooms had signage instructing people to knock and wait for an answer before entering, to maintain people's dignity.
- One patient explained how the consultant had explained in detail their treatment options and ensured they had all the information they required. We observed a nurse explaining paperwork to a patient attending their first appointment, following a diagnosis of their illness. Everything was explained very calmly and they also ensured the patient and their partner had the correct phone numbers should they need to ring for more information. They were told to contact the clinic if "they were worried about anything at all".
- People we spoke with told us they felt listened to and were given sufficient information about their treatment. Patients' confidentiality was respected. Patients and staff told us there were always rooms available to speak to people privately and confidentially.
- Notices were displayed for patients informing them that chaperones were available and offering them the right to have treatment and consultation from the same sex staff. An example of this was in the cardiac clinic, where information was displayed explaining that patients would be required to remove their clothing to the waist. One patient told us, "It is really good that they tell you what to expect before you have the test; it puts you at more ease."
- Throughout the two days we visited the outpatient department, we observed nursing, healthcare and receptionist staff interacting in a positive and caring manner with patients. We saw that enquiries made at the reception desks were responded to in a polite and helpful manner. We saw patients being redirected to other clinic locations with a clear and reassuring approach.
- We spoke with reception staff at the imaging department, who demonstrated a clear understanding of their role. We observed patients being treated with courtesy and dignity by reception staff, who signposted them to other waiting areas when required. Reception staff told us that, when patients arrived for appointments, their name, date of birth, address, and telephone number were checked with them at this desk.
- The liver clinic was cramped, which meant there was no privacy for patients. We could hear the conversations taking place between patients and staff. We observed patients having their vital signs taken on the corridor of the clinic.
- Patients we spoke with were positive about the outpatient services and told us they were satisfied with the treatment they received. Patients made positive comments about nursing staff, healthcare assistants, receptionists and doctors.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved and informed about their care. They told us they were given sufficient information to help them make any decisions they needed to make. We were told that treatment options were clearly explained.
- We also observed the doctors behaving in a friendly and respectful manner towards the patients in their care. One patient told us, "The doctor is particularly good; they took time to understand my problem."

Emotional support

- Staff explained how they tried to provide support to patients who were given distressing news. One nurse explained how they ensured they were with the patient when the consultant spoke with the person. They would also make sure they stayed with the person afterwards to ensure there was no delayed reaction.
- Patients and relatives we spoke with confirmed that they had been supported when they were given bad news about their condition. Staff explained how they ensured patients were in a suitably private area or room before breaking bad news to them. We were told that it was always possible to locate a suitable room for these discussions. Nurses were always available to help and support patients with information when they were in clinic.
- The chaplaincy team told us that they made occasional visits to the outpatient areas and would always attend, if requested, in order to offer spiritual support.
- Information was displayed in the various waiting areas about any support services that might be appropriate. This included helpline numbers and support networks for specific illnesses.
- Staff were observed to be sensitive to the needs of patients who were anxious and distressed about their

procedure at the imaging department. Staff were noted to allay patients' fears and anxieties about the proposed procedure, and they explained the procedure and stayed with the patient to provide support and reassurance.

- Patients we spoke with were positive about the clinics and the staff they saw. They told us they were satisfied with the professional approach of the staff.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The outpatient service was not responsive to patients' individual needs. Overall, not all patients were seen within the national waiting time target for waiting to be seen in a clinic. In some clinics, we observed consistent delays in patients being seen at their appointed time throughout the two days we were onsite at the hospital. Delays in clinics were not always explained to patients. The information board displaying waiting times was not prominently displayed where all patients would see it and, occasionally, the waiting times stated on the board were not correct, nor were they a true reflection of the waiting times.

We noticed that some clinics were overcrowded and staff were struggling to cope with the patient numbers. The trust was aware of concerns in this area and said, "Some departments are getting very busy and running to full capacity, which is starting to cause some issues around capacity and waiting areas, this has been escalated to the relevant departments/teams." This demonstrated that the trust understood the challenges and identified risks within the outpatient department.

The outpatients and diagnostic imaging department was monitoring developments that impacted on care delivery, such as developing policy to monitor and reduce non-attendance at hospital appointments, longer waiting times, delivering on their referral-to-treatment (RTT) commitment and complaint responsiveness. In general, resources and facilities were good and met the needs of patients attending the department.

Service planning and delivery to meet the needs of local people

- Patients told us they were allocated enough time with the doctors when they attended their appointments, and that their appointments were not rushed. Doctors were well informed about patients' medical history, and patients' medical records were available to doctors.
- We found that patient waiting times varied in different clinics, from a few minutes to over an hour and we observed consistent delays in patients not being seen at their appointed time in some clinics. Information about waiting times was not always updated to reflect the true waiting times. Even though waiting times for patients to be seen in some clinics were long, we observed good patient flow in the main waiting areas of most clinics.
- Some reception and nursing staff told us they would inform patients if clinics were running late. However, several patients we spoke with expressed frustration at the lack of information about waiting times. We were told by some staff at the outpatient clinics that there was no monitoring of clinics that were running late. Most of the staff we spoke with could not provide us with audits or monitoring data that had taken place to identify the frequency of late clinics and the length of time patients waited after their allocated appointment time to be seen by a doctor or nurse. We also noted that there was no action plans in place to address these issues at the clinic level.
- We were told by the management team that an increase in staffing had been agreed for the diagnostic imaging department. This was identified due to some changes in the running of the department and additional staff were recruited to the team.
- We were told CT scans were done in-house, with inpatient scans reported on the same day. Outpatients reported within 7 days, with 84% reported within three days. The CT scans team currently worked seven days per week, due to an increase in demand for the service.

Access and flow

- Hospital Episode Statistics (HES) for July 2013 to June 2014 showed that 735,148 outpatient appointments were made. We noted that 79% of patients attended either their first, or follow-up appointments. The data showed that the hospital's ratio of follow-up to new appointments was better than the England average. Out

of the total appointments made, 3% had been cancelled by patients and 7% by the hospital. The hospital's 'cancelled appointments' of 7% was higher than the England average at 6%.

- Staff gave patients reminders of appointments by text and voicemail. Voicemail reminders were sent five days prior to an appointment, which was followed up by a text reminder the day before the appointment.
- The data also showed that 10% of patients did not attend their appointments, which was higher (worse) than the England average of 7%, and the trust average of 9%. We were told by trust managers that the hospital's 'did not attend' rate was continuously monitored to enable changes and adaptations to be made to minimise waste of resources. For example, texting and phone calls had been used to remind patients of their appointment date and time. Measuring the non-attendance rate was important, because non-attendances meant that resources were not being used well and can have negative impact on patients receiving services at the hospital. The trust managers were not able to tell us what difference had these initiatives made to the 'did not attend' rate.
- We were provided with a referral-to-treatment (RTT) report from April 2013 to November 2014, which showed the trust operational standards were that 95% of on non-admitted patients should start consultant-led treatment within 18 weeks of referral and 92% of incomplete pathways should start consultant-led treatment within 18 weeks of referral. The worst performing RTT by specialties were in the cardiothoracic surgery and neurosurgery specialty, which were 72% and 74% respectively, for incomplete pathways. For the non-admitted pathway, the neurology and neurosurgery clinics were the worst performing, at 83% and 87% respectively.
- The trust RTT for non-admitted patients (incomplete pathways) was 96%, which was higher (worse) than the national average of 94% for patients starting treatment within 18 weeks of referral from April 2013 to November 2014.
- Cancer waiting times were similar to the England average for all the three measures at the trust level for 2013/14. The percentage of people seen by specialists within two weeks of an urgent GP referral for all cancers was 95%, and the percentage of people waiting less than 31 days from diagnosis to first definitive treatment for all cancers was 98%. The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers was 86%, all these were within the England average.
- The trust performed worse on the percentage of diagnostic patients waiting more than six weeks for appointments. The score was 5% compared with the national average of 2%.
- The clinical investigations department had a dedicated porter to assist patients in getting to and from the department. This portering service enabled inpatients to be brought to the department at an appropriate time to improve the efficiency and smooth running of the department.
- Paper referrals from general practitioners (GPs), consultants and the emergency department were managed by the Outpatients Administration Centre (OPAC) located at the Denmark Hill site. Choose and book referrals were managed by a separate team also located at this site. Choose and book referrals were directly bookable by patients who could access and book appointment slots by phone or online. They could also be booked indirectly by OPAC staff. If choose and book referrals could not be managed within 18 week timescales, the system would alert staff, who would go to the referrer and obtain a paper referral that could be managed outside of the choose and book system.
- Once referrals were received, clerks then booked the patient onto the system before sending the referral to the relevant consultant for triage. Managers told us that the expectation was that consultants would triage referrals within 48 hours. However, this was not always happening. The manager of OPAC was working on a service-level agreement, which was at draft stage at the time of our inspection. They hoped that, once completed and agreed by specialties, this document would have clear protocols and key performance indicators (KPIs) around the timeframes for triaging referrals.
- During triage, referrals would be rated for urgency and then forwarded to the OPAC team to make the appointment. Two-week wait appointments were made within two weeks, urgent appointments were made within one to four weeks, and routine appointments were made within eighteen weeks. Central booking staff then booked appointments using the urgency scale. We were told that the team used the same criteria across all specialties, and would escalate to divisional leads if they

could not make appointments within the agreed timescale. Staff did not have an escalation policy. Therefore, the OPAC manager had included the escalation of two 18-week breaches in the service level agreement (SLA) draft that they were working on at the time of our inspection.

- Where booking staff had escalated patients who they were unable to book within the timescales required, divisional managers would steer staff on how to manage these bookings. We were told that this would be addressed by providing extra clinics, converting follow-up appointment slots into new appointments, double booking clinic spots or by agreeing breaches in the RTT.
- One issue raised by staff as a potential reason for 18-week breaches was the cancellation of clinics. Clinic cancellations were managed by a separate team at the Denmark Hill site. Trust protocol dictated that clinics should be cancelled with at last six weeks' notice. Staff told us that this was not always adhered to, but that if they received requests for clinics to be cancelled within the six week notice period without a valid reason these would be sent back to the requester who would need to find additional resources to run the clinic as planned.
- Clinic staff told us that, in order to manage clinic cancellations, each specialty held 'firebreak clinics' every five to six weeks. These were clinics that were kept empty in order to move cancelled clinics into the free appointment slots. Staff told us that, if they still were unable to re-book patients within the 18-week target they would refer this back to divisional leads who were asked to arrange customised clinics.
- Clinic preparation staff prepared patient health records for clinics. These staff worked for separate divisions and managed clinic lists for their specialties.
- Once staff members received clinic lists they would request health records from the medical records library. Once they had received health records they would attach outcome sheets to the record and ensure that they contained patient ID labels. Following clinics, health records would be returned to them where they would use the completed outcome sheets to book any follow-up clinic appointments required.
- The medical records department was a closed library. This meant that only staff with required swipe cards could access the facility. Staff in the library would pull medical records for clinics, and inform clinic preparation staff where health records were not in the library. When this was the case clinic preparation staff would locate and collect the relevant health records.
- The hospital used mainly electronic records, however, in some clinics, like liver and orthopaedic, some notes are paper-based records. Staff told us that, where health records could not be found in time for clinics, a temporary set of health records would be created. This set would contain patient labels and copies of last clinic letters, referrals and relevant diagnostic results. Where temporary notes had been used library staff would marry these with the main health records.
- Calls coming into the call centre were recorded. The recordings were used during staff training and to monitor calls following patient complaints. The call centre monitored the number of calls coming into the service, which was broken down by call type and specialty. They also monitored the length of time it took for calls to be answered, the length of time calls took, and the number of people who ended the call before it was answered. On Monday 13 April 2015, calls took on average 180 seconds to be answered. We were told that Mondays were the busiest day for the call centre.
- One issue raised with us during focus groups was around patients who had two patient ID numbers, which could confuse clinic bookings. OPAC staff told us that this happened when some patients transferring from the Princess Royal University Hospital had a number prefixed with an 'N'. The IT system at the trust would not accept this, so the patient needed to be inputted into the system as a new patient. This had caused some confusion. Staff also told us that two ID numbers could occur through user error and when patients had changed their name without informing the trust.

Meeting people's individual needs

- We noticed that some clinics were overcrowded and staff were struggling to cope with the patient numbers. The trust was aware of concerns in this area and said: "Some departments are getting very busy and running to full capacity, which is starting to cause some issues around capacity and waiting areas. This has been escalated to the relevant departments/teams." This demonstrated that the trust understood the challenges and identified risks within the outpatient department.
- Staff ensured that patients who were distressed or confused by the outpatient environment were treated

appropriately. Patients with a learning disability or a diagnosis of dementia were moved to the front of the clinic list. The outpatient staff liaised, where needed, with ambulance transport staff to ensure that this process ran smoothly. This was evident in the elderly/ over 65 one-stop clinic, where the clinic staff coordinated transport for patients attending the clinic.

- In response to the increased needs of patients presenting at the sexual health clinic, the staff described how they screened each patient with a brief questionnaire. This assisted them to identify those patients who may be at risk due to their lifestyle. This had enabled them to provide additional services to meet the needs of these patients by engaging a dedicated alcohol adviser and a domestic violence counsellor to attend drop-in sessions. They reported that this had been well received by patients and they intended to continue the initiative.
- Appointment booking systems did not consider the variable needs of patients. This was particularly evident in the most clinics, including: dental, ophthalmology, breast, renal and liver clinics, where patients might require a longer appointment. This also contributed to appointments overrunning. We also noted that the clinic scheduling template allowed over booking of clinics. In one time slot, four patients (two new and two follow-up patients) were booked on that same time slot. These caused delays and the overcrowding of clinics.
- We were told that translation services could be accessed through Language Line Solutions for people whose first language was not English. However, there were no posters or written information available to inform people of this service.
- The radiology waiting area catered for patients referred from inpatient wards and outpatient clinics and those referred directly by their GPs. The radiology department operated seven-day services. The only dissatisfaction expressed by patients we spoke with was about long waits in the department.
- We noted that the environment within the reception area of some outpatient clinics allowed for confidential conversations. However, in other clinics, like orthopaedic, cardiac, respiratory and liver outpatient clinics, the waiting areas were small and easily filled up. We saw patients either standing in the clinic or on the corridors waiting for their appointment.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Initial complaints would be dealt with by the outpatient matron, but if the matron was not able to deal with their concerns satisfactorily, they would be directed to the Patient Advice and Liaison Service. Staff explained the complaints procedure to us. However, complaint information was not readily available. We also found that Patient Advice and Liaison Service information was not on display in all the outpatient clinic areas of the hospital.
- We were given an example of a complaint regarding a patient being given the wrong testing equipment at the sexual health clinic and staff described the action that had been taken as a result. We saw that changes to practice had been made and that this had been discussed during team meetings to ensure that male and female testing kits were appropriately marked during storage. We saw that actions had been completed within the given timescale.
- We reviewed five complaints received and action plans. The trust responded to the complaint and an action plan was implemented and completed. Action from the complaint was that the outcome of the investigation was to be shared at team meetings. However, we did not see evidence of any lessons learned being shared with staff.
- Complaints were discussed at departmental-level and also at Directorate Clinical Governance Group meetings. However, there was no evidence to show that lessons learned were consistently shared with staff. Most of the staff we spoke with could not recall when actions from complaints were shared with them.

Are outpatient and diagnostic imaging services well-led?

Good

The leadership, governance and culture ensured the delivery of person-centred care. Staff were supported by their local and divisional managers. Most risks were identified and addressed at local level or escalated to divisional level if necessary.

Staff felt their line managers were approachable, supportive and open to receiving ideas or concerns. Most

staff knew and understood the vision of the hospital and were able to demonstrate how this was implemented in practice. Staff enjoyed their work and felt that it made a difference to how patients felt about the hospital.

Clinical staff in all the outpatients and diagnostic imaging areas stated their managers were visible and provided clear leadership. There was an open culture amongst staff and managers. Staff said they felt empowered to express their opinions and felt they were listened to by the management.

All staff had been involved in some aspects of the service improvement plans and nursing staff reported being encouraged to find innovative ways to improve the service. Never events were discussed at the departmental level and action taken to ensure that all the never events were never repeated. We were told by the Head of Ophthalmology department that all incidents including never events were thoroughly investigated using the root cause analysis and lessons learnt were shared with all staff concerned at the department.

There was limited close working relations with other hospitals within the trust. For example, the two never events at the ophthalmology department were not shared with the ophthalmology department at the Princess Royal University Hospital.

Vision and strategy for this service

- Senior managers told us what their vision for their service areas was. Most of the staff spoken with were aware of 'King's Values' and 'Team King's', which sought to ensure that everybody at the trust was valued equally. There were shared objectives and strategies in place to achieve an improved service provision across all the trust's sites.
- Staff were confident about the vision and values of the organisation and one member of staff told us, "Everything we do is based on the values of the trust." Another member of staff said, "Sometimes information from the top of the organisation gets missed as it comes down to floor level, however, the staff engagement was good."
- Staff showed a good understanding of the values and vision of the trust and felt able to raise concerns.

Governance, risk management and quality measurement

- The diagnostic imaging department had risk assessments in place to protect patients and staff during care and treatment. For example, there was a risk assessment for staff who were pregnant and a checklist to risk assess children and pregnant patients who used the service.
- We saw separate local risk registers for different divisions and directorates that included the outpatients department, diagnostic imaging department etc. these enabled the Corporate Governance Group to understand the most significant risks and approve action to mitigate those risks.
- Risks were identified and addressed at the local level and escalated to the management when necessary, however this was not consistent across the trust and some departments of the hospital did not talk to each other across the various sites of the trust locations and at the trust wide level. Some departments did not have a close working relation nor cooperation with their counterpart at the Princess Royal University Hospital; for example never events in ophthalmology at this hospital was not shared with the ophthalmology department at the Princess Royal University Hospital.
- We were told the hospital had a risk register and managers were responsible for updating the register with their department's risks. Managers told us they were aware of the risks in their departments and were monitoring and managing those risks. We were provided with service-specific risks data associated with the outpatients and diagnostic imaging department. These demonstrate the monitoring of risks by the trust.
- Governance meetings were held monthly, which were attended by managers throughout the outpatients and diagnostic and imaging departments. There were also specialty governance meetings held for each division, but not for the whole outpatient and diagnostic imaging department. The outcomes from these meetings were shared with staff during staff meetings and monthly bulletins.
- There were regular team meetings to discuss issues, concerns and complaints across divisions and departments, however, some staff told us they were not given feedback from these meetings about incidents and lessons learnt by their line managers.

Outpatients and diagnostic imaging

Leadership of service

- There were clear lines of accountability and responsibility within the outpatients and diagnostic imaging department. Staff in all areas stated that they were well supported by their managers, that their managers were visible and provided clear leadership.
- Staff told us the hospital management team were accessible and visited their departments frequently. Supervisors and team leaders in the outpatients and diagnostic imaging department stated the main challenges to delivering care were maintaining an appropriate skills mix and the recruitment of suitably qualified staff.
- The staff who we spoke with told us that the director of nursing was always helpful and supportive as was the head of nursing for outpatient services. Staff said that they could approach their line manager and senior managers with any concerns or ideas. These conversations helped us to judge that the organisational leadership had created an open and collaborative approach across the trust. The trust had a program of 'Ward to Board – Go See Visits', where board members visited clinical areas to interact with staff.
- We found competent staff managing each of the clinical areas visited. Staff told us that they had confidence in the people managing them and that leadership within the outpatients and diagnostic imaging department was good.
- Senior staff were visible to them, although they appreciated that it was a big trust and, therefore, understood why they did not seem them often.

Culture within the service

- Staff told us that as the clinic sizes increased, space became a premium and that there was a culture within the organisation to try and find additional space by removing staff facilities. We were told that, on the cardiac clinic, the rest room facilities for staff had been decommissioned and was now utilised as an additional consulting room and this had caused considerable upset amongst the 26 members of staff. They said that they worked hard, often over their hours to accommodate an additional workload and were unhappy that the trust did not appear to value them by providing basic comfort facilities.
- There was a positive culture amongst staff. Staff were committed and proud of their work. Quality and patient experience was seen as a priority and to be everyone's responsibility. Radiologists and imaging staff felt well supported and there were good opportunities for professional development. Most staff supported each other and there was good team working within the departments.
- All the staff we spoke with at the outpatients and diagnostic imaging department told us the communication between different professionals was good and that it helped to promote a positive culture within the department. A consultant we spoke with told us they thought the communication between the different professionals was "excellent" and that it helped promote a "very positive working environment". Clinical staff we spoke with told us they felt able to raise concerns and discuss issues with the managers of the department. All staff we spoke with were professional, open and honest, and were positive about working at the hospital. Staff acted in a professional manner; they were polite, honest and respectful.

Public and staff engagement

- The trust newsletter, '@King's', for staff and the public, included information on changes taking place at the trust-wide level, such as how complaints were managed, information available to patients as well as significant events occurring and new innovation within the trust. For example, there was information regarding this inspection in the @King's magazine. Information was also provided regarding specific departmental changes.
- Staff we spoke with said they felt engaged with the trust and could share ideas or concerns within their peer group and with their managers. Staff were given trust messages directly via email, as well as through bulletins and on screen savers. Staff we spoke with said they felt well informed of developments and issues within the hospital and the wider trust in general.

Innovation, improvement and sustainability

- A trust dashboard for outpatients was available to aid managers and clinicians in making improvements to the service.
- Senior managers told us there were plans in place to deliver on the trust RTT target, complaints responsiveness, deliver improvement on cancer patient experience and quality of the patient experience in the outpatient and diagnostic imaging departments. They told us they were confident that the improvements

could be delivered. However, these improvement plans had not been fully implemented at the time of our inspection and not all staff were aware of these plans either.

- We were concerned about the delays in waiting times throughout the outpatients department. A senior nurse told us that one of the main challenges in the service were regular delays for patients' waiting times and the overbooking of clinics. However, there was no systematic action taken at the directorate level to address the situation.
- We were told by staff during the focus group meetings and this was corroborated during the onsite inspection by clinical staff that, due to the merger with Princess Royal University Hospital and Orpington Hospital, the trust inherited a shortage of staff across the nursing workforce and there had been few opportunities to implement innovative activities. Clinical staff were more concerned about maintaining the service and keeping patients safe.
- The imaging and diagnostics department were working on succession planning due to the merger and number of vacancies across all the trust sites.

Outstanding practice and areas for improvement

Outstanding practice

We found the following areas of practice to be outstanding:

- Trauma nurse co-ordinators tracked pathways and progress of trauma patients by visiting them daily on the wards. This role also included networking with other trusts and co-ordinating repatriation in advance
- The ED had an established youth worker drop in scheme operated by a London based organisation, which was effective in supporting vulnerable young people. Staff could refer young people to the service, although engagement was voluntary. The service also supported young people to access specialist services such as housing support and social workers
- The iMobile outreach service was innovative and there was evidence that it was producing positive outcomes both for patients and the critical care service as a whole.
- The pioneering specialist services in neurosciences, liver and haematology.
- The surgical directorate had set up the first national training for trauma skills course in the country. Training included the first multi-disciplinary fresh frozen damage control trauma training
- There were well-established pathways for pregnant women, which provided appropriate antenatal care, including access to specialist clinics for women with medical need.
- The foetal medicine unit provided interventions such as foetal blood transfusions, fetoscopic insertions of endotracheal balloons and laser separation procedures of placental circulations for complicated monochorionic twin pregnancies.
- The enhanced scanning programme included combined screening for chromosomal abnormalities at 12 weeks, with women given the results on the same day.
- The gynaecology and urogynaecology services offered a one-stop service with diagnostics carried out by a specialist doctor. The hospital was a regional training unit for this service and the unit was recognised as a gold standard unit by BCUG.
- For children with complex liver conditions and those who required surgery as neonates, staff developed and advocated the use of innovative and pioneering approaches to care.

Areas for improvement

Action the hospital MUST take to improve

- Review its facilities within critical care so that it meets both patient needs, and complies with building regulations. This includes bed spacing and storage facilities, particularly for IV fluids and blood gas machines.
- Ensure the trust complies with the Mental Capacity Act 2005 in regard to mental capacity assessments, particularly in the use of restraint, and that staff are trained and aware of their responsibilities.
- Ensure that the 'Five steps to safer surgery' checklist was always fully completed for each surgical patient.
- Re-configure the Liver outpatient clinic in order to avoid overcrowding.
- Ensure patients referral to treatment times do not exceed national targets.
- Improve patient waiting times in all outpatients' clinics.
- Review the capacity of the maternity unit so that women and their babies are receiving appropriate care at the right place at the right time.
- Implement a permanent solution to the periodic flooding following heavy rain of the renal dialysis unit and endoscopy suite areas.
- Ensure that current trust policy around syringe drivers affords optimum protection for patients against the risk of adverse incidents.
- Ensure the cover for the concealment trolley for deceased patients is in good repair and not an infection control risk.

Action the hospital SHOULD take to improve

- Fully complete controlled drug registers in the ED.

Outstanding practice and areas for improvement

- Complete safeguarding flowcharts for children attending the ED.
- Improve the number of senior ED medical staff trained in safeguarding children training at level 3 to meet Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings recommendations.
- Identify and mitigate risks to patients attending the ED, such as the development of pressure sores, falls and poor nutrition.
- Improve the uptake of training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguarding for staff working in the ED, medical care, surgery and children and young people services.
- Review staff understanding of the Mental Capacity Act in critical care and end of life care, to ensure their practice and documentation reflects the legislation.
- Develop guidelines for admission to the children's CDU.
- Review the area used for the children's CDU to ensure the environment fulfils the criteria for a ward area.
- Review the practice of undertaking adult consultations in the children's ED.
- Improve patient flow and waiting times in the ED, including their arrangements for making decisions to admit patients.
- Take action to improve the percentage of ED patients seen, treated and discharged within four hours.
- Consider ways of improving the documentation of patient safety checks.
- Improve attendance at mandatory training.
- Improve theatre utilisation and a reduction in cancellations.
- Improve the referral to treatment times.
- Improve patient flow through the surgical pathway.
- Consider ways of improving the discharge process by engaging with external agencies.
- Consider how staff can be made aware of the broader strategy for the surgical division.
- Review the systems for checking equipment to ensure that they are in date, in working order and stock is effectively rotated.
- Ensure it continues to review its critical care bed capacity so that it can meet its expected admissions.
- Review its patient record documentation to ensure it is fully completed and information between wards is seamless.
- Review its use of the Waterlow assessment to ensure those patients that need pressure relieving support, receive it.
- Review the nursing, consultant and junior doctor levels on the neonatal intensive care unit.
- Review the space between cot spaces on the neonatal intensive care unit as they were sometimes restricted or limited.
- Provide clear and up to date information on outpatient clinic waiting times.
- Monitor the availability of case notes/medical records for outpatients and act to resolve issues in a timely fashion.
- Review medical cover for gynaecology and obstetrics.
- Stop overbooking outpatient clinics including the liver OPD clinic.
- Share outpatients and diagnostic imaging performance data with clinical staff.
- Make sure the preferred place of care /preferred place of death or the wishes and preferences of patients and their families is documented.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All premises and equipment used by the provider were not: - suitable for the purpose which they are being used - properly used - properly maintained because; 1. The bed spacing and storage facilities, particularly for IV fluids and blood gas machines within critical care, did not meet patient needs or complied with building regulations. 2. The Liver outpatient clinic was overcrowded with patients. 3. The space capacity of the maternity unit was inadequate, which meant that women and their babies were not always receiving appropriate care at the right place and at the right time. 4. There was periodic flooding following heavy rain to the renal dialysis unit and endoscopy suite areas. 5. The current trust policy around syringe drivers used with end of life care patients did not afford optimum protection against the risk of adverse incidents. 6. The cover for the concealment trolley for deceased patients was not in good repair and was also an infection control risk. Regulation 15 (1) (c) (d) (e)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulation activity because; 1. The 'Five steps to safer surgery' checklist was not always fully completed for each surgical patient. Regulation 17 (1) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of patients was not always met because; 1. The hospital did not comply with national guidance regarding critical care patients' access to a dietician. Regulation 14 (2) (a) (ii) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider was not complying with regulation 11 (1) and (3) as the provider was not always acting in accordance with the Mental Capacity Act 2005 as people who use the service did not always have their capacity assessed before physical restraint was applied.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider was not complying with regulation 12 (1) and (2)(c) as persons providing the care and treatment to service users did not always have the qualifications, competence and skills to do so safely as they were not always aware of their responsibilities under the Mental Capacity Act 2005 and training rates for staff in the Mental Capacity Act 2005 were well below the trust target of 90%.