King's College Hospital NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

We carried out this unannounced inspection of medicine, including elderly care and children and young people at King's College Hospital to check on the safety and quality of care in those areas. In addition to these two core services, we inspected the well-led key question for the trust overall. This part of the inspection was announced to assist in arranging for the right people to be available to speak with us.

We inspected services for children and young people in order to check that learning from an adverse event had been acted upon and was now embedded in daily practices.

Our inspection of medicine, including elderly care was carried out to check if recent learning from inspection of this service at the trusts other locations had been shared and embraced in practices.

One of the triggers for our well-led inspection was as a result of our findings following recent maternity core service inspections. We wanted to review how joined up the governance arrangements were at a service level with the broader trust systems and processes.

We did not inspect the following services at King's College Hospital, which were previously rated requires improvement: Urgent and emergency services because we undertook a winter pressures inspection earlier in the year; surgery and outpatient, as we have been monitoring progress through our routine engagement. Maternity services have recently been inspected and the report has been published. We did not inspected gynaecology as we had no concerns or risks to respond to.

At our last inspection we rated the trust overall as requires improvement and we were checking to see if improvements we knew about would change the trust's rating.

Our rating of services stayed the same. We rated them as requires improvement because:

Our findings

We rated safe, effective, responsive and well-led as requires improvement and caring as good. We rated well-led at provider level as good, which is an improvement on the previous inspection.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

At King's College Hospital we rated 1 of the trust's 10 services as good and 1 as requires improvement. **In rating the trust overall, we considered the current ratings of the 8 services we did not inspect this time and those which were previously combined with another service**.

Our rating of well-led at the trust improved. We rated well-led as Good because:

- The trust had improved the strength, strategic focus and accountability of its leadership team. It was now led by experienced and knowledgeable executive and non-executives. They had developed objectives and plans to meet these and made sure the people under them carried out their responsibilities effectively.
- The newly developed strategy was directly linked to the trust's visions and values. The trust involved clinicians, patients and groups from the local community in developing the strategy. From this they had a clear plan to provide outstanding care for their patients, with financial and environmental stability.
- The trust had committed to be a clinically led organisation and had a model of clinical leadership through its care group structure. This was designed to improve outcomes and deliver high quality care for patients.
- Leaders worked with representatives of the wider system for health care provision in order to bring about improvements to patient experiences.
- Staff understood the service's vision and values. Most staff felt respected, supported and valued and were able to focus on the needs of their patients. Staff were clear about their roles and accountabilities. The service planned and managed services to meet demands, considering the challenges affecting health care provision, including inequalities.
- Leaders ran services well using reliable information and now had improved and effective governance procedures to oversee performance and quality. They engaged with staff, patients and other stakeholders to understand the experience they had to bring about positive changes.
- There had been significant improvements in risk management and in the corporate risk register and Board Assurance Framework. These were now dynamic documents, used appropriately by the Board and sub committees to review risks to delivery of the strategic and operational objectives.
- There were improved systems and processes to identify, mitigate and monitor risks, which were understood and implemented. The value of learning from adverse events and complaints was understood by staff and had improved.
- Leaders recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation. There were arrangements to support staff with mandatory safety and professional training.

However:

Our findings

- Safe staffing levels were sometimes difficult to achieve, despite best intentions. Junior doctors did not always have compliant rotas and on occasion inaccurate information about trainee doctors was supplied.
- Like the previous inspection, some staff reported not being listened to and were frustrated that concerns, including cultural issues raised were not responded to as they expected.
- Board members recognised they had work to do to improve diversity and equality across the trust and at board level. The Workforce Disability Equality Standards were not being met and a few Workforce Race Equality Standards needed further work to be achieved.
- There was no clinical lead for sepsis.
- Outcome measures to improve the action areas related to the staff survey were not stated for all care groups.
- The incident process and complaints handling did not always get completed as quickly as expected. Learning from incidents was not always shared across different care groups.

How we carried out the inspection

This inspection was overseen by Nicola Wise, head of hospital inspection and was undertaken by inspectors, an inspection manager and specialist advisers for the core services. Additionally, we had specialist advisers for the well-led inspection.

For our children and young people inspection, we spoke with 25 parents and 6 children, as well as over 30 members of staff, including: nurses; student nurses; matrons; play specialists; clinical nurse specialists; doctors; consultants and support staff. We observed care and treatment being provided and reviewed 26 patient records. After the site visit, we interviewed the clinical director; nursing leads; the acting general manager and the deputy clinical director and patient safety & governance lead.

During our medicine core service inspection, we observed one nursing shift handover, observed three multidisciplinary board rounds and sampled four patient records. We spoke with 31 members of staff, including: nurse staff; physiotherapists; discharge coordinators; consultants; registrars; ward managers and senior leaders in the division. We spoke with 14 patients and 5 relatives.

For the well-led inspection, we spoke with non-executive directors and 32 members of the executive team, as well as union representatives from staff side. We spoke with several staff who worked in clinical areas who contacted us to raise matters of concern. Following up on these matters, we visited one department in December 2022 and spoke to several staff. We reviewed a range of formal documentation provided during and after the site visit and considered information shared with us by staff before and during the inspection period. We had discussion with external stakeholders and sought information from Healthwatch.

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

What people who use the service say

Our findings

People said staff mostly treated them well and with kindness and supported them to make informed decisions about their care. Some patients told us staff were sometimes not as caring towards them and did not attend as quickly as they would normally when staffing levels were low. Most patients told us staff made sure they and those close to them understood their care and treatment. Patients and relatives told us staff gave up to date information about their medicines and treatments and explained things in a way they could understand.

Outstanding practice

We found the following outstanding practice:

- The model of link consultants for infection prevention and control in each care group had improved the Infection Prevention and Control teams' approach to reducing hospital acquired associated infections.
- Care of the elderly consultants attended monthly meetings at local care homes to support GPs. They were available for contact by the care home and GPs for expert advice.
- The service had conducted the only living related bowel transplant in children within Europe.
- The trust was pioneered the use of rectus muscle sheets to close abdomens.

Areas for improvement

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

King's College Hospital Children and young people

- The trust must ensure they manage staffing levels in children and young people's services, so they ensure patients safety is not compromised and that staff can respond to patients in a timely manner.

Action the trust SHOULD take to improve:

- The trust should review and improve the practices of the human resources team to enable its own policies/ procedures to be enacted promptly.
- The trust should consider how it may improve the accuracy of information related to trainee doctors and continue to review their rotas to ensure they meet required standards.
- The trust should improve opportunities to listen to the views of its staff and how it considers information expressed by those individuals.
- The trust should have a lead clinician for sepsis, so the profile of this matter remains high on the agenda.
- The trust should continue to work on the Workforce Disability Equality Standards and Workforce Race Equality Standards to improve its achievement of expected targets.
- The trust should ensure care groups identify target dates for specific actions within the staff survey action plan.

King's College Hospital Medicine including elderly care

Our findings

- The service should ensure that fridge temperature variations are escalated and addressed, as per policy.
- The service should ensure that patients risk assessments are recorded in a single accessible location.
- The service should ensure that each ward meets safe staffing levels for nursing staff.
- The service should ensure staff are up to date with statutory and mandatory training.
- The service should continue to work with system wide partners to ensure timely discharge of patients.

Is this organisation well-led?

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable for patients and staff.

The executive team had been through several changes since the previous inspection. The soon to retire chair demonstrated strong, professional and considered leadership. They were suitably skilled, visible, approachable and had a full understanding of the strategic issues facing the trust. The chair understood governance, risk and performance and knew what was happening in the trust. A succession plan was in place for the chair role. The chair spoke of the importance of the trust continuing to find issues out for itself and not to be over-confident.

Non-executive directors (NEDs) spoke about the improved stability of the executive team, with an openness and transparency in evidence. Overall, they were very positive about the executives and indicated the pandemic had demonstrated the strength of the whole team top to bottom.

The organisation had transformed leadership of the Princess Royal University Hospital (PRUH) in terms of investment, executive leadership and improved facilities. There was one executive director for the PRUH and south sites, who led a site-based leadership team of 6 directors. The executive director was a voting Board member. There were 5 whole care groups with 4 care groups beneath, including those related to medicine and surgery. We were told by NED's and others the internal barriers that existed across the trust sites had been broken down and now there was more collaborative working.

There were 8 executive directors at King's College Hospital, including the chief executive officer (CEO). Site executive structures had given clear identity and ownership of each site. Staff identified with where they worked and had strong site directors working well together, which meant silo working had been reduced.

The chief executive knew the strengths and capabilities of the executive team and how individuals complemented one another in their responsibilities. He had considered different attributes and gave roles and responsibilities through corporate portfolios as best suited to these. We reviewed files of the executive team and non-executives and saw evidence of the required checks of their suitability to hold their positions. Several appraisals were seen, and we were told all executives had been appraised this year. Corporate appraisal rates were at 88% with a target of 100%. The whole trust rate was 90.4%.

Our findings

The trust aspired to be a clinically led organisation. They had developed a model of clinical leadership through the care group structure to deliver safe effective high-quality services. There was a clear organisational structure setting out the leadership arrangements for the various care groups, of which there were 27 in total. Reporting lines were clear and role holders understood who their line managers were and who the associated post holders were. Leaders were aware of the priorities of the trust, including elective recovery and cancer targets. The trust had designated people for these areas.

The acting director of corporate affairs oversaw the governance of the Board and the sub committees. They were responsible for statutory functions such as: re-appointments; registers; compliance; internal audit and health and safety. The latter was a move away from the traditional model of sitting with capital and estates.

Relevant sub-board committees operated within the organisation, with appropriate reporting lines and clear programmes of work. We were told communications and interaction with the leadership team were positive, open and purposeful. The trust Board was described as: “very supportive around safety and quality” and recognised the value of progress.

Site chief executives had responsibility for their care groups, some of which were cross-site. Their roles were slightly different, depending on involvement with external stakeholders. They were accountable to the chief executive, escalating for example, significant organisational or reputational risks. They met 2-weekly with the chief executive formally and informally in between. The non-executive team were highly experienced and worked closely together. They told us governance had improved, and better data provision was one of the factors which had helped.

The CEO chaired the South East London Acute Provider Collaborative, and was the Acute Care Partner Member of the South East London Integrated Care Board. The Site Chief Executive for King's College Hospital was a Board member of both Lambeth Together and Partnership Southwark.

We spoke with stakeholders who provided positive reflections on leadership of the trust, and how the improved clinically led model had helped to bring the two main sites together. One comment made was the Princess Royal University Hospital was “no longer an afterthought.”

Individual members of the executive team spoke of feeling part of a team and whilst the organisational structure was complex, it was the right one for leading services. Stability of the executive team had been welcomed. The health and safety lead told us there had been a positive change since the new leadership, with a closer working relationship with the executives. The reporting lines had changed for their role, which they said positioned them and their team to perform their responsibilities fully. They added the move to corporate management had given them the ability to meet legal requirements confidently. The team identified gaps at the trust and was able bring concerns to the fore, ensuring the trust was now compliant.

There were several different levels of education offered to leaders and staff in general, including doctors. Following implementation of the clinical model, the trust set up a series of half day sessions. They were led by the chief medical officer and the lead for professional practice, with support from the educational team. Kings’ kaleidoscope (a training and development platform) was launched, which had number of strands led by the organisation development team. One strand had a focus on leaders of the future related to what a clinically led organisation should look like and making everyone aware of their ability to contribute to clinically led organisation.

Vision and Strategy

Our findings

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood how they contributed to the achievement of the strategy and how progress would be measured.

The trust had a clearly defined strategy, developed with the involvement of over 4,500 staff and stakeholders, including the public. At the heart of the strategy was the vision for King's to be BOLD, with 4 strands: Brilliant people; Outstanding care; Leaders in research, innovation and education and Diversity, equality and inclusion in everything they did. Detail within the strategy showed what would be done to bring the plan to reality. The director of strategy was passionate and positive in their discussion and had a clear understanding of the roll-out, governance around it and monitoring. They were responsible for applying the strategy, building in innovation and partnerships with King's Health Partners. They had 5 staff and reported to the chief financial officer.

There were additional strategies set at service level, for example; Infection Prevention & Control Strategy for 2021-2024 and the People and Culture Strategy, which included freedom to speak up and a focus on the diversity of their staff and an inclusive culture. The Pharmacy services had set out their action plans with priorities mapped under King's BOLD Vision for 2022-23. The detail clearly stated how they would contribute to the trust's strategic aims. The chief pharmacist saw medicines as part of the team and critical to patient care and believed very strongly that they contributed to the success of the trust's strategy.

The director of strategy attended trust Board meetings. They also worked with the Integrated Care Boards (ICB) and on a new Integrated Care System (ICS) strategy and in the acute provider collaborative. NB: NHS England established 42 statutory integrated care boards (ICBs) on 1 July 2022, in line with its duty in the Health and Care Act 2022, (replacing Clinical Commissioning Groups.) This was as part of the Act's provisions for creating integrated care systems (ICSs). Integrated care systems are partnerships of NHS bodies and local authorities, working with other relevant local organisations. They come together to plan and deliver joined up health and care services to improve the lives of people in their area.

Each ICS has an integrated care board, which is a statutory NHS organisation responsible for developing a plan in collaboration with NHS trusts/foundation trusts and other system partners for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the defined area.

Members of the leadership team worked with external stakeholders and system partners to try and address some of the difficulties experienced in patient flow through the services.

A commitment tracker detailed the annual delivery plan and monitored against the 20 actions, including that related to health inequalities. The delivery plan was updated in October 22 at the trust Board meeting, via the Strategy, Research and Partnership Board Committee.

Culture

The executive team felt respected, supported and valued and endeavoured to foster the values of the trust in all they did. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and tried to provide opportunities for career development. Whilst the service promoted an open culture where patients, their families and staff could raise concerns without fear, staff who raised matters did not always feel heard and of suffering detriment after raising matters.

Our findings

The trust was the first in England to appoint an equality, diversity and inclusion (EDI) director at executive level. This demonstrated the trust listening to what staff were saying, even if there was more to do to create an inclusive culture. The EDI director had a responsibility for planning and delivering a systematic and sustainable culture across the whole organisation. The role holder reported directly to the chief executive, meeting with him every three weeks. They had a team consisting of 2 deputies, 1 for workforce and 1 for patients and community. There were 2 site representatives at King's hospital and 2 at the PRUH and south sites and 1 for staff networks.

In addition to support from the chief executive, the EDI executive director was provided with support through a mentor and a coach. They treated the role as one of transformation and although expectations were high, it was acknowledged that it would take time to change. To get a view on the trust's position, the EDI executive director had spoken to staff, with over 400 conversations in 60 days. Staff spoke for example, of their "despair and hope." The initial aim was to raise awareness, creating processes to embed change and supporting the executive team to champion EDI.

The Workforce Race Equality Standard report for 2021/2022 showed 3 of the indicators had not been met, although these were improving. This included: Relative likelihood of White presenting staff accessing non-mandatory training and continuous professional development (CPD) compared to staff from ethnic minority groups; staff from ethnic minority groups believing King's provides equal opportunities for career progression or promotion and staff from ethnic minority groups experiencing discrimination at work from manager/leader/ or other colleagues. The latter 2 results were better than the previous year, but the first measure was worse, 0.88 in 2020/21 to 1.04 in 2021/22. We noted the trust had reduced the rate of disciplinary cases involving staff from ethnic minority groups in 2021/22 from 70% down to 60%. There was work still to do in this area, although the results met the target for this measure.

Not all staff shared their ethnicity, particularly at Band 5, where 13% (344) had not declared their ethnicity on the database. This was a 9% increase from the previous and although the trust had a 1% decrease in overall staff form ethnic minority groups, they broadly reflected the communities in the local areas.

Recruitment processes included shortlisted through blind process, although the report indicated that only 1 in 10 staff from ethnic minority groups shortlisted candidates were appointed compared to almost 2 in 10 White shortlisted candidates. The data suggested the candidates who did not share their ethnicity had a better chance of appointment, with an almost 3 in 10 conversion rates.

We reviewed the trusts Model Employer Plan, which started in 2018. This set out ambitions for the remaining period up to 2028. Revised information had been stated with respect to targets for people from ethnic minority group recruitment at various staff grades. This linked to a Race Equality Code Action Plan, which clearly stated actions and priorities, with RAG ratings alongside each activity. The trust had reported on their Workforce Disability Equality Standards for 2021/2022, of which only 2 of the 12 standards had been met. Six of the 13 measures had worsened, including for example, staff satisfaction down from 32.7% to 30.2% and reasonable adjustments – 66.5% down to 64.2%. Five measures had improved, with 1 not being applicable and 1 unchanged.

Work had been done by the trust related to EDI. The strategy published in July 2021, clearly stated the importance of diversity, equality and inclusion. The road map for EDI had been developed and was launched in May 2022. This included four key areas complementing the People and Culture Plan. The equality, diversity and inclusion director told us the road map needed to be brought to life, the focus being on "inclusion, not race."

There was access to a trust-wide learning and development, which included for example: leadership and skills boosters, as well as national leadership academy studies. This programme recognised the importance and value of investing in staff at all levels, including those seeking to progress their careers.

Our findings

The Chief Medical Officer (CMO) reported to the CEO. Medical staff had a professional line of responsibility to the CMO through the site medical directors. There were corporate medical directors who reported to the CMO. The site CEOs set objectives and carry out appraisals for the site medical directors in conjunction with the CMO.

The trust was very keen to create and embed a culture which encouraged staff to speak up. The freedom to speak up guardian role, (FTSUG), which was part time in 2019, had increased to full time hours in 2020. They were very knowledgeable and keen to promote the value of speaking up across the trust. At the time the FTSUG role was challenging in terms of capacity, covering all sites and they were aiming to have a deputy to assist them. Despite this, they were able to describe where they had assisted in making improvements for the individual raising the concern.

One of the priorities of the FTSUG had been to increase awareness of the importance of speaking up. Information was provided at the new employee induction and there had been a focus on international nurses and doctors. Training had been delivered to the trust Board too and they were said to be "fully supportive of having a deputy." Daily bulletins with contact details also helped to raise the profile, along with walking the floor. The FTSUG had an email in-box but told us most people contacted them directly. Where the issue was human resources related, they tried to direct staff accordingly.

An annual report was produced by the FTSUG and we reviewed the report for 2021/22. We noted the proportion of staff who felt it was safe to speak up at King's was 54%. For the period of the report 194 speak up cases had gone through the guardian. This was a 32% increase on the previous year. Of these, 37 (19%) related to workplace culture, 47 (24.2%) to patient safety and quality and bullying and harassment 39 (20.1%), for example. The trust was in the top 25% for reporting concerns nationally, which was a good sign. It was noted nursing followed by allied health professionals were the top staff groups speaking up. When split out, midwives were noted to have an increase of 400% for raising concerns. The trust indicated that historically this group had been less likely to speak up, so they were pleased this had improved.

We had been made aware from a group of staff of a matter which they said impacted on them directly, as well as the patients they treated. They felt they had not been listened to and issues had not been fully considered in the process of planning and agreeing a change to the working environment. We were told the matter had gone on too long and not been handled as well as it could have through the human resource (HR) processes. This matter was discussed with several members of the executive team, each of whom was aware of the situation. We heard the background to the matter, rationale for the change and detail related to the handling of the situation. There was acknowledgement of having stepped outside the normal process in trying to resolve staff concerns.

Human resource processes were criticised by some staff. This included sharing of confidential information, which had resulted in hurt and ongoing worry to individuals, although examples of the latter were not shared directly by staff to us.

We had been made aware through direct contact from staff of concerns related to the culture in 2 clinical areas. Leaders were aware of these matters and were able to demonstrate how these had been responded to, as well as what work was still to be done to bring about changes in behaviour and professional relationships. We were made aware internal investigations had been carried out in one department, in addition to independent reviews. Feedback from whistle-blowers regarding the internal processes was they had not been wholly objective or appropriate in the circumstances.

Several staff contacted us after our site visit. They expressed concerns about professional working relationships, issues of sexual harassment and poor behaviours from a minority of male staff, which they considered should have been escalated externally. We visited the area in December 2022. We spoke to a staff from different disciplines in the relevant department and were not able to substantiate these claims, although there was an awareness of some professional disharmony between a minority of staff. The trusts had investigated matters, where information had been reported and

action had been taken to better understand the issues of concern. This included appointing an external person to undertake a formal investigation earlier in the year. We reviewed the redacted report from this, which made clear what the issues of concern were for staff. Many of these matters had been going on for some time and had not been addressed by previous leaders. The recommendations made from the independent review were clearly stated and work had commenced to address the areas of concern. We were told information from the report had been shared with the Board and non-executive directors. A meeting was planned to discuss further.

The CEO told us they would have no hesitation in escalating matters to other agencies in the event of evidence being provided. A clinical director from another discipline had been charged with overseeing cultural changes in one clinical department. They discussed progress with us and the ongoing work in this area, recognising this would take time and would rely on the whole staff group participating. Actions taking place included the use of the Maintaining High Professional Standards in the NHS (MHPS) process to investigate and assess any risks related to adverse behaviours. Although we acknowledged the executive team were taking these issues seriously, there remained a risk of staff losing confidence in leaders, should these expected improvements not materialise.

Union representatives told us executives were approachable and responsive, but felt middle managers were less so. They said training in staff management may be helpful to some of the middle managers to assist in dealing with matters efficiently. Union representatives spoke positively about the well-being team and changes which had taken place related to equality, diversity and inclusion.

There was a chief information officer who sat on the boards of both partner trusts and they were involved in the arrangements for the new electronic patient record. The chief digital information officer spoke positively of the change in culture across the trust, driven by greater unity in the executive and non-executive team. They told us there was greater presence and a sense of disciplined behaviour and pride. Gold command during Covid-19 had helped with leadership visibility and the improved communication which came out of such meetings. Having an executive team at PRUH and south sites had increased a level of connectivity and they said staff felt more cared about. This was a theme echoed by other members of the executive team at PRUH and south sites.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. The executive and non-executive team were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The non-executive directors (NEDs) told us governance arrangements had needed to be restructured and this had been done with what was described as “good results.” The trust had increasingly been recognised as a local facility, which fitted well with the international and local populations. They felt the trust was positioned to attract the next generation of world class leaders. The trust received a formal report from the Good Governance Institute, which identified recommendations for effective governance within care groups. Staff from each care group had completed Good Governance Institute Training and workshops. During the workshops, staff self-assessed their own governance maturity against 8 headings, 1 of which was risk management, between June and August 2021. This programme of work continued until March 2022 and approximately 80 staff including; clinical directors; heads of nursing; general managers, and governance leads participated in this.

In addition to the above, the trust Board had training and ad-hoc sessions were also provided to 117 staff by the director of quality governance, head of risk and/or risk and governance manager. The trust had 5 ‘train the trainers’ for this area.

Our findings

One of the triggers for our well-led inspection was as a result of our findings following recent maternity core service inspections. We were keen to understand how some issues we identified had not been picked up by the local leadership and internal governance systems. Senior leaders expressed disappointment in the findings of the recent inspection and immediate action had been taken to improve the service. It was acknowledged as a lack of attention to routine practices and expected standards, which the trust sought to rectify immediately. The focus was on putting something in place, which was more robust and created trust, with the right support. Learning from this had been used to launch a campaign on essential standards. Maternity was represented on the board, keeping a high level of oversight and challenge as needed.

Maternity governance arrangements included reporting to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. Data from MBRRACE was reviewed twice a year at the Women's Health Board. Further, all unexpected neonatal deaths (or transfers for cooling) were also referred to the Healthcare Safety Investigation Branch (HSIB). Where trends were identified by HSIB, including trends relating to location, the trust received a notification letter with a requirement to respond with an action plan. These reports were shared with CQC.

The director of quality governance had proposed to change the previously used ward to Board quality assurance framework to a new system. In July this year the trust changed to this new software. It was expected to improve oversight and management of quality; patient safety; compliance and accreditation processes through monitoring and measuring of care quality. The aim of this was to drive improvement and support quality assurance. The framework covered audits related to for example: hand hygiene, infection control and medicines management. Since the introduction of the system audit volumes had increased, although there was no comparative data from the previous system to understand the actual figures. We reviewed information showing how the audit tool had been used to address issues we had found at the recent maternity inspection.

Governance arrangements related to the ward to Board tool were clearly set out and responsibilities stated for the ward managers; matrons; heads of nursing; clinical directors and general managers. Minutes were taken for respective committees, several of which we reviewed. We found these to be structured around the agenda and informative in detail. We reviewed the Audit and Quality Performance and People Board Sub Committee minutes and noted these to be detailed. They demonstrated agendas which covered items on quality, safety and patient experience, and the level of discussion was relevant to the assurance sought. The Audit Committee minutes demonstrated an overview of the board assurance framework (BAF), risk management, assurance and an overview across the Board committees. This included reporting from internal audits.

Audits were reviewed at the monthly Quality Assurance Group. Care groups met on a monthly basis within the Quality Governance Committee. This was chaired by the clinical director. Information related to for example, complaints and incidents were reported upwards to the site chief executive and then the trust chief executive.

The trust Board received assurance about financial control and delivery through 3 principal sub-committees: audit; finance and commercial; and major projects. The chairs of these committees had experience of senior financial leadership in large multi-national organisations as well as in the NHS. Their experience, along with that of the chief financial officer (CFO) had led them to set clear expectations about reporting and performance, supporting the development of a financially aware culture in the trust.

The trust had an Infection Prevention & Control Committee, (IPC) with various committees feeding into it, such as those related to ventilation, water and decontamination. Escalation was to the chief nurse, where immediate safety or risks

were identified. The director for infection, prevention & control (DIPC) provided a performance report on a half yearly basis and an annual report was taken by the chief nurse to the trust Board. The DIPC was the senior infection control nurse and it was notable that there was no other regular attendance from a deputy or associate chief nurse for IPC at Board level.

We were told the infection prevention & control (IPC) team had spent time revising the integrated quality report so it included as many related areas as possible, such as estates. This was aimed at getting the right information reported and recorded. Care groups presented on rotation to the Infection Prevention & Control Committee, covering a range of topics, such as intravenous lines or hand hygiene, what was going well and not so. They told us it was hard to deliver a corporate message related to IPC with so many care groups.

The executive director for equality, diversity and inclusion (EDI) met regularly with the NEDs and sat on the Performance and Quality Committee. There was a section for EDI on the executive report and they had a slot to present an update. The EDI delivery group had standing agenda items at the Quality People and Performance meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The risk manager reported to the director of quality governance. They had a team of 1 Band 8A and 1 Band 6, and for the incident management system; 1 Band 8A and 1 Band 5. The risk manager told us there had been a refocusing on what risk looked like. Recently, there had been a better split of proactive and reactive risks and refocus of people's attention to the risk register, so this was not a "dumping ground.

The Board of Directors had approved the Risk Management Strategy for 2021-23. This outlined the key principles along with the trusts' framework and processes for effective risk management. Responsibilities, accountabilities and reporting lines were clear within the strategy. The Executive Risk and Governance Committee was responsible for ensuring the strategy was delivered and risks management continually improved. A Risk Management Policy provided information to support staff in relation to identifying, evaluating, actioning and closing risks.

In addition to the corporate risk register there was a site risk register. This described issues related to several areas or the whole trust, which could not be mitigated by care groups or corporate services. Site risk registers were managed by the executive manager for the location. Risk registers were also owned and overseen by department or specialty group and care groups.

The acting director of corporate affairs was responsible for the Board Assurance Framework (BAF). They did the check and challenge with the executives and took the minutes at Board meetings. The BAF identified key risks which may impact on meeting the trust's strategic objectives and targets and was monitored each quarter. An annual workshop was held to identify new risks at strategic level.

We reviewed the corporate risk register and noted entries ranged from as long ago as 2011 up to more recent months this year. The trust had started a programme of reviewing the longer standing risks and either closing or revising these depending on the evidence and actions taken. Risks were scored and red, amber and green (RAG) rated. A summary of the controls was present, as well as the next review date.

Our findings

Information provided to us during the inspection showed there were 683 open risks on the trust risk register as of 21 October 2022. High risks had increased by 12 to 160 in total and there were 404 moderate and 119 low risks. The information showed how many risks had been opened and closed for the period 1 July to 30 September 2022, the latter of which was 41. We noted a large proportion of red risks related to capital estates and facilities. It was clear from the information that much work had been done to improve the oversight and management of risks from open to closure.

Access to risk registers and the reporting system used to be just for the Patient Safety Team but this had changed since the last inspection. The director of quality governance explained that locally risk registers were entered onto the incident management system, which could be added to as needed. The care groups could view these risks and flag high risks to the executive team. Updating of risks was a responsibility of individuals, groups or committees, according to designated accountabilities. The risk manager was able to access the dashboard to check what had been added, and whether risks were graded correctly. The Risk and Governance Committee reviewed, updated and escalated to the BAF, where risks were identified as impacting on the trust's strategic objectives. They reviewed high level risks each quarter and moderate risks 6-monthly. Corporate risks were reviewed every month. Minutes of the Risk and Governance Committee reviewed by us confirmed the range of information discussed, including risk registers and the BAF.

There was recognition that more work was needed to increase the idea of risk ownership, at the clinical lead level, such as matrons. Presentations on risks were made by the risk manager and their aim was to make access to the risk register available on the reporting system to everyone, once they have done their e-learning. The risk manager said it was difficult for one ward to know what other wards' risks were, and therefore looking for themes was less easy.

Service level oversight and governance was in place - for example, the chief pharmacist told us of the arrangements related to governance, assurance and monitoring. They understood the risk related to medicines and had a plan to mitigate these and address them.

Leaders were aware of the organisation risks as well as those related to the wider healthcare economy and systems. Actions were in progress to address risks related to service delivery and patient flow, for example, delayed ambulance handovers at PRUH and the launch of an extended discharge lounge. There was a good level of confidence in the Boards awareness of risks and the risk manager told us the NED's challenge was "very robust and knowledgeable." We reviewed the Winter Pressures Operational Plan. It was noted this detailed the full arrangements to run in conjunction with usual business activities for the months of November 2022 and up to 31March 2023. The actions were set around 8 key objectives as set out in the NHSE planning guidance and focused on each service areas, as well as specific responsibilities and duties.

Leaders were focused on performance related to patient activity and throughput. Elective activity, referral to treatment and long waits data was fully considered as part of managing risks, such as season demands or disruptions. We saw data up to the 17 November 2022. This showed 104-week waiters have been reduced to zero and above 78-week waiters were on track to eliminated by March 2023. Elective inpatient, new outpatient and outpatient follow ups were below the trust target and appeared to be getting worse over time. We saw day cases activity was above the trust target. The trust was able to see which specialty services were behind or ahead on activity.

The trust had systems and processes, such as risk assessment monitoring tools and the electronic reporting system for negative events. A designated team for health and safety oversaw this part of risk management. It was recognised that a greater understanding was needed amongst staff, particularly middle managers, who they suggested were not familiar with their responsibilities and lacked knowledge about basic things. Although there was an electronic training

programme for staff, this was a tick box exercise. Staff needed to understand why and ask questions and they believed this could be strengthened by staff training being given by the health and safety team, which had now been agreed. Health and safety would be providing face to face training, where they could test out knowledge, with a refresher 18 months afterwards.

The health and safety manager hoped to introduce more detailed internal audits and trend analysis, which they told us would be very useful. This would help the trust to look at itself more broadly, rather than seeing success and disasters, not the in between.

Board and senior executive leaders evidenced their focus on achieving, and maintaining, financial sustainability. This focus was reinforced by financial planning and reporting processes, which had reduced the risk of adverse unplanned financial variation; and had encouraged care group teams to adopt more efficient and effective practice through benchmarking. The trust had been successful in the management of its supply chain and told us that, despite inflation, it had reduced the costs of supplies by 1%. The trust had a partnership with a neighbouring organisation to improve its management of its estates and facilities, including contract compliance.

The trust told us they were hopeful it had moved beyond its period of exceptional financial challenge; and that it, with regulators and partners, now had higher assurance about the operation of financial processes and control. The improvement was said to be as a result of stability in the leadership team.

We received information confirming NHS England had recently approved the recommendation that the trust should move from segment 4 to segment 3 of the NHS Oversight Framework. This meant they no longer needed help from the Recovery Support Programme. (The System Oversight Framework (SOF) is designed to help NHS providers achieve and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding – segment 4 was a requirement of intensive support)

The Patient Safety Committee had a Harm-Free Sub Committee chaired by the medical director where issues were quickly identified, analysed and where necessary considered as part of thematic reviews. New surgical techniques or the use of new surgical equipment was considered by the New and Novel Procedure Committee, which fed into Patient Safety Committee Harm-Free Sub-Committee, before agreeing to go ahead.

Risks related to infection prevention and control (IPC) were overseen by a team of staff of varying roles, including; 2 non-nurse practitioners; nurses and 3 staff responsible for surveillance, as well as microbiologists. The latter had 2 vacancies. Roles and responsibilities were split between the team and included safety and risk monitoring activities. Examples of these were; antimicrobial stewardship and monitoring infections. They also managed the bladder and bowel service and vascular access team and provided training. A named consultant was available in each care group to link with, should the need arise.

The most recent surveillance data for infections showed the trust had gone over the expected target, although it was not known the reasons for this. It was pointed out to us the low number of single rooms and older buildings presented a challenge in minimising infection risks. The quality improvement team had been asked to focus on various areas, including the avoidance of inserting patient catheters where not needed and early removal of these.

We asked the IPC representatives about their confidence in the training on sepsis within the trust. They told us they were not involved in the training but were aware the training was on the Learning Education Appraisal Platform (LEAP) system for early recognition. Although there were 2 staff with an interest in sepsis, there was no designated clinician leading on this.

Our findings

Identifying and responding to safeguarding risks was a high priority of the trust. Recent changes within the safeguarding team had taken place, with newer leadership personnel for both children and adults. In terms of visibility of the service, the team had been looking at a 7-day service. They now had a trial on-call service to ensure a level of safeguarding service advice was available.

The Safeguarding Committee met quarterly and received and reviewed information from the respective safeguarding teams. The committee was chaired by the executive lead and was attended by a range of staff including representatives from care groups and designates from local authorities and partnership board. There were separate reports for adult and children safeguarding data, with an intention to have a joint report. The adult report had only been populated for the last year and went to the trust Board the previous day.

The safeguarding leads had looked at cross-site cover and reporting trends and had already identified differences in reporting. They had recognised a piece of work needed to be done around mental capacity act and liberty protection safeguards (LPS). A subgroup had started to review the structure and an LPS steering group had been set up too.

We reviewed the trust Sustainable Healthcare for All - a Green Plan for King's 2021-2026. The plan clearly set out the organisational focus on three key areas, including: improving air quality, reducing avoidable single-use plastics and reducing carbon, water and waste. We noted the plan was aligned to the Greener NHS Sustainable Development Assessment Tool (SDAT), wider United Nations Sustainable Development Goals (SDGs).

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Integrated quality reports were prepared by the Quality Governance Team. The information collected and presented related to aspects of patient safety, including but not limited to incidents; never events, patient safety alerts and safeguarding referrals. However, there was little in terms of trend analysis. We saw evidence of actions taken and learning related to areas where actions had been identified. This included improvements related to Maternity, Dermatology and Paediatric Critical Care Outreach. Data within the integrated quality report focused on: quality audits; outstanding care; responsiveness to patient complaints, whether the trust was delivering effective care and treatment and leadership. The continuous quality improvement team (CQI) identified targets for the next quarter based on the information arising from the report.

The trust Board received integrated performance reports for key local and national targets. This included those related to: patient waiting times; emergency care standards; quality; patient experience and cancer targets. Information fed into this from the Quality, People & Performance Committee. (QPP) Outcomes were RAG rated and trends were clearly stated. Trust Board minutes demonstrated the report and data within was discussed along with the financial information.

We noted the integrated performance reports also provided monitoring data in respect to the workforce, covering such areas of appraisals; mandatory training; vacancy rates; turnover and sickness absence. This information enabled the executive team and trust Board to consider where additional actions may have been needed.

Our findings

The chief digital information officer was also the Senior Information Risk Owner (SIRO) and had a responsibility to implement and manage information risks within the trust. They chaired the Information Governance Steering Group and reported into the Governance Committee. A report was provided to the trust Board every 6-months about the workforce. This included information on new starters and leavers. They reported there being a strong process to retrieve equipment and trust passes prior to leaving the organisation.

Training in information governance was currently 93.5% against a target of 95%. The standard was expected to be achieved by Christmas, and there was a strong campaign led by the three responsible leaders to meet this.

A member of staff alerted us to a matter which related to the remote printing of patient sensitive data at an area within the trust. This material was not always collected immediately by someone on site and had on occasion been left, despite a member of staff escalating and taking action to secure it. However, staff did not then deal with the material, which included letters to patients. We escalated this to the trust. They responded with the immediate action taken and followed up with a detailed summary of the matter and how the issue would be mitigated.

Executives told us of the plans and progress on the new electronic patient record, which was expected to be put into the trust in 2023. Much work had been done around this through a joint leadership team working with another London trust, as well as discussion and persuasion of the integrated care system to embrace the new platform. The chief digital information officer was also the lead for south east London ICS, with a remit to ensure there would be the right interface and digital balance across sites.

Engagement

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

Our discussion with external stakeholders provided assurance of positive engagement from the trust and members of the executive team. They reported improved working relationships since the current chief executive came into the role. We were told of collaborative working on system and day to day operational issues, with examples of mutual support, particularly during the pandemic. There had been improved engagement and consideration of issues, not just those that affected services locally but across London.

The site chief executive for PRUH also held the role of Convening Chair for One Bromley and was involved with relevant stakeholder groups such as ‘One Bromley.’ One Bromley brings together local NHS health providers, the council, commissioners and voluntary sector to work together to deliver better care for all in a more formal manner. We saw minutes of Borough Partnership Meetings and these described partnership discussion and actions. An example of focus was the issue of loneliness and there was an action plan to improve this for 2022-2026.

There was a joint committee for the Acute Provider Collaborative (APC), which was strongly focused on quality and safety. (All trusts providing acute health services are required to be part of 1 or more provider collaboratives as part of new ways of working across health and care in England. The aim being to work with both NHS partners and others such as local authorities, to use resources in the best way for all patients, and develop consistently high-quality services, for example; cancer or diagnostic services.) Minutes of the south east London APC showed discussion related to governance, performance and working relationships across the patch.

Our findings

The IPC team worked collaboratively with the integrated care system (ICS) and attended the south east London IPC meeting. They also linked with care homes where needed and had met recently with the Integrated Care Board (ICB) regarding a care home. We saw evidence of a public meeting with the ICB, in which information was set out, for example; system and purpose, governance arrangements and partnership working.

The trusts patient experience director reported to the deputy chief nurse. There were approximately 30 people within the patient experience team. They were responsible for patient advice and liaison service (PALS); spiritual care and chaplaincy; user involvement team; voluntary teams (almost 780 active volunteers); patient feedback; complaints into quality improvement (QI) and the patient experience.

We were told the patient experience team were recruiting 10 experts by experience for evaluating outcomes and they would be working with Healthwatch. It was impressive to see the patient experience strategy included in the trust strategy under the 'Putting Patients First' strategic objective, and the commitment to person centred care and co-production. Experts by experience were to assist with implementing co-production and what this would look like from a patient perspective. Really good work had been done with patients around communication, for example, Ophthalmology department patients were not getting through on the telephone. All staff now had a new script. “hello, my name is xx; I apologise for the time you have waited; how can I help you?” A new discharge pack was co-designed, and they were working on a welcome pack. Letters had been reviewed and cut from over 400 to 100 to make it clearer and easier for patients to read and understand. Language line now offered an app which patients could access.

An emotional support survey had been carried out by the chaplaincy department during 2021/22. This focused on 10 wards across three hospital locations. The results from this had led to the identification of quality improvements and 6-points for taking forward, which were linked to the strategy.

Discussion with staff side did not identify any concerns other than they felt people promoted to managerial positions didn’t always get training for how to handle staff disciplinary matters. We did, however, see evidence of this training being available to staff via the trust’s internal programme.

There were 2 guardians of safe working hours, one for each main hospital site. They were supported by a senior workforce manager and 2 administrative staff who did the required exception reports. It was felt the resources were not enough to enable the guardian to do what they wished to. Allocated time for the guardian role was 1 day per week, and junior doctor forums were held quarterly. Attendance had increased at the last meeting and further work was needed to raise the profile through increased communication. We were told most issues were raised via the incident reporting system, although some doctors had sought the guardian out directly.

Key themes raised by junior doctors included gaps in and non-complaint rotas and indications of cultural issues, racism and non-inclusivity in the Neonatal Intensive Care Unit (NICU). These matters were not raised with us during our recent inspection when we visited the NICU. They had also received positive feedback of the culture in others such as critical care. The guardian had escalated safety issues when raised by doctors and these had been addressed, along with reports of racism. These matters were being addressed through correct channels. They told us they also had frequent meetings with unresolved issues, such as incorrect information coming from human resources (HR). This included the incorrect names of doctors coming for their placement, wrong grade and pay being wrong for the shifts undertaken. Escalation routes included via the chief people officer and director of education, where it was a training issue.

The trust sought the expert insight from external agencies, such as Health Education England. A risk-based Learner and Educator Review was requested following the 2021 General Medical Council National Training Survey (GMC NTS) within the clinical Radiology service. The survey had identified several areas of concern across the trainee programme. A final

report had been produced in the summer, which indicated areas of improvements had been made, although there remained some recommendations. We reviewed the action tracker provided against the recommended actions and we saw progress was being made on them. Similarly, a review had been undertaken about Medicine (including Geriatric Medicine, Foundation year one Medicine and GP Medicine) at PRUH, with a report published in February 2022. Whilst some improvements were noted, there remained areas where further action was required. The trust developed a tracker and we noted most areas had met a green rating, with others still at amber and in progress.

The staff survey carried out in 2021, and the results had led to priorities being set out for each care group. These were stated in a formal commitment and included what would be done and how the actions were to be measured in most cases. We noted there were no outcome measures stated in the Haematology; Renal; Radiology; Cardiac and Liver, for example.

Clinical Fridays involved site executives attending different areas, speaking to staff and patients, and sharing their findings afterwards. Non-executive directors also visited areas and spoke with staff directly. Ask the chief executive was reported to be a popular approach to raising questions.

Staff were involved in various trust development activities. We were told the clinicians were encouraged to be involved in the development of the new electronic patient record and whilst half were less sure about getting the financial support for this, half were active participants in the design of it. Work had since been done to engage with those who had not been as involved to start with, as well as more widely with staff groups, such as porters and pharmacy. Rapid decision groups were set up for design and testing and patients were also involved. The new record was anticipated to reduce the risk of using systems which did not talk to one another, as was the case at the time of our inspection.

Some staff reported to us not being involved in decision making related to changes in the working environment which impacted on patient care; and that when they tried to obtain information, this was not provided. They added that escalation through HR channels were not handled correctly and delays in process had happened. We explored this with members of the executive team and were provided with information demonstrating consultation had taken place, was paused for consideration of staff feedback and had since been recommenced. Should it be necessary, this staff group would have the opportunity to have any grievance considered at the end of the consultation period, as per policy.

We saw an example of a project designed to improve services, where a consultation period had been held and members of relevant staff were involved in discussions and provided feedback on proposals. Equality impact assessments were part of the process, as were changes to the proposal before the outcome was agreed. Documentation was reviewed by us and clearly showed the end to end process.

The trust had an executive lead for learning disability and autism, ensuring the needs of these patients were focused on by the wider team. There were various EDI networks in the trust, including: Black, Asian and minority ethnic (BAME) network; LGBTQ+ network; Kings Able for disability; Women's network and Interfaith and belief network. Each network received £10,000 to help them and one EDI team member supported each group. All chairs of the 5 groups sat on the EDI delivery group. At QPP they reported on staff networks and used information, where appropriate, to develop policies and as learning opportunities at NED level. We were given other examples where actions had been taken to improve EDI, such as positive action career development and interview preparation skills in the BAME network.

We met at regular intervals with the trust and received information related to performance in addition to presentations from various care groups. These meetings were open and transparent, with opportunities for questioning and requests for additional information.

Our findings

Learning, continuous improvement and innovation

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

The trust had a Learning from Deaths Policy, which set out the standards and expectations of staff for reviewing and learning from deaths. This was recognised as essential to the delivery of outstanding care to all patients. The trust reported unexpected deaths and serious incidents in line with the procedures to the National Reporting and Learning System (NRLS). This is a central database of patient safety incident reports set up to improve safety in healthcare. They also reported serious safety incidents to the Strategic Executive Information System (StEIS). Incidents reported via these systems were reviewed by CQC as part of our monitoring of safety and risk. Where necessary we requested information from the trust to assist us in doing so. The timely response to such requests had improved over recent months and as of 13 October 2022 there were 7 serious incidents open and under investigation.

We found the trust had an established system for reviewing unexpected deaths, investigating them and for sharing the learning arising from such cases where relevant. We reviewed several examples of patient deaths which had been subject to review. The information demonstrated good practice principles, for example; duty of candour, with transparency and sharing of information via communications and letters to respective families. Learning was shared with staff and if required training was provided, as well as provision of support to individuals involved. We noted where families had been signposted to additional support and they were given the chance to pose questions as part of the investigation.

The trust undertook internal reviews where the information reported into national audits indicated the trust was outside of the expected targets. We saw for example: The Internal Mortality Investigation related to Bowel Cancer 2-year Mortality following Major Resection, part of the National Bowel Cancer Audit (NBOCA) run by the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the Royal College of Surgeons of England. This was detailed and contained information related to the data and actions taken.

There was a clear policy for managing complaints, although these did not always get completed within the stated timelines. A recently appointed complaints manager with 20 plus years' experience spoke with clarity and commitment to improving the approach to handling and responding to complaints.

We had access to complaints as part of our routine contact with the trust and saw the investigations and responses to those where we had been contacted directly by complainants. In preparation for inspection, we asked to select at random from a list of complaints closed by the trust and were provided with 5 complaints chosen by the trust. One of those we reviewed had been raised 11 October 2021, the first response letter was undated but stated the delay in response letter was due to waiting for clinical feedback. The final letter with an apology was sent on 23 March 2022. Others were responded to in a timely manner, with an apology and an offer of a face to face discussion for example. Where the complainant was not happy with outcome, they exercised their right to approach the Parliamentary and Health Service Ombudsman.

We asked the risk manager about learning from risks and how well information was cascaded. They acknowledged this was not an area they were all good at, particularly where learning could be shared across different care groups. The risk manager was trying to improve this by reviewing the information related to meetings, such as debriefs.

Our findings

We asked members of the executive team about learning related to interprofessional working relationships and whether any work had or was being done to improve such arrangements. We were told a recent meeting had taken place with the clinical director and part of discussion was around interprofessional working relationships between medical bodies and workflow. Assurance on how the clinical teams were working came via the introduction of a daily flow meeting, for which the clinical director had oversight. They discussed how patients were flowing through areas and had good insight around how multi-professional teams were working, as well as inpatient and outpatient workload.

The director of strategy said the trust was diversifying the research portfolio of King's Health Partners and they were trying to attract people into life sciences, industry and health clinical trials for new innovations. Pathway improvement were also important for the DGH role specialist services will benefit DGH. We reviewed the Board pack for King's Health Partners, which included detail around the strategic priorities and actions to be taken.

Safeguarding leaders spoke about work they were doing to develop a pathway for children presenting with mental health illness, which was recognised as being a significant safeguarding issue. This was a system matter, which required collaborative working with the wider team.

A big part of the trust site strategy was focused on "sensible decompression" and improving areas for staff. Recent improvements had included the new outpatient and off-site facilities. There were changes to patient services as the regional neurosciences centre for south east London and Kent had identified a need to improve capacity. The aim of which was to reduce the patient waiting list resulting from COVID-19, reduce inpatient admissions for patients that could receive medicine infusion in an ambulatory setting, and establish a low risk neurology infusion pathway in the hospital. To improve the service offered to patients the trust wanted to make a dedicated green pathway for neurology patients and had developed a business case for this.

Work was in progress at PRUH in conjunction with One Bromley to offer the virtual ward for children and young people leading up to winter. They were aiming to expand this to 30 beds to broaden patient accessibility. (Virtual wards allow patients to get the care they need at home safely and conveniently, rather than being in hospital.)

In terms of innovative practices, the frailty services at PRUH had been significantly improved, with advanced clinical practitioners (ACP) and clinical nurse practitioners (CNS), having advanced skills in dementia and delirium. The main advantages of this was expected to show through the patient experience and quality and outcomes, as well as through improved patient flow. The intention was to have ACPs in the Emergency Department to assess patients that were suitable for the acute frailty unit. They were also looking at ways to develop skills of CNSs and were looking to improve the orthopaedic pathways. The PRUH had Band 7 nurses in surgery with extended skills to enable safe and effective discharge of patients, helping with patient flow.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Good ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Good ↑ Feb 2023	Requires Improvement ➔➔ Feb 2023

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
King's College Hospital	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Good ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023
Princess Royal University Hospital	Requires improvement Aug 2021	Requires improvement Aug 2021	Good Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021
Orpington Hospital	Requires improvement Sep 2022	Good Sep 2015	Inadequate Sep 2022	Good Sep 2015	Good Sep 2015	Requires improvement Sep 2022
Overall trust	Requires Improvement ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Good ➔➔ Feb 2023	Requires Improvement ➔➔ Feb 2023	Good ↑ Feb 2023	Requires Improvement ➔➔ Feb 2023

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for King's College Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↓ Feb 2023	Good →← Feb 2023	Good →← Feb 2023	Requires Improvement ↓ Feb 2023	Good →← Feb 2023	Requires Improvement ↓ Feb 2023
Services for children and young people	Requires Improvement →← Feb 2023	Good →← Feb 2023	Good →← Feb 2023	Good →← Feb 2023	Good →← Feb 2023	Good →← Feb 2023
Critical care	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018
End of life care	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019
Surgery	Requires improvement Jun 2019	Requires improvement Jun 2019	Good Jun 2019	Requires improvement Jun 2019	Requires improvement Jun 2019	Requires improvement Jun 2019
Urgent and emergency services	Requires improvement Feb 2020	Good Feb 2020	Good Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020	Requires improvement Feb 2020
Maternity	Requires improvement Dec 2022	Requires improvement Dec 2022	Good Dec 2022	Requires improvement Dec 2022	Requires improvement Dec 2022	Requires improvement Dec 2022
Outpatients	Requires improvement Jun 2019	Not rated	Good Jun 2019	Requires improvement Jun 2019	Requires improvement Jun 2019	Requires improvement Jun 2019
Overall	Requires Improvement →← Feb 2023	Requires Improvement →← Feb 2023	Good →← Feb 2023	Requires Improvement →← Feb 2023	Requires Improvement →← Feb 2023	Requires Improvement →← Feb 2023

Rating for Princess Royal University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jan 2018	Good Jan 2018	Good Jan 2018	Good Jan 2018	Requires improvement Jan 2018	Good Jan 2018
Services for children & young people	Requires improvement Sep 2015	Good Sep 2015	Good Sep 2015	Outstanding Sep 2015	Good Sep 2015	Good Sep 2015
Critical care	Good Jan 2018	Good Jan 2018	Good Jan 2018	Requires improvement Jan 2018	Good Jan 2018	Good Jan 2018
End of life care	Requires improvement Jun 2019	Requires improvement Jun 2019	Good Jun 2019	Good Jun 2019	Good Jun 2019	Requires improvement Jun 2019
Surgery	Requires improvement Jun 2019	Good Jun 2019	Good Jun 2019	Requires improvement Jun 2019	Good Jun 2019	Requires improvement Jun 2019
Urgent and emergency services	Requires improvement Aug 2021	Requires improvement Feb 2020	Good Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021
Outpatients	Requires improvement Jun 2019	Not rated	Good Jun 2019	Requires improvement Jun 2019	Requires improvement Jun 2019	Requires improvement Jun 2019
Maternity	Requires improvement Dec 2022	Good Dec 2022	Good Dec 2022	Requires improvement Dec 2022	Good Dec 2022	Requires improvement Dec 2022
Overall	Requires improvement Aug 2021	Requires improvement Aug 2021	Good Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021	Requires improvement Aug 2021

Rating for Orpington Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Requires improvement Sep 2015	Not rated	Good Sep 2015	Good Sep 2015	Good Sep 2015	Good Sep 2015
Surgery	Good Sep 2015	Good Sep 2015	Good Sep 2015	Good Sep 2015	Good Sep 2015	Good Sep 2015
Medical care (including older people's care)	Requires improvement Sep 2022	Not rated	Inadequate Sep 2022	Not rated	Not rated	Requires improvement Sep 2022
Overall	Requires improvement Sep 2022	Good Sep 2015	Inadequate Sep 2022	Good Sep 2015	Good Sep 2015	Requires improvement Sep 2022

King's College Hospital

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Description of this hospital

King's College Hospital NHS Foundation Trust

King’s College Hospital (KCH) is part of King's College Hospital NHS Foundation Trust. The trust provides local services primarily for over a million people living in the London boroughs of Lambeth, Southwark, Bromley, Bexley and Lewisham.

The trust is one of four major trauma centres, covering south east London and Kent. King’s College Hospital is also a heart attack centre and the regional hyper acute stroke centre. The Hospital offers a range of 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 fetal medicine.

Medical Care (including older people's care)

The medical care service at Kings College Hospital provides care and treatment for general medical services and specialist services including renal, liver, haematology, cardiology and stroke services, as well as care of the elderly services. They provide these services across 20 medical wards.

Services for Children and Young People

King’s College Hospital NHS Foundation Trust (Denmark Hill) provides a host of secondary and tertiary services for neonates, children and young people. The neonatal intensive care unit (NICU) provides level 3 surgical and medical care for babies born from 22 weeks gestation who often have 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 (PICU) which is equipped and staffed to provide level 3 intensive care support and is supported by an eight-bed paediatric high dependency unit (HDU).

In addition, there is a children’s general medical ward, a children’s surgical ward, a ward specialising in treating children with liver conditions and a children’s day treatment centre.

Our findings

Children’s care provided in the emergency department was not reported on during this inspection as this is covered during an inspection of the urgent and emergency service.

Medical care (including older people's care)

Requires Improvement

Is the service safe?

Requires Improvement

Mandatory Training

The service provided mandatory training in key skills to all staff. Staff mostly kept up to date with mandatory training.

Staff received and mostly kept up to date with their mandatory training across the medicine sector. Information provided showed at the time of the inspection staff had completed between 84% and 93% of mandatory training against a target of 90%. The service informed us they had recently made changes to their training completion reporting system, and this was why they were below the target of 90%.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training using a dedicated training system and were able to alert staff when they needed to update their training.

Safeguarding

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

Staff received training specific for their role which was reflected on the training records provided to us. They were able to describe common signs of abuse and knew how to make a safeguarding referral and who to inform if they had concerns. Not all staff had completed safeguarding training. Staff competition rates of safeguarding training was at 91%, below the target of 95%.

Safeguarding concerns were discussed at the multidisciplinary team meetings. Social care teams from the community were involved in the discharge process. This was to ensure the needs of vulnerable patients or those with additional requirements were met.

Medical staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff could raise safeguarding referrals on patients' electronic records to the safeguarding team which was led by a safeguarding practitioner who produced a quarterly report on safeguarding data. However, the safeguarding lead worked between two sites and found it challenging to cover both due to a vacancy.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

The service managed infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

During inspection most staff followed good hygiene practice and followed infection control principles including wearing personal protective equipment (PPE) correctly. Hand washing basins were accessible and clean and hand sanitiser stations were available all throughout the wards. However, one staff member did not wash their hands after removing a protective apron.

Areas were cleaned regularly, and we observed staff cleaning surfaces. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The daily checklist to show cleaning had been done was not always signed as completed by the nurse in charge.

Audits were completed regularly to ensure staff were compliant with hand hygiene and infection control principles including the use of personal protective equipment (PPE). Staff were compliant with the principles in the latest audit on the wards we visited.

Patients, who had potentially infectious illnesses, were isolated in single rooms or in group bays which were clearly signposted to staff and other patients.

Environment and equipment

Staff managed clinical waste well. The design and use of facilities, premises and equipment were mostly maintained kept people safe. Staff were trained to use them.

Patients told us they could reach call bells and we observed staff putting them in reach of patients after each contact. We observed staff responding promptly to call bells on inspection. Some patients told us that staff did always respond quickly, if staffing levels were low.

The design of the environment followed national guidance including separate bays for male and female patients. The dementia wards also had a dementia friendly room that patients and family members could relax in.

Staff carried out daily safety checks of specialist equipment. Daily checks for the resuscitation trolley checks were completed and signed for. Specialist equipment had clear labels of electrical safety checks.

The service had mostly enough suitable equipment to help them to safely care for patients. Most staff told us they had enough equipment to perform their role, although some staff told us computers were not always working. They had to borrow equipment from other wards when this happened.

Some moving and handling equipment had not had an annual safety check. This was raised with the service who removed the equipment from use until the safety check was complete.

We observed staff dispose of clinical waste safely. Clinical areas were visibly clean and tidy.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration. Staff completed risk assessments for each patient and removed or minimised risks on admission and regularly as per policy. However, the risk assessments were not always accessible to staff in a timely manner.

Staff used the National Early Warning System2 (NEWS2) tool to identify deteriorating patients. The tool is based on a scoring system relating to the change in physiological measurements including breathing rate, oxygen saturations and blood pressure. Staff were able to describe how and when to escalate concerns using the NEWS2 tool. Staff told us the electronic records no longer flagged high scoring measurements on the computer. They shared concern that staff with less knowledge may miss these measurements as requiring attention. Following inspection, we were told that the record system alerted the user when actions are needed.

Staff had access to a critical care outreach team who they could contact if they needed support with a deteriorating patient. All staff we spoke with found this service helpful when managing deteriorating patients.

Patient notes had completed risk assessments for malnutrition, falls and venous thromboembolism (VTE) for each patient on admission. These risks were recorded on patient records.

The service had 24-hour access to mental health liaison and specialist mental health support. We observed a member of the specialist mental health support team assisting a ward with 1:1 care of a patient with complex mental health needs.

Staff shared key information to keep patients safe when discussing their care with others. During inspection we observed board rounds, where all staff involved in each patient's care discussed their care needs holistically. We observed on one shift handover where not all staff received the information, as some did not attend, and others arrived late.

Nurse staffing

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, the service did not always have nurses to meet the planned numbers.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. However, staff told us that they regularly did not have enough nursing staff to meet the planned numbers. Following the inspection, we reviewed staffing levels from August 2022 to October 2022 for the Mary Ray, Donne and Marjory Warren Wards. The service did not always meet safe staffing levels for nurses and health care assistants. Nursing staff levels on the day of inspection in Mary Ray Ward were unsafe as there were four nurses on shift compared to six being planned. Managers told us they supported the ward when the staffing numbers were low. Matrons reviewed staffing levels in the morning and moved staff as needed to meet the needs of patients. We found no evidence that patient safety was affected.

The service had a reducing rate of sickness absence for nursing staff. The service had a sickness rate of 8.98% in January 2022 which reduced to 5.12% in September 2022. The service had a turnover rate of 12.43% of nursing staff in September 2022 against a target of 14%.

Medical care (including older people's care)

The service had a high vacancy rate for nursing staff and allied health professionals. The nursing staff vacancy rate was 14.17% and the allied health professional vacancy rate was 16% compared to a target of 10%. Staff told us they were actively recruiting in the short term and were developing a plan for further recruitment and retaining staff for the future.

The service made regular use of bank nurses to make up the shortfall in staffing numbers. Bank staff told us they were well supported on unfamiliar wards with detailed inductions to the ward area and staff. Managers tried to limit their use of agency staff but made sure all they had a full induction and understood the service when used.

Medical staffing

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

The service had enough medical staff to keep patients safe. We reviewed staffing levels for the Donne Ward, Marjory Warren Ward and Mary Ray Ward and found the service had a good skill mix of doctors in training and senior medical staff on each shift and reviewed this regularly.

The service had low turnover, sickness and vacancy rates for medical staff. The service had low rates of bank and locum staff. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

Records

Staff kept detailed records of patients' care and treatment and stored them securely. Records were not always clear and easily available to all staff providing care.

Patients medical notes were comprehensive, and all staff could access them easily on the patient's electronic record. We sampled 4 patients records and found some risk assessments were not always stored efficiently due to both paper and digital records being used. This affected ease of access to information to staff. Following our inspection, the leaders carried out a review and recommended paper risk assessments were to be withdrawn from use.

When patients transferred to a new team, there were no delays in staff accessing their electronic records. We saw evidence of assessments from the frailty assessment unit accessed on the medical wards.

Records were stored securely. Electronic records could only be accessed by staff on computers. Paper copies of risk assessments were stored beside patient's beds. The service was aiming to move all records into electronic form with the introduction of a new electronic system in the coming year.

Medicines

The service used systems and processes to safely prescribe medicines. However, staff did not always follow processes to safely record, administer or store medicines.

Staff followed systems and processes to prescribe medicines safely. Medicines were prescribed electronically by medical staff and checked by pharmacy staff. Staff generally followed the correct processes for administering medicines. In one instance we observed staff not confirming with the patient their details to ensure medicine was being given to the correct person. We found medicine on the floor by the patient's bed that had been recorded as taken earlier in the morning on the patient's record. We raised it with medical staff who issued another dose to be taken. The staff member raised it as an incident.

Staff reviewed each patient's medicines regularly on ward rounds and at multidisciplinary meetings and this was recorded on patient's electronic notes. Patients told us that staff provided advice to them about their medicines and they were comfortable about asking any questions.

Staff mostly completed medicines records accurately, although not always recorded in a timely manner. We observed staff recording administration of medicine 2 hours after it was given. We raised this with the staff member and matron and were told this was not common practice.

Staff did not follow processes for the storage of medicines. We found on all wards that staff were not always completing fridge temperature checks or escalating out of range maximum fridge temperatures. This was raised to the ward managers and pharmacists on the wards for further investigation. This issue was not identified by a pharmacy audit completed by the service in September 2022.

Staff followed national practice to check patients had the correct medicines when they were admitted, or when they moved between services.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff monitored the prescribing of medicines used to control behaviour and could describe the policy for patient constraint.

The trust had an effective process for sharing medicines safety alerts across all the wards.

Incidents

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

All staff knew what incidents to report and how to report them. Although staff knew how to report concerns, staff did not always report staffing concerns as an incident.

Staff told us they raised concerns and reported incidents and near misses in line with trust/provider policy. Staff had reported 547 incidents or near misses in the past 12 months with 233 requiring investigation. Themes that were identified were in the areas of medication, pressure ulcers, falls and violence towards staff.

Staff reported serious incidents clearly and in line with trust policy. There was a process for responding to serious incidents, including action plans to prevent future occurrences. In the past 12 months the hospital reported 22 serious incidents related to medical wards. These included instances such as diagnosing monitoring and review, falls and medicine errors.

Managers shared learning and feedback with staff through meetings and emails. We were shown examples of feedback from meetings minutes and emails sent to ward teams.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Medical care (including older people's care)

Staff discussed learning from safety alerts and incidents to improve practice at staff meetings. Junior doctors received a fortnightly leaflet with updates and learning specific to their role.

Is the service effective?

Good 

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff mostly followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and guidelines had been developed in line with national policy. These included the National Institute for Health and Care Excellent (NICE) guidelines. However only 81% of the acute speciality medicine divisions clinical guidelines were in date against a target of 90%. The trust informed us they were working to reach the target of 90% with a dedicated working group.

Policies were accessed via the trusts internal systems.

We observed detailed handover meetings between staff where all patient's needs were referred to which included their physical, psychological and emotional needs.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink. The service offered an additional soup course on wards where patients needed extra nutrition.

Staff supported those who needed support to eat safely through mealtimes. Specialist support from staff such as speech and language therapists were available for patients who needed it. We noted information from speech and language therapists on patient records. There was a system to highlight which patients needed support with clear visual cues of stickers above the patient's beds and colour coded food trays

Staff fully and accurately completed patients' fluid and nutrition charts in records we sampled. Staff used the Malnutrition Universal Screening Tool (MUST) to monitor patients at risk of malnutrition which was completed on admission and updated when required.

Patients told us that us the service had many food options which catered to many cultural and religious beliefs. The service also had a menu with pictures to help patients decide what they wanted to eat.

Medical care (including older people's care)

Pain relief

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

Staff assessed patients' pain using a recognised tool. We saw on patients records regular updates on patient's pain scores. However, staff did not always record pain relief safely as we observed staff record pain relief 2 hours after it was given. There was a risk patients may have been given additional pain relief if staff did not know tablets had already been given.

Patients told us they received pain relief soon after requesting it.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national clinical audits and reviewed any outliers that were identified.

Outcomes for patients were mostly positive, consistent and met expectations, such as national standards in the medical group. The service was better or within expected ranges for outcomes of their audited patient groups. For example, the service scored within or better than expected ranges for all 11 patient outcome indicators in Secondary Care Chronic obstructive pulmonary disease (COPD) Audit.

Managers and staff carried out a comprehensive programme of repeated audits of patient outcomes to check improvement over time. Managers used information from these audits to improve care and treatment. The trust had developed an improvement project which included developing training packages for staff and updating policies.

The service was part of a trust project gathering information from patients about what outcomes of their care were most important to them so that the service could improve upon these.

The service produced a quarterly report on patient outcomes describing performance and results from national audits. In the most recent report, the trust had mostly reported positively on its performance indicators in the medical division.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. New staff were given a full induction including 3 days of mandatory training and 6 weeks of clinical supervision.

Managers supported staff to develop through yearly, constructive appraisals of their work. The appraisal rate for the trust was 92.76% for eligible staff. Staff told us they their appraisals were constructive, and they had the opportunity to discuss training needs.

Staff told us that they were supported from the practice development team. This team provided supervision and support through induction but were also available to support staff once induction was over.

Medical care (including older people's care)

Managers discussed with staff updates on patient safety, staffing, staff wellbeing and training at team meetings on the ward. They made sure staff attended these meetings or had access to full notes by emailing them when they could not attend.

Managers made sure staff received any specialist training for their role. For example, staff on the dementia wards received specialist dementia training to assist in the caring of these patients.

Staff reacted swiftly to an emergency that occurred whilst during inspection. Staff were aware of their role and supported the medical staff to care for the patient.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked effectively together as a team to benefit patients. They supported each other to provide good care.

We observed on all wards staff holding regular and effective multidisciplinary meetings involving the nurses, healthcare assistants, doctors, physiotherapists and discharge coordinators to discuss patients' needs and improve their care. The meetings discussed patients' medical, social, psychological and behavioural needs and had input from all healthcare professionals.

Staff on the wards told us they felt comfortable approaching other healthcare professionals and discussing patients' needs outside of team meetings.

Seven-day services

Key services were available seven days a week to support timely patient care.

Daily ward rounds were led by appropriately trained doctors on all wards, including weekends. Rounds were normally led by trained registrar doctors who were able to assess patients with consultants on call to assist with assessing patients with complex needs.
Support was available from mental health services 24 hours a day, 7 days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service displayed relevant information promoting healthy lifestyles and support on the wards including hand hygiene and antibiotic awareness. It also displayed information for various dementia charities for patient to contact for support.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, patients who smoked were offered smoking cessation products to help stop smoking.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Medical care (including older people's care)

Staff told us how and when to assess whether a patient had the capacity to make decisions about their care particularly on dementia wards. One patient we spoke with told us that the service handled her needs well when she could not consent. She appreciated the staff made decisions in her best interest and regularly reviewed her ability to consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Consent was recorded in the patients notes that we reviewed and noted that consent was reviewed regularly in dementia wards.

Staff received and kept up to date with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff could describe and knew how to access policy and get accurate advice on MCA and DoLS which was available on the trust's intranet. Staff we spoke to were aware of their role and responsibility in the administration of rapid tranquilisation if needed.

Is the service caring?

Good

Compassionate care

Staff respected the privacy and dignity of patients and took account of their individual needs. Staff mostly treated patients with compassion and kindness.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff being kind and reassuring to complex patients who were in moments of distress.

Patients said staff mostly treated them well and with kindness. We spoke to patients across four wards who said they were treated with kindness and respect with some of the feedback being "staff are amazing" and "everyone is polite". On the day of inspection, staff on one ward were planning to get a birthday cake for a patient's birthday. Some patients told us staff were sometimes not as caring when staffing numbers were low. They did not attend patients as quickly as they would normally and sometimes did not spend as much time with the patient.

Staff followed policy to keep patient care and treatment confidential. Information for staff about patients was either anonymised when in public view or in staff only access areas. Staff made use of curtains around beds to ensure patient privacy when needed.

Staff understood and respected the individual needs of each patient. These needs were discussed at team meetings each day. They showed understanding and a non-judgmental attitude when caring for patients with mental health needs. We observed staff on the dementia and delirium ward being calm and attentive to patients in distress. Staff had put common words and phrases in French at the bed of one complex patient who preferred speaking in their native language.

Medical care (including older people's care)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and maintain their privacy and dignity including one patient who had become aggressive and was calmed by staff by going on a walk around the ward.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. This was reflected in the multidisciplinary team meetings where staff discussed all needs of the patients.

Understanding and involvement of patients and those close to them

Staff generally supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Most patients told us staff made sure they and those close to them understood their care and treatment. Some patients and relatives told us that staff gave up to date information about their medicines and treatments. However, others told us that doctors did not always keep relatives up to date about their family members care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Communication needs were highlighted on patients records and translation services were available for patients if they needed it.

Patients told us staff supported patients to make informed decisions about their care by involving them in the conversations about their care.

Is the service responsive?

Requires Improvement 

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Arrangements related to patient admission and discharge were overseen by ward leaders and other coordination staff.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Bays were separated by gender and there was cohorting of patients with similar needs. A member of staff was always present for patient safety in bays with patients with complex needs.

Medical care (including older people's care)

Facilities and premises were appropriate for the services being delivered with suitable bed areas and toilets. Side rooms were available on some wards for patients who required minimal supervision requirements or who were isolating to prevent passing on infectious disease.

The service had systems to help care for patients in need of additional support or specialist intervention.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service provided a learning development team who supported wards by organising activities and giving advice to patients with learning disabilities and to staff caring for them.

Staff supported patients living with dementia. The service offered 'This is me' booklet to dementia patients. This contained easy to access information about the patient's preferences. The dementia ward had a dementia champion with details displayed on the noticeboard of who could assist staff when needed. The dementia ward contained a dementia friendly room where patients could relax away from the business of the ward. The ward also had access to an activity co-ordinator who would organise activities for patients such as art-based activities.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Managers told us they could access interpreters or signers when requested by staff, patients and carers. Translation services, if needed were booked via the trust's language line.

Patients told us they were given a wide choice of food and drink to meet their cultural and religious preferences. Staff took orders from patients from a menu with pictures to help patients decide. The menu also contained options to meet dietary requirement included vegetarian, gluten free and easy to chew.

Access and flow

People could access the service when they needed it and received the right care promptly. However, times to discharge patients were not in line with national standards.

At trust level 75% of patients in September 2022 had a delayed discharge. A delayed discharge is when a patient is not discharged at the earliest time they can go home and means the bed is not available for other unwell patients. On one ward we visited one patient had been on the ward for six months, even though they were medically well enough for discharge. Staff told us that the patient was medically well but could not be discharged due to complex social needs. Other patients faced similar problems where one patient with safeguarding issues could not be discharged due to no care homes being able to accept them.

Managers and staff worked to make sure patients did not stay longer than they needed to, and planned patients discharge as carefully as they could. The service recognised that discharging patients in a timely manner was a system wide problem. Discharge planning was started at the point of admission unless patients were very unwell. The service had an escalation policy for patients who could not be discharged that went through to senior leaders.

The wards worked closely with social workers in the community and had dedicated discharge staff to assist in organising discharge of patients to the community. The discharge coordinator acted as a point of contact between clinical staff, families of patients and patient's social workers. Discharge coordinators we spoke expressed frustration with lack of available beds and carers in the community and also social workers not replying to communication about patients in a timely way. They told us this led to delayed discharges on the ward.

Discharge coordinators worker to support external partners by completing Trusted Assessments on behalf of care homes. These were holistic assessments that were previously done by care home staff to identify and confirm the needs of patients prior to admission to the care homes. Discharge coordinators had been fulfilling this role since the start of the Covid-19 pandemic.

Staff we spoke to told us there was clear notes from occupational therapists and doctors describing equipment needed at patients' homes for safe discharges. They were able to in some instances order equipment to be delivered to patients' homes for the same day.

The service informed us of plans to introduce respiratory virtual wards to the trust. These wards allow for medical staff to care for patients in their own home.

The number of times patients were moved, including at night were currently high as patients had to be moved from their admission ward to wards that cared specifically for their illness/disease. Evidence was provided post inspection detailing that between 25-30% of patient transfers occurred at night. The service managed patients that were not on the most appropriate ward by ensuring consultants contacted wards regularly to ensure they were receiving appropriate care and treatment until a bed could be found.

On inspection it was evidenced that consultant led daily board rounds, these were thorough and of high quality to meet patients' needs.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them. The service mostly shared lessons learned with all the staff. The service included patients in the investigation of their complaint.

Patients told us they knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. Staff were encouraged to handle complaints locally and would direct complaints to the central complaints team if it could not be resolved.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Feedback and actions taken from complaints was displayed on some wards and included in the monthly staff meetings. For example, the latest feedback from one ward was staff not wearing name badges. The ward manager highlighted this at the latest staff meeting and ordered name badges for everyone who did not have one.

Medical care (including older people's care)

Is the service well-led?

Good 

Leadership

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

The medical wards were led by an acute speciality medicine leadership team which included a senior head of nursing, a senior general manager and clinical director. They were supported in each speciality by matrons, ward managers, service managers and clinical leads.

The leadership team had a good understanding of the challenges they faced including staff shortages and timely discharge of patients. Leaders reviewed these challenges at quarterly meetings where they discussed progress and challenges ahead. They worked to meet these challenges as a team.

Ward managers and matrons were visible on the ward, supporting staff when required.

Leaders supported staff to develop their skills and take on more senior roles.

Vision and Strategy

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

The care group followed the trust vision called “B.O.L.D” which stood for Brilliant people, Outstanding care, Leaders in research, innovation and education and Diversity, equality and inclusion which was made to improve services at the hospital and trust wide. This was developed with input from 4,500 staff, patients and members of the local community,

The acute speciality medicine care group was signed up to a trust programme called modernising medicine. They had started to make improvements to increase workforce, develop estate and improve clinical pathways across all clinical services, including the medical wards.

Leaflets containing information on the summary of the strategy about the trust’s vision were produced for staff.

Culture

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

Staff were aware of the values of the trust and felt they reflected how they needed to behave at work.

Staff told us that they felt mostly supported and valued by managers. Some staff told us morale was low due to staff shortages and this was impacting their wellbeing. Staff continued to try and deliver their best care despite pressures they faced.

Staff had access to systems to enable them to speak up and they told us they were listened to. Staff were aware of the Freedom to Speak Up Guardian service. They were offered wellbeing booklets every quarter which contained information on maintaining wellbeing.

Leaders monitored the diversity of the staff at the regular governance meetings.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a clear governance framework and regular governance meetings were held to discuss information about the service including performance, incidents and complaints.

Staff had regular governance meetings within their speciality led by clinical leads to discuss to issues and learning. This information was channelled from each speciality into dedicated performance, risk and outcome meetings were information was analysed and discussed at a senior level.

Governance systems were used to support the development of a quality service. Governance systems were used to develop the service and address the issues impacting on the service and staff.

Information was shared at ward level through daily handover meetings and monthly ward meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They sometimes identified and escalated relevant risks and issues and identified actions to reduce their impact.

The service had a risk register relating to the medical division of Kings College Hospital where risks were graded and monitored at regular meetings. The service had nominated individuals to lead on each risk to ensure mitigations were in place and that improvements were made for each risk. There was evidence on the risk register of regular discussion and revaluation of the risks.

The service had identified themes of concern and areas of improvement. The areas identified were patient falls, pressure ulcers, medication issues and violence and aggression. The service was performing a review of each concern to learn where things went wrong and to drive improvement.

The service monitored the effectiveness of care, treatment and performance. The service took part in national and local audits and evidence of improvements or trends were monitored.

Leaders held a monthly quality and safety meeting for each ward where staff would present issues that were identified on the ward. However not all wards participated each month and actions for issues were not always recorded.

The service had identified issues in relation to delayed discharges. In May 2022, 14% of patients were discharged before 1pm. This was below the target of 33%. The service had begun to work with external partners to improve the 'Discharge to Access' and 'SAFER' tools. These are tools used to reduce delays in discharge for patients. We saw evidence of these tools being applied on the wards.

Information Management

The service collected reliable data and analysed it. Staff could find data they needed to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust had recently acquired funding for a new electronic patient record to update patient records and ensure patient information was accessible in one place. It would be rolling out in 2023.

The trust had a policy website that contained all relevant policies for staff. We found the trust policy website difficult to search and access policies in a timely manner.

Staff were able to access trust performance through an internal website. The trust provided data to external audits and surveys as required. The trust had a 100% compliance rate with submitting data for national audits.

Engagement

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

The consultants on the elderly care ward collaborated with local care homes and residential homes. They met with care homes every week and residential homes every 2 weeks. At these meetings, they were able to support patients, staff and GPs to help prevent admission to the hospital from the care home.

Patients and their families could give feedback on the service by completing as survey at the end of their stay and felt comfortable approaching staff during their stay to discuss issues. They generally gave positive feedback about the service. The service also generally scored well, with many wards over 90% positive feedback in the "NHS Friends and family test" (a quick and anonymous survey used for patient feedback)

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

In response to patient, relative and staff feedback the trust had recently launched new patient property products and processes. This includes a general property bag made from cardboard which helped ensure that property was packed and presented in a dignified way; a new valuables tamper proof bag and a washing bag. There was also a new denture pot, with a clear lid to avoid unintended disposal of dentures, whilst maintaining dignity.

Services for children and young people

Good ➔➔

Is the service safe?

Requires Improvement ➔➔

Mandatory training

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

All staff completed a thorough induction process when they first start to work for the trust. The mandatory training we checked during this inspection was refresher training and was on a rolling basis, depending on when the staff member joined the trust.

The mandatory training was comprehensive and met the needs of children, young people and staff.

Training on how to recognise and treat sepsis in children and young people was mandatory for staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Where mandatory training was required to be updated, practice development nurses booked training and updated the ward managers.

Staff told us they were given the time to complete this training and if the training was completed in their own time, that time would be given back to the staff member.

At the time of our inspection 5779 out of 6731 (86.58%) staff had completed their refresher mandatory training. Healthcare assistants (HCA) were at 92.52%, nursing staff at 92.88% and medical staff at 80.66%. We were told staff were required to completed 100% mandatory training by the time of their yearly appraisal. Yearly appraisals were from April to August every year.

Monthly training compliance was monitored via Learning Education Appraisal Platform (LEAP) reports which was generated by division and core groups.

The service also had bitesize teaching training for staff called “We can talk”. This was one-day self-directed training providing acute hospital staff with the knowledge, skills and confidence to support young people in mental health crisis.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. All staff received mandatory training in safeguarding adults’ levels 1 and 2, and safeguarding children levels 1-3.

Staff knew how to identify children at risk of, or suffering, significant harm and worked with other agencies to protect them. During our inspection we were told safeguarding referrals were frequently made. The safeguarding team were informed, and the ward manager liaised with any social workers when relevant.

Staff we spoke with said the safeguarding team were supportive and provided advice when required.

We were told when a child was admitted, where relevant, if a social worker was involved in their care, the ward staff would obtain the social workers contact details. Patients with complex health needs often had formal arrangements in place with regular contact with the social worker and families.

Staff we spoke with were able to identify the safeguarding lead and identify the process of making a safeguarding referral.

A safeguarding policy relating to safeguarding children and young people was accessible and had last been reviewed in May 2022. The policy was version controlled and included information on how to make a referral to different external organisations.

The safeguarding policy also included the child chaperone policy. It set out responsibilities including clinical examinations, cultural and religious issues, training and monitoring. The policy stated matrons/heads of nursing should ensure all clinical staff who may be called upon to act as a chaperone had read and understood the policy. The policy did not specify any training requirements.

Staff followed safe procedures for children visiting the ward. We were told siblings visiting the ward must be accompanied by an adult. At the time of inspection, one of the wards were not allowing siblings to visit to control the spread of infection. That was reviewed, depending on specific patient circumstances.

Staff had knowledge of the Gillick competences and Frasier guidelines and knew how to apply them. Gillick competence was used to assess a child's capability to make and understand their decisions in a wider context, particularly around consent to treatment. Fraser guidelines are applied specifically to advice and treatment that focuses on a young person's sexual health and contraception.

Cleanliness, infection control and hygiene

The service managed infection risks well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

We reviewed the Infection Prevention and Control Policy which included standard procedures and guidelines, with additional associated policies, for example, central line ongoing care, venepuncture clinical competence and hand hygiene. The policy was version controlled and in date.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff complying with the trust's policies for infection prevention and control. Staff wore appropriate PPE, such as masks and aprons and followed the 'bare below the elbows' policy. Hand sanitizers were visible and available throughout the service and on all the wards we visited.

We observed staff washing their hands both before and after patient contacts. We were told staff cleaned the wards every day and completed a safety checklist at the beginning of their shift to ensure the bed space was clean. We saw the completed safety checklists. During our inspection we saw cleaning staff carrying out their duties. We heard a member of the cleaning team call after a visitor to a ward to remind them to return and wash their hands.

Hand hygiene and PPE compliance audits were completed weekly. Ward managers carried out daily hygiene code checks and there was a monthly audit.

We were told a deep clean was scheduled yearly, with the last one completed in August 2022.

During our inspection staff told us patients were tested for Covid-19. Patients completed a lateral flow test on admission and every 72 hours and before surgery.

Staff cleaned equipment after patient contact. We saw the bed areas were cleaned thoroughly by healthcare assistants. Following discharge of a child, we saw appropriate cleaning of the bed and surrounding equipment. We also observed cleaning of all the toys, so they were ready for use by other children. Staff could explain the different types of cleaning required after a patient discharge.

Staff labelled equipment to show when it was last cleaned. We saw green stickers completed with details of date, time and staff initials and placed on equipment after every patient contact.

We were told damp dusting around the clinical areas was completed after every shift.

Clinical waste bins and sharps bins were correctly labelled and properly disposed of.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance as far as possible. The environment in which children and neonates were cared for was appropriate. However, the increased capacity of the NICU meant space between cots was cramped. That meant access to cots was sometimes restricted or limited. Staff told us of the potential risk to the babies by having a cramped space for the staff to work in and the high use of multiple medical devices within the neonatal intensive care rooms.

We inspected the paediatric intensive care unit (PICU) which had 8 beds/cots but 5 were occupied by long term patients meaning the unit could only take an additional 3 patients. Rays of Sunshine staff told us often this meant them having to cancel elective operations and keep patients on the ward longer.

After our inspection we were sent confirmation of plans and secured funding to redesign the neonatal unit to make enough space to expand the number of cots by 8. Initially, 5 new cots will be commissioned with 2 intensive therapy unit (ITU) cots, 2 high dependency unit (HDU) cots and 1 special care baby unit (SCBU) cot. The remainder will be phased in at a later date. Funding over winter was also secured for PICU to increase to 10 level 3 beds and reduce from 8 to 6 level 2 beds.

Children, young people and their families could reach call bells and we saw staff responded quickly when called. However, we were told there was sometimes delays in answering the call bell, particularly on a night shift.

All the wards we inspected had information on the walls for staff and patients and their families/carers. These were visibly clean and had clear, well signposted information on them. There were many information leaflets around the ward reception areas for patients and their families/carers to take.

We inspected Rays of Sunshine which had a positive environment with colourful, informative posters including pictures.

One of the wards we inspected had a safe room which was a ligature free room with a bathroom opposite the room.

Each of the clinical areas where children were inpatients were locked and prevented unauthorised access. Parents or carers were able to gain access to the ward by using a buzzer system controlled by staff (administrative or nursing) sitting at the reception area.

Following the inspection, we requested the child abduction policy. The service informed us the policy was currently in draft format and had been sent to the relevant stakeholder for review.

Staff carried out daily safety checks of specialist equipment. Whilst on inspection we saw the equipment had up to date electrical safety testing and service testing stickers.

The service had suitable facilities to meet the needs of children and young people's families. We visited multiple wards which were spacious and had ample lighting. We observed a quiet room where parents and visitors could go. Those were visibly clean with easily wipeable furniture. The quiet rooms we inspected had tea and coffee making facilities and a fridge for the patients, families or carers.

Each ward had a playroom for children to play in. The playroom had posters on the door for information about the play specialists and their working hours. The room was well ventilated and signposted to ensure children using the playroom must be supervised at all times. The play specialists would clean and wipe down the toys after patient contact.

The service had enough suitable equipment to help them safely care for children and young people. Staff knew who to contact if they identified a fault with the equipment or any environmental issues.

We inspected the emergency trolleys on several wards which were fully checked once a week and the security tag changed to reflect this. The equipment on the top of the trolleys was checked daily.

Staff disposed of clinical waste safely. We saw each room and clinical area had domestic waste and clinical waste bins which were clearly labelled. Clinical waste was put into orange bags. A domestic team changed the bins every day. Staff told us there was a bin storage room for clinical waste on the corridor where all the children's wards are based. If required, the domestic team were contactable for more frequent visits.

Staff informed us training for disposal of clinical waste was part of their mandatory training for IPC.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. The bedside paediatric early warning system (BPEWS) observation charts gave staff directions on whether escalation would be required. The BPEWS charts were completed by staff on admission and then at planned frequencies during the patient's stay according to the care plan in place for each patient.

We looked at completed BPEWS charts and saw repeat observations were completed within the necessary time frame. Staff we spoke with were aware of how to escalate concerns of a deteriorating patient and who they would speak to.

Staff completed a three-point check when assessing patients; the patient's name, date of birth and hospital number to ensure the correct patient received the right care.

Services for children and young people

Staff completed risk assessments for each child and young person on admission / arrival, using a recognised tool, and reviewed it regularly, including after any incident. Risk assessments included risk of falls scores, mental health, nutrition, skin integrity and bedside rails.

The service had access to a mental health liaison and specialist mental health support if staff were concerned about a child or young person's mental health. As well as mandatory training for mental health support, staff told us there was bitesize teaching for mental health called "We can talk". Staff said to us they were encouraged to have open discussions with patients about their mental health.

Staff we spoke with said there were good links with the mental health team. The mental health board had regular meetings to discuss any concerns about a patient's mental health. Feedback from those meetings had led to developments or changes to the child or young person's care plan.

We were told by the paediatric lead nurse there has been further investment for regular mental health meetings and emergency department (ED) training to get more robust plans in place and look at risk assessments for patients.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. Staff told us this risk assessment was completed on admission, whether through the ED or another admission route.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. Patient allergies were noted in the patient records. On admission to the ward, the patient's height and weight were recorded. This would be reviewed on Wednesdays and Sundays and where required, daily recordings were completed.

Shift changes and handovers included all necessary key information to keep children and young people safe. A handover sheet was completed, and nurses were allocated to care for specific patients. A bedside handover was also completed.

Staff told us there had been incidents on wards involving patient's families or carers which required assistance from the security team. Staff said the security team were prompt, professional and ensured the safety of patients, staff and others on the ward.

Staffing

The service had nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. However, the service was often running with less nursing staff than planned. There was also a heavy reliance on locum doctors.

Staff informed us that staffing levels were often below the planned figures. We saw similar staffing levels across all the wards we visited. Staff told us reduced staffing impacted on the level of care provided to patients where they felt they had to prioritise nursing duties. However, we did not see or have any evidence of unsafe practise or occasions when patient's safety was compromised.

Staff we spoke with on Rays of Sunshine ward told us, with the agreement of the ward consultants, they had reduced the bed number by 4 to 14 to ensure they could meet the safe staffing levels and provide safe patient care.

Services for children and young people

Whilst on inspection we saw the daily staffing ward notice boards displayed staff numbers below planned figures. We saw in NICU, nursing levels were such that 1:1 care could not always be provided in line with national standards. We were informed the neonatal unit often had a 1:2 ratio when looking after babies.

Staff on Princess Elizabeth Ward told us there were often only 2 nurses on duty which meant staff were caring for 5-7 patients each. This was not evidenced by the supplied actual staffing figures. However, they did show staff were below the allocated number on most of the day shifts and just over half for the night shifts over the 84 day's figures supplied. Staff told us safe staffing levels were 3-4 patients each which meant there were often delays in medicines rounds and providing overall safe care to patients.

We inspected Toni and Guy Ward which had 3 nurses on shift when the actual number should be 6 nurses. The ward manager told us they would often assist when the nursing numbers could not be made up.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift, in accordance with national guidance. However, that was not reflected in the actual numbers on shift.

Following our inspection, we reviewed staffing levels from 25 July 2022 to 16 October 2022, a period of 84 days, which showed staffing levels were frequently below the levels of staffing required for both day and night shifts. Rays of Sunshine ward met their planned staffing levels twice during day and once at night during the above period. The PICU met its staffing target twice during the day shifts but not at night. Although the NICU was often meeting or sometimes exceeding the staffing levels during the day shift (just over 50% of the time), it never reached the planned staffing levels at night during the above review period. Other wards showed similar results.

We were informed the skill mix was difficult to achieve for each shift where there were several new starters and less senior staff. Staff told us when staffing levels were ok, staff members would often be moved to help on another children's ward leaving staffing levels below the optimum level.

The ward manager could adjust staffing levels daily according to the needs of children and young people. However, at least one ward manager told us they had been often below safe staffing levels for almost 18 months, even when the ward manager was included in the figures. We were told by the senior leadership team a business case had been submitted to increase funding to recruit additional nursing staff as part of the NICU expansion.

The service made regular use of bank nurses. We were informed bank nurses were often used to make up the shortfall in staffing numbers. The service requested staff familiar with the service. Staff informed us agency staff had also been used in the past.

Managers made sure all bank and agency staff had a full induction and understood the service. We were informed a checklist is completed prior to any agency or bank staff member starting a shift. It included information such as registration checks, tour of the ward, safeguarding procedures, looking over the resuscitation trolley and a discussion of medications management. The agency and bank staff member would complete a walk around and discuss any training needs. The nurse in charge would sign and date a form to confirm that had happened.

From April 2021 to September 2022, the nursing vacancy rates for the paediatric outpatients was 20%, for the PICU it was 18%, for Rays of Sunshine ward 30% and for Toni & Guy ward 20%.

The trust was actively recruiting against a reported national nursing staff shortage. Ward managers and matrons we spoke with told us new staff had recently joined and more were expected in the coming months. Senior management told us 57 nursing staff had been recruited. Thirty-five had started in September, 7 were due to start in November, 14 in January 2023, and 8 newly qualified nurses were still awaiting a start date.

We asked the trust what plans had been put in place to lessen the impact of not enough nursing staff and they told us the following:

- All e-rosters were completed in a timely fashion with all ward managers and matron working clinical shifts which were rostered each week/month.
- They had a 24/7 senior nurse (band 7) on duty 365 days who reviewed staffing levels across the whole of children's areas and ensured all areas are safe
- They had 2 internal bed meetings per day which included the nurse in charge, ward manager, Matrons, Lead nurses, Head of Nursing to review bed capacity and staffing levels. Staff were moved around as required.
- All Practice Development Nurses (PDNs) worked clinical shifts as well as non-clinical.
- Clinical Nurse Specialists (CNSs) during the past year were asked to work clinical shifts when staffing was extremely short on the wards to support.

Medical staffing levels on Rays of Sunshine ward during the day was 1 consultant, 2 or 3 registrars, 2 or 3 senior house officers (SHO) and one advanced nurse practitioner. During the night there was a consultant on call (who lived with 30 minutes of the hospital), 1 SHO and a registrar responding to calls or bleeps.

All doctors below the level of consultant are now commonly referred to as junior doctors, although many will have years of experience.

Medical staffing on Toni & Guy ward was consultant cover weekdays 9am – 9pm and at weekends 9am – 5pm. We were told they were trying to recruit a further 3 consultants to provide the same weekend cover as weekdays.

The NICU had 9 resident consultants backed up by consultants on call 24/7. At night 1 SHO covers intensive care.

There were general medical and paediatric intensive care consultants to cover 7 days a week. Consultants were on call during the night.

Managers could access locum staff when they needed additional medical staff. We were informed there was a heavy reliance on locum doctors. A locum doctor is a doctor who provides temporary cover for another doctor who is not available. For August, September and October 2022, the figures for shifts filled by bank or agency junior doctors were 53, 70 and 60 respectively. For consultants the figures were 19, 35 and 15 respectively. In both cases the use of agency staff was below 1%. Vacancies for junior doctors at the time of the inspection were 14 whole time equivalent (WTE) permanent posts and 1 WTE fixed term post. For consultants the vacancies were 3 WTE permanent posts and 2.2 WTE fixed term posts.

Records

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

Patient notes were comprehensive, and all authorised staff could access them. The service had an electronic system which ran alongside paper records. Staff told us they could easily and quickly access patient records. When children and young people transferred to a new team, there were no delays in staff accessing their records.

We inspected 22 patient observations charts. All the records were contemporaneous. The observation charts included detailed BPEWS and accurate pain assessments. Staff we spoke with understood the treatment plans for individual patients.

We accessed and reviewed several online patient records across wards. All were completed to an acceptable standard.

Records were stored securely. We observed all paper records on the wards being stored in a locked cabinet. The key was kept with a registered nurse.

Following the inspection, we reviewed the Data Protection Policy. The information was up to date and relevant. The policy was version controlled and the next review date was 31 October 2022.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. We observed staff administering medicines in line with trust policy. Staff informed us they receive daily support from the pharmacy team.

Following the inspection, we reviewed the Medicines Management Policy. This was version controlled and the next review date was February 2023. The policy included safe prescribing, dispensing and supply, storage and security of medicines, dose preparation and administration and safe disposal of medicines.

A range of other medicines policies were available to staff, including for example: Homecare Medicines Policy, Controlled Drug Policy, Access to Medicines Policy; Self Administration of Medicine Policy.

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people and their carers about their medicines. Staff told us the medical team and/or the nursing team reviewed patients' medicines daily and again depending on any medical results received. Staff were positive about the arrangement and told us there was good collaborative working between the two teams.

Staff completed medicine records accurately and kept them up to date. We reviewed the controlled drug (CD) book on Rays of Sunshine ward. The CD count was correct, and all the CD's were in date.

We were told the pharmacy technician reviewed the medicines stock list and ordered the required medicines appropriately. The medicines were checked every morning by the paediatric pharmacist, who also reviewed the order book. Staff told us the pharmacy team were approachable and visible. The pharmacy team were on call and available 24/7.

All the fridges we checked where medicines were kept were at the correct temperature and recorded correctly on the audit sheet.

Services for children and young people

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services. The patient's medicine charts were electronic so moved with the patient if they moved between services.

Staff learned from safety alerts and incidents to improve practice. Staff informed us safety alerts were shared by email and printed and displayed prominently around the ward to keep staff updated. Safety alerts were also discussed in the Child Health and Governance Risk Committee (CHGRC) meeting and Child Health Incident Meeting (CHIMe) and feedback was provided to staff.

The service ensured patient's behaviour was not controlled by excessive and inappropriate use of medicines.

The trust had a Restraint and Restrictive Practices Policy which was very detailed and followed the National institute for Health and Care Excellence (NICE) guidelines. The policy covered a range of sections, such as roles and responsibilities, governance, legal framework, types, chemical and rapid tranquilisation. It stated anti-psychotics and antidepressants, or both, must not be prescribed in response to challenging behaviour without appropriate clinical reason. It also stated chemical restraint must only be used as part of an agreed support, and only to be given by staff who had relevant qualifications, skills and experience.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

In the 12 months prior to our inspection children's services staff reported 1261 incidents. Incidents were categorised according to a colour system – Red (major), Amber (moderate), Yellow (Minor) and Green (no obvious harm). Only 2 incidents were listed as red, with141 amber, 805 yellow and 313 green.

The highest total number of incident reports received were about:

- Medicines
- Appointment, admission, transfer and discharge
- Staffing issues

Staff knew what incidents to report and how to report them. Staff we spoke with understood their roles and responsibilities in reporting incidents. Staff told us there was a 'no blame culture' at the hospital and they were encouraged to report incidents.

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

Staff we spoke with understood the practise and responsibilities of duty of candour and complied with the Being Open & Duty of Candour Policy.

Duty of candour means every healthcare worker must be open and honest with patients when something goes wrong with their treatment or care. It is a legal obligation that care providers must inform the people affected by the incident, offer reasonable support, provide truthful information and a timely apology.

Services for children and young people

Managers ensured patients, families and staff were kept informed about incidents and provided support during any investigations. Staff told us all discussions were noted in the patient notes.

Managers investigated incidents thoroughly. We saw a breakdown of incidents by category that allowed trends to be identified.

Staff involved in an incident received direct feedback after the investigation was complete which included personal learning.

Incidents were discussed at the monthly Child Health Incidents Meeting (CHIMe) and the Child Health Governance and Risk Committee Meeting (CHGRC). Learning and improvements was shared with staff via the Child Health safety newsletter and general staff meetings.

There was evidence of change of practice from incidents. Staff told us a large piece of work had been completed on staff recognition of sepsis following an incident last year. This included mandatory training for sepsis and a business development plan for an 'I-mobile' team assisting with the escalation and earlier intervention processes.

Is the service effective?

Good 

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff we spoke with knew where to find policies and local guidelines which were available on the trust's intranet.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Staff told us the induction for new starters included training for mental health. There was a mental health nurse who provided specialist support for patients with mental health needs. Staff we spoke with understood the needs of patients requiring assistance for their mental health. Where staff were unable to assess a patient then they would escalate to the mental health nurse.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. The nurse on a handover had a comprehensive understanding of the patient's needs. They provided background information about each patient and included their emotional and psychological needs and what measures had been put in place i.e. assessments completed, and action plans put in place. The information was recorded in the patient's file.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for children, young people and their families' religious, cultural and other needs.

Services for children and young people

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. The patient records we looked at included an assessment of each patient's nutritional requirements. Staff told us if a patient required specialist nutrition, then their food and hydration intake would be closely observed.

Staff fully and accurately completed children and young people's fluid and nutrition charts when needed. Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition. They completed hydration assessments by the patient's bedside. Results were recorded in the patient's record to ensure the patient's nutritional and hydration needs were assessed and monitored.

The nutrition and hydration committee group held meetings to discuss the hydration and nutrition needs of patients. The group reviewed and ensured the correct risk assessments were completed for each age group.

Staff told us a menu card was provided to patients every day at 6am, so patients could select their menu in the morning. The catering team provided differing menus for different age groups. Sandwiches, snacks and drinks (squash and water) were available throughout the day. Staff told us when a patient was going for surgery and were nil by mouth, they would ensure food was available for the patient when they returned from surgery.

Specialist support from staff such as dietitians was available for children and young people who needed it. Occupational therapists, physiotherapists and dietitians worked alongside clinical staff. There was a multidisciplinary team approach to see the holistic care of the child. Staff told us there was also support for patients following their discharge.

Staff on Princess Elizabeth Ward told us there was a dietitian on the ward who completed a yellow sheet for all patients, and this was placed in all the patients' records. The dietitian also completed specific referrals if the patient needed extra support with their nutrition or hydration.

The patients and family or carers we spoke with on Toni & Guy and Rays of Sunshine Wards provided positive feedback about the food and drinks.

We were told when mums were breastfeeding, food and drink was offered to them. The ward worked together with PICU or the post-natal unit for any breastfeeding assistance. We inspected the fridges where the breast milk was kept. Each one was labelled correctly with the date, time and baby name. All the fridges we checked were at the correct temperature and recorded correctly on the audit sheet.

The nursing team were responsible for ensuring patients drank the recommended amount of water depending on their age. Staff on Princess Elizabeth Ward told us each patients' weight was taken on admission and every Wednesday and Sunday. The patient's height and weight would be put on the electronic system which would allow staff to monitor the patient's nutritional needs and escalate to the dietitian if required.

Specialist support from staff such as dietitians was available for children and young people who needed it. Occupational therapists, physiotherapists and dietitians worked alongside clinical staff. There was a multidisciplinary team approach to assess the holistic care of the child. Staff told us there was also support for patients following their discharge.

Patients with complications related to excessive weight (CREW), sometimes referred to as bariatric patients, were treated by a newly formed combined paediatric team.

Services for children and young people

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice. The service used multiple systems to record patient pain scores i.e. the use of FLACC, emojis or scoring pain level from 1-10. Staff told us they provided pain relief based on the score and information provided by families or carers.

FLACC is an acronym of Face, Legs, Activity, Cry, Consolability and is a measurement used to assess pain for children between the ages of 2 months and 7 years or individuals who are unable to communicate their pain.

Staff reviewed the patient every hour after. Staff would complete the same assessment again to see if the patients pain level had decreased or if they required further pain relief.

Staff prescribed, administered and recorded pain relief accurately.

If there were language barriers or non-verbal patients, staff told us they would use FLACC to understand the level of pain they had.

If a patient was suffering from chronic pain, a referral was made by the ward to the pain nurse who would work closely with the pain consultant, patient and family or carers.

Children and young people received pain relief soon after requesting it. The patients and families we spoke with told us staff provided prompt pain relief. Families were complimentary of the level of care provided to their loved ones.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

The service participated in relevant national clinical audits in order that benchmarking and measuring of clinical effectiveness could take place. Staff told us the service focused on national audits which were reviewed within the care groups and within the corporate group. These included:

- mothers and babies reducing risk through audit and confidential enquiries across the UK
- liver transplantation – paediatric annual report
- paediatric diabetes national patient reported experience measures (PREMs) report.

The service also contributed to the Paediatric Intensive Care Network (PICANet) Annual report 2021, published Jan 2022.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards. The service told us they monitored national audits which were rated green, amber and blue. The results of 10 national clinical audits were reviewed this quarter, 8 were rated green, 1 amber and 1 blue.

The trust audited how they complied with the clinical guidelines against a trust target of over 90%. For children's services the in-date figure was 63% and it was acknowledged staffing levels during the Covid-19 pandemic meant some audits had not been completed on time. However, the trust had participated and submitted in 100% of mandatory national audits. We were supplied with a copy of a clinical effectiveness report for children's services dated October 2022. In the report it stated the care group clinical audit programme had been shared with the trust's patient outcomes team. Audits were also discussed at the Child Health and Governance Risk Committee and the Child Health Clinical Audit and Quality Improvement Programme.

Ward managers told us they completed monthly audits in hand hygiene, PPE, staffing and training, the outcomes was shared monthly on a newsletter. The newsletter also included patient feedback and incident audits/trends.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used information from the audits to improve care and treatment. They also investigated outliers and implemented local changes to improve care and monitored the improvement over time. Outliers are results better or worse than the normally expected results.

Managers shared and made sure staff understood information from the audits. Staff told us ward meetings, unit monthly meetings, care group newsletters and performance noticeboards provided information about audits and kept staff well informed.

Competent staff

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

The clinical educators supported the learning and development needs of staff. We were told there was a lead nurse for education and training, who also ensured the practice development of nurses across the care group. There were 8/9 practice development nurses across children services.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. On Rays of Sunshine Ward most staff were trained in paediatric immediate life support. A few staff had completed the advanced paediatric life support course.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with told us they had attended a two-week induction programme and had completed mandatory training, including basic life support. The induction programme included e-learning, equipment training and meeting the team.

Managers supported staff to develop through yearly constructive appraisals of their work. In these meetings managers encouraged developmental conversations and proposed potential courses or study days to attend. Managers we spoke with told us during the appraisals they would discuss achievements through the year, set objectives for the year ahead and how best to achieve them.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us there were daily huddles which kept them well informed. Ward meetings took place biweekly or monthly and important information from those meetings would be shared via email. In addition, the staff area had folders containing the information.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with told us they felt well supported when discussing their training and development needs. We were told new members of staff had study days booked in for one year to ensure they were provided with enough time to complete their studies. Staff said there were good working relationships in the teams.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Ward managers told us there were opportunities for development and progression. However, currently there was not enough time for staff to do this due to the increased rate of staff vacancies. Staff said it was physically impossible to do both. Ward managers told us the senior management team were supportive, visible and approachable and understood the concerns regarding staffing.

Managers made sure staff received any specialist training for their role. All staff had an electronic profile which suggested training required for their role. Managers liaised with the learning and development team following appraisals and highlighted any specialist training required for the staff member. Staff we spoke with were positive and complimentary about the learning and development team.

The learning and development team also scheduled training following incidents. This training would be specific to the concerns raised by the incident.

Managers identified poor staff performance promptly and supported staff to improve. The ward managers we spoke with told us they would support staff in practise. A learning and development plan would be formulated with the assistance of the practise development nurses. Specific, Measurable, Achievable, Relevant and Time-bound (SMART) objectives were discussed and a set timeframe to complete them would be agreed. When staff members performance did not improve, ward managers would contact the employee relations team for advice.

Managers recruited, trained and supported volunteers to support children, young people and their families within the service. Staff told us volunteers were on the wards to support children with reading and to help comfort them. They were there to provide a distraction if required and to assist with feeding. The welcome board on the wards we inspected had information about how the volunteers could assist. However, staff members we spoke with did not know the official title of the volunteers or how many volunteers were on each ward.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Staff held regular and effective multidisciplinary team meetings (MDT) to discuss children and young people and improve their care. Staff we spoke with told us most meetings were MDT meetings i.e. ward meetings, governance meetings, Child Health Incident Meeting (CHIMe) and Child Health and Governance Risk Committee (CHGRC), child executive meetings and child health board meetings. MDT meetings also incorporated services that were not directly managed within childcare but managed children.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. Staff told us there was good MDT working across the children's division and with other services across the trust, such as the speech and language therapy (SALT) team.

Services for children and young people

Staff referred children and young people for mental health assessments when they showed signs of mental ill health or depression. A risk assessment was completed by the staff member and if escalation was required a referral was made to the mental health nurse.

Seven-day services

Key services were available seven days a week to support timely patient care.

The children's services operated 365 days a year and 24 hours a day, except for the outpatient department and day care treatment centre.

Support from doctors and other disciplines, including mental health services and diagnostic testing was available 24 hours a day, seven days a week.

Consultants led daily ward rounds on all wards, including weekends. Staff told us there were various consultants available 24/7. Resident consultants within the unit were available 24/7 ensuring the patient was assessed and when required any urgent matters dealt with quickly.

We were told most consultants live a short driving distance from the hospital.

Children and young people were reviewed by consultants depending on the care pathway. We were told if a patient's pathway was complex the consultant would lead the care and were stationed within the area the patient was.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards and units. The wards we inspected had wellbeing walls which provided patients and their families information about free NHS wellbeing resources and details on how to obtain emotional and psychological support.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle**.**

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff told us they would explain the procedures to the patient and ascertain their consent from them and/or their family or carer. If required, an MDT approach would be taken.

Staff made sure children, young people and their families consented to treatment based on all the information available. Staff knew the process of obtaining consent. However, where consent could not be obtained and there were differences of opinion, an external service would be asked to comment and to obtain a mutual agreement. Patients and family members we spoke with told us they were well informed before they consented for any treatment.

Services for children and young people

When children, young people or their families could not give consent, staff made decisions in their best interest, considering their wishes, culture and religious beliefs. The service had a young person's monthly forum which allowed children to have a voice. An example of this was incorporating Halal options into meal choices.

Staff recorded consent clearly in the children and young people's records. On the neonatal unit, consent was recorded on paper records. The other paediatric services consent was recorded digitally.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. Staff were able to explain the Gillick Competence 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.

We reviewed the Consent Policy, which was in date and due for review on 26 September 2024. The policy included information related to:

- provision of information to support informed consent,
- responsibilities,
- incapacitated adults and the Mental Capacity Act 2005,
- best interest of patients,
- treatment of children and refusal of treatment by children.
- Restraint and Deprivation of Liberty Safeguards
- Advance decisions
- Consent training.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. We were informed staff regularly assessed the needs of mental health patients. When risk assessments were completed and/or concerns were raised, staff would work alongside mental health nurses to ensure the safety of the patient.

Is the service caring?

Good

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. In our conversations with staff they spoke about past and present patients by name.

Services for children and young people

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. One example told to us by a parent was of twins put in a larger room so they could be together for their care.

Most of the parents or carers we spoke with were very satisfied with the care their child had received. They told us the staff treated them well and with kindness.

Staff followed policy to keep care and treatment confidential.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We reviewed the arrangements in place for when a patient died. The bereavement team were caring and compassionate. The team were able to provide age appropriate books for siblings to help them understand what had happened, although it was noted that currently the books were only available in English. Families were provided with a bereavement support booklet which explained everything the hospital would do and had information about registering the death and online links to support providers websites.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their family's wellbeing.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Patients and family members we spoke with confirmed this. We were told both the medical and nursing teams listened to any concerns and explained the treatment proposed and why it was necessary.

Children, young people and their families gave feedback on the service and their treatment and staff supported them to do this. The friends and family test 12-month survey showed patients and their families rated both the inpatient and outpatient as having met the benchmark or just below the benchmark set by the hospital. This was in line with what we were told by patients and their families.

Patient feedback forms were on a digital tablet on the wards we visited. There was also an A5 poster with a digital quick response (QR) code that patients scanned and provided feedback digitally. Staff told us a paper version was also available and given to the patient on discharge. However, staff said this was often not prioritised and forgotten about when patients were discharged.

Services for children and young people

The hospital had recently started a young person's patient forum for 11 to 16-year olds, called 'King's Young People', which originated from an idea of a young patient. They met online after school finished and the forum provide an opportunity to make improvements to children's services.

Staff supported children, young people and their families to make informed and advanced decisions about their care.

Is the service responsive?

Good 

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The population around the King's Hospital site is diverse and patients can present with complex health needs. Managers planned and organised services, so they met the needs of the local population. As well as local patients, the hospital was a national hub providing a highly specialised service to children with liver problems. It is the largest of only three such centres in the Country. Patients were referred to the hospital from other UK hospitals and internationally.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

The hospital was built in the early 20th century and the original building makes expansion of services and the addition of new services complicated. Despite that, the premises and facilities were generally appropriate for the services being delivered.

The service had general paediatricians working with GP's in the local London boroughs of Lambeth and Southwark. They were able to hold MDT meetings with GP's and child mental health practitioners. They also held external specialist paediatric surgeries for local patients.

Staff could access emergency mental health support 24 hours a day, 7 days a week, for children and young people with mental health problems and learning disabilities.

Managers monitored and took action to minimise missed appointments and ensured those who did not attend appointments were contacted. Within the children and young people's outpatient department, for patients who had to be seen by different specialities, staff grouped appointments together, where possible, to limit patient travel and save them time.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Staff made sure children and young people living with mental health problems, learning disabilities and long term conditions received the necessary care to meet all their needs.

Services for children and young people

Wards were designed to meet the needs of children, young people and their families. The service had made the wards as welcoming as possible for children and young people of all ages.

Facilities were available on most wards for a parent or carer to stay overnight with the patient. Rays of Sunshine Ward had accommodation available near to the hospital, which was mainly used by families of patients who were undergoing transplant assessments.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. That was especially true for young people with complex liver disorders. Older patients who had liver transplants attended joint adult and children and young people clinics where they were seen by both consultants for a seamless transition to adult services.

Children's services had plans in place for young people to transition to adult services. They provided 3 questionnaires for the patient, one for parents and a transition booklet. The programme was called Ready Steady Go. In addition, they had specific internal planning documents for patients undergoing treatment for Cystic Fibrosis, diabetes, inflammatory bowel disease and liver transplantation.

We were told by staff very few children and young people patients were treated in adult based areas, but if they were, they were always included in the children and young people consultant's ward rounds.

The service had play specialists and for those patients able to attend an education centre was available five days a week. However, at the time of our inspection it was closed for half-term.

Staff had received mental health training in the form of a programme called "We can talk". There was also e-learning available on how to respond to people in crisis.

Translation services, including sign languages, were available for patients and families who did not speak English as their first language.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help children, young people and their families become partners in their care and treatment.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were in line with national standards.

Children and young people accessed the children's services via their GP, referred by other hospitals, via the emergency department and sometimes via an international referral.

Children's services had their own outpatient department and a day treatment centre named the Philip Isaacs day Treatment Ward.

It was reported by staff and management we spoke with the number of cots in both the Neonatal Intensive Care Unit (NICU) and the Paediatric Intensive Care Unit (PICU) were not enough for the number of patients. The PICU had 8 beds, but 5 were occupied with long term patients which meant effectively there were only 3 PICU beds available at any one time. We were told this occasionally meant elective surgeries were cancelled and patients kept longer on the wards, although we were told liver transplants were never cancelled.

During the 12 months before our inspection NICU staff declined to accept 76 patients due to issues with capacity. PICU staff had to decline to accept 59 patients referred from the critical care network and 25 elective (planned) patients due to lack of beds. During the same time period 1 NICU patient was transferred to another centre due to lack of ICU cots at the King's College Hospital. No PICU patients were transferred out.

Despite this managers and staff worked hard to make sure children and young people did not stay longer than they needed to and kept the number of cancelled operations to a minimum.

The trust had plans and funding in place to increase the number of available ICU beds which would begin in the spring of 2023. A new paediatric iMobile (critical care outreach) team will provide rapid response and stabilisation to patients who need immediate attention and transfer.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. Long term children and young people patients, such as transplant, oncology and cystic fibrosis patients, had open access to the services when they required it.

Discharges were actioned as soon as possible due to bed pressures with at least daily consultant ward rounds to expedite discharges.

Staff supported children, young people and their families when they were referred or transferred between services.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns and the service clearly displayed information about how to raise a concern in patient areas. We saw each had a noticeboard and one of the items displayed was how to contact the Patient Advice and Liaison Services (PALS).

The hospital had a complaints policy approved by the patient experience committee. It was in date and next due for review in November 2024. The policy set out its purpose, scope, the duties of staff and the timescales to be adhered to.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with told us they had few complaints as they worked with patients and families to mitigate minor issues. But we were assured they also knew when to escalate matters more formally.

Staff knew how to acknowledge complaints. Children, young people and their families received feedback from managers after the investigation into their complaint.

Services for children and young people

In the 16 months prior to our inspection the hospital had received 24 complaints about the children's services at the hospital site. After investigation, 6 were not upheld, 7 were partially upheld and 8 were upheld. Three complaints were resolved locally on the ward. In each case the outcome was recorded, and managers shared feedback from complaints with staff and learning was used to improve the service. We saw evidence of changed protocols resulting from the complaints investigations. We saw evidence of staff being open and honest and apologising in line with the Being Open and Duty of Candour Policy.

Is the service well-led?

Good 

Leadership

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

The children's services had their own clinical lead, head of nursing and a newly appointed general manager. Deputy directors, outcome and governance leads senior managers, matrons and lead nurses all reported to the senior team.

Leaders we spoke with understood the challenges with staffing and quality & sustainability and were able to identify the actions required to tackle them.

Regular meetings between the matrons, sisters and staff nurses and attended by the nursing leads took place to discuss what was happening within the department. Information was then fed back to the executive team.

Staff we spoke with confirmed the leadership team were visible and approachable. We saw matrons and ward managers working alongside other nursing staff and with doctors and consultants.

Vision and Strategy

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

In July 2021, King's College Hospital NHS Foundation Trust published their 5-year strategy which included their BOLD vision for the future of the trust. The BOLD acronym stood for Brilliant people, Outstanding care, Leaders in research, innovation and education, and Diversity, equality and inclusion at the heart of everything we do. Children's services had appointed a new general manager to embed the new strategy.

We were told staff said at their exit interviews (when they left the trust) they hadn't felt heard in child health. There had been a change in leadership with a new clinical director and management was fully engaged with staff retention, training and listening to staff.

Services for children and young people

Culture

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

The trust was invested in the wellbeing of their staff, especially considering the sustained pressure staff had faced and were still experiencing after the pandemic. There was recognition that the wellbeing and morale of staff was impacted over the last few years.

Staff told us they had support through the employee assistance programme, which included support with financial issues, bereavement and other pressures. Staff also talked about many wellbeing resources.

Staff we spoke with told us they felt supported, valued and respected at work. They told us their management team were approachable. They said there was cohesive service management on the wards and a strong, open and honest senior management team.

Over half of the trust's staff were people from ethnic minority groups. Children's services had set up their own Equality, Diversity and Inclusion (EDI) group which formed part of the trust's EDI vision and strategy. It had monthly meetings with ambassadors and core members. EDI was included as an objective in consultant discussions.

We spoke with staff from ethnic minority groups who told us they had felt more confident and assured of equal treatment over the last two years and in particular, since the appointment of the newly created substantive role of Director of Equality, Diversity and Inclusion in April 2021.

The trust had a published document titled 'Roadmap to Inclusion 2022-2024' and stated in the foreword, the roadmap "will ensure we turn our ambitions into real, meaningful improvements for colleagues, patients, and everyone connected to King's. It sets out the tangible and practical steps we will take to achieve our ambition to put diversity, equality and inclusion at the heart of everything we do".

The trust had a system called great-ix which is an initiative to allow NHS staff to say thank you to each other and help make their colleagues feel valued and appreciated. They had introduced the King's quarterly staff awards ceremony and the annual King's Star awards to regularly recognise individuals and teams who make outstanding contributions to patient care.

Governance, risk management and performance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

The management team had weekly safety huddles to review anything that had happened that week. They had monthly Child Health Incidents Meetings (CHIMe) and Child Health Governance and Risk Committee (CHCRG) management meetings. We reviewed several meeting minutes and saw safety alerts, incidents, reported incident trends and great-ix were discussed.

Reported incidents were discussed and allocated to members of the senior team for investigation and to report back to the meetings. Incidents were tracked, reviewed and any learning cascaded to children's services staff and throughout the trust if applicable.

Patient and carer experiences were also reviewed, and actions taken. For example, the children's outpatient department had received a large amount of feedback data; of which 85% were very good or good. However, 9% had rated the service as poor, mainly around appointment bookings and clinicians being delayed. An audit of waiting times was put in place and a working group set up focussing on waiting times. An action tracker was also created for patient feedback to improve the patient experience.

The service had a risk register which showed 14 children's services risks identified at the King's College Hospital site, these included the nursing staff vacancies and the NICU issues. Each risk had a senior manager allocated to it, what controls were in place, principal objectives, actions planned, target completion date and the next review date.

Participation in a host of national and local audits meant the service could measure their clinical effectiveness and performance against a range of peer groups and national outcomes. Links had been established with the two other children's liver centres in Leeds and Birmingham to compare patient outcomes and improve services.

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.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

At the time of our inspection Children's services used a mixture of digital and paper systems for patient records and other documentation. Patient consent was paper based in neonatal but digital in paediatrics. The clinical director told us bedside paediatric early warning system (BPEWS) charts were planned to be digital by the week after our inspection.

All authorised staff had the access they required to patient records, care plans, policies and other documentation.

Staff underwent information governance training and had a named person to contact if they were concerned about any breaches. The trust had a comprehensive data protection policy, although we noted it was due to be reviewed at the end of October 2022.

The service regularly audited their clinical performance and engaged with staff and patients to review and improve the service.

Patient outcomes and other data was regularly submitted to the NHS and national bodies as required.

Engagement

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

The service ensured patients had the opportunity to give feedback via the standard friends and family test (FFT) feedback forms and the newly formed King's Young People group.

The trust ran regular patient forums and encouraged local people to be involved with their hospital.

The service had close links with a local mental health hospital and with Child and Young People's Mental Health Services (CYPMHS), which used to be known as Child and Adolescent Mental Health Services (CAMHS).

General paediatricians collaborated with Lambeth and Southwark GP surgeries holding specialist surgeries and MDT meetings which helped with fewer hospital attendances for local patients. They also had 2 paediatric nurses able to visit local patients at home.

Feedback was requested from staff at regular staff meetings and in their appraisals. Staff told us they were comfortable to comment on future plans or changes to the service.

The service conducted a yearly staff survey. Last year amongst other changes which included the great-ix system and updated staff rooms, the service introduced its own equality, diversity and inclusion (EDI) group. This year's survey had just been conducted and the results were not available at the time of reporting.

Learning, continuous improvement and innovation

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

All staff had opportunities for learning and to improve services via the LEAP system, presentations and other education. However, as previously mentioned, it was not always possible for staff to take up those opportunities.

The network governance board looked at quality and how the service compared across the network.

The service had its own child health research lead and the corporate research lead also worked within the service. The clinical director told us he wanted the service to be at the forefront of child and young people's healthcare. He cited the service had conducted the only living related bowel transplant in children within Europe and had pioneered the use of rectus muscle sheets to close abdomens. Also, he said they gave the latest monoclonal antibody to the youngest sickle cell patient and they are rolling out new cystic fibrosis (CF) drugs to their CF patients.

The service held Grand Rounds (involving the formal presentation by an expert of a clinical issue) and audit presentations each month so staff could understand the innovations and research going on.

The general paediatric team won the London area best training unit for their education. The junior doctors got twice weekly 'bleep free' education sessions. We were told there was a lot of simulation training, which was how a lot of learning was derived from incidents. The outcomes were shared with the London School of Paediatrics and the NHS network.

For leaders there was the leadership programme from the trust and the senior team had all had compassionate leadership courses to help improve listening to people. They had introduced 'town halls' meetings where all the staff could gather together to hear about the leadership, innovation and start to think about leadership roles for themselves.

Services for children and young people

The service had secured funding to develop the paediatric oncology shared care unit (POSCU) to provide further support for their patients.

The paediatric team had worked collaboratively with another nearby paediatric team and secured funding from NHSE for 2 years to develop a new combined Complications Related to Excessive Weight Service (CREW) with medical, nursing, therapy and administration provision. There were now 36 patients being seen by the CREW service.