CareQuality Commission

King's College Hospital NHS Foundation Trust

Princess Royal University Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Princess Royal University Hospital (PRUH) is part of King's College Hospital NHS Foundation trust. The Trust provides local services primarily for the people living in the London boroughs of Lambeth, Southwark, Bromley and Lewisham. The PRUH serves a population of approximately 300,000 in the borough of Bromley.

King's College Hospital NHS Foundation Trust employs around 11,723 whole time equivalent staff with approximately 2,572 staff working at the PRUH.

We carried out an announced inspection of the PRUH between 13- 17 April 201. We also undertook an unannounced visit to the hospital on 22 April 2015.

Overall, this hospital requires improvement. We found the maternity and gynaecology services and services for children and young people were good. Urgent and emergency care, surgery, medical care, critical care, end of life care outpatients and diagnostics and imaging required improvement.

Patients received effective care and they were positive about their interactions with staff. Action needs to be taken to improve the responsiveness and some aspects of the safety and leadership in order to meet the needs of patients.

Our key findings were as follows:

Safe

- Since our last inspection a lot work had been done to improve the reporting and investigating of incidents. Many staff we spoke with told us they were was an open culture and they were encouraged to report incidents.
- One of the key problems facing the hospital was the recruitment of substantive staff. Although the hospital was actively recruiting staff and there had been some improvement since our last inspection in December 2013, recruiting substantive staff was still a problem across most services.
- Staff were aware of the policies for infection prevention and control and adhered to them. The clinical areas we visited were clean and tidy.
- There was good pharmacy support for clinical areas. However on some areas, including medical wards and theatres medicines were not always stored safely. For example r was unlocked when theatre lists were running and on medical wards rooms storing medicines were not always locked and medicine trolleys were not always secured to the wall.
- Access to and availability of equipment had improved since our last inspection. However equipment was not always cleaned and checked in line with trust policy.
- In some services the environment needed to be improved. The environment in the surgical assessment unit was cramped and afforded patients little privacy. Confidential information could be heard when staff went through the theatre checklist with patients. A recent reconfiguration to the main waiting area of the imaging department meant that people with limited mobility had to negotiate two sets of manual doors. The amount of chairs in the waiting area of the imaging clinic had also been significantly reduced which had resulted in patients standing and waiting for their appointment most of the time.
- The hospital used paper records and on some medical wards and critical care we found omissions in patients notes. For example there were omissions in risk assessments or assessments by a physiotherapist or occupational therapist.
- The availability of medical records in the outpatients department was a significant issue at our last inspection in December 2013. At this inspection, we found some improvements had been made, including a new medical records library at Orpington Hospital site which meant that records were delivered to the clinics more quickly. However, problems still remained in outpatients departments, day surgery unit and medical wards.

Summary of findings

- The introduction of a new IT system had caused significant problems. There were problems with how the new system interfaced with existing IT systems which resulted in some patients having five or six hospital numbers. Some clinic dates did not migrate accurately which meant that many people attended for an appointment on the wrong day. The hospital was working to resolve the issues
- Attendance at mandatory training had improved along with the system for recording and monitoring attendance.

Effective

- Most of the services we inspected provided effective care. National guidance was used to inform the care and treatment of patients and services participated in national and local audits.
- There was good multidisciplinary working in many of the services except for some of the medical wards where staff felt the focus was on discharging patients quickly. They felt that little attention was paid to concerns raised by other healthcare professionals. Some of the therapists felt their opinion was not always valued by certain members of the nursing and medical team.
- Staff appraisal had been identified as an issue at our last inspection and there had been some improvement. In some areas all staff had had an appraisal whereas in others, they were still working towards this. In theatres, the number of staff who had had an appraisal was low, with at least ten staff who had not had an appraisal since 2012.
- Patients received timely effective pain relief and the nutritional needs of patients were being met.
- Understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was variable: in some areas it was very good, but in others such as in medical care, more work was required. In surgery we found some of the consent forms did not include all the risks and benefits of a procedure.
- Documenting of do not attempt cardio pulmonary resuscitation (DNACPR) orders required more work The trust policy was not embedded and there was a variation in completion of orders.
- Average length of stay was higher than the England average for most of the elective and non-elective procedures at the Princess Royal University Hospital.length of stay was higher than the England average for most of the elective and non-elective procedures at the Princess Royal University Hospital
- The risk of readmission for elective general medicine was noticeably worse worse than the England average at the Princess Royal University Hospital In surgery the relative risk of re-admission to the PRUH following surgery was reported to be less than the England average for the top three elective and non-elective surgical specialities.

Caring

- Patients we spoke with were positive about how staff cared for and engaged with them. They told us staff treated them with dignity and respect and maintained their privacy.
- We observed staff being friendly towards patients and treating them and visitors with understanding and patience.
- Patients felt they were listened to and were involved in discussions about their care and treatment.
- Parents felt involved in the care of their child and participated in the decisions regarding their child's treatment.

Responsive

- The hospital continued to experience severe difficulties managing patient movement ("flow") around the hospital. There were difficulties in managing bed capacity. Both of these issues impacted on several core services. Bed capacity had consistently been above 90% since April 2013. This had been identified at the previous inspections and although some action had been taken, particularly in the emergency department (ED), the problem persisted.
- The ED was not achieving the four hour standard to see, treat and discharge patients within four hours and once a decision to admit a patient was made they often had to wait more than 12 hours for a bed to become available.
- In surgery, operations were cancelled, and not always rescheduled and undertaken within 28 days. Critical care had experienced over 100% capacity in the four months preceding the inspection with over 40% of discharges being delayed by more than four hours between January and March 2015.
- The hospital referral-to-treatment times had been deteriorating since October 2013. It was below the England average but above the 90% standard.

Summary of findings

- There were regular delays in outpatient clinics, with patients waiting from a few minutes to over an hour. Staff were aware of the delays along with over booking of appointments but no systematic action had been taken to address the situation.
- In medical care the pressures on beds meant that that medical patients were sometimes admitted to non- medical wards and moved several times during their stay.
- Services, such as translation services, were available to meet the needs of individual patients. Specialist nurses were available and patients were referred to the falls team or tissue visibility nurses if they sustained a fall or developed a pressure ulcer. There was a learning disability nurse attached to the safeguarding team.
- There was good staff awareness about caring for patients who were living with dementia and how to meet their needs.
- Staff were aware of the complaints process and received feedback through governance meetings and newsletters.

Well-led

- At the last inspection we found significant problems with clinical governance at all levels in the hospital. Since our last inspection the leadership, governance and culture of the hospital has improved.
- Most of the services either had or were developing a local or trust wide strategy.
- Unlike the End of Life service at Denmark Hill site the service at the Princess Royal University Hospital was not commissioned which impacted on resources and long term planning. A business case had been submitted to the local clinical commissioning group but it had not been approved.
- Systems for clinical governance had been developed and were being embedded across services. Compared with the last inspection staff were able to tell us about how they monitored the quality of care they provided.
- Leadership had been strengthened and improved since our last inspection with additional staff being appointed clear management structures. The improvement was evident in improvements in service delivery, training for staff and monitoring the quality and safety of care provided. Many staff were positive about the local leadership and felt supported by their immediate line managers.
- There was an open culture and staff were encouraged to report incidents and concerns. Staff told us they were encouraged to share their ideas and felt they were listened to and treated with respect. They also commented on the good teamwork.
- Many services and staff had embraced the changes being part of Kings College Hospital NHS Foundation Trust had brought. A small number of staff felt the good work being done at the PRUH did not always get the recognition it deserved and that it was the "Kings way or no way".
- Work had been undertaken to improve engagement with staff and this was evident in discussions with staff, although more work was required with some senior medical staff. .
- Staff surveys had been undertaken to examine the cultural differences across the trust and a three year plan developed to address the differences identified. The most recent survey had found some improvements at the Princess Royal University Hospital.
- At the last inspection we commented on the commitment and motivation of staff and although not all of the problems had been resolved staff remained positive and motivated about working at the hospital.

We saw several areas of outstanding practice including:

- Recent data from the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP) had given the PRUH stroke service a Level A ranking. This is the highest possible rank and only eight per cent of stroke units in the country currently achieve it. This is a significant improvement as the hospital was previously rated as Level D and has risen to Level A in 18 months, making it one of the most improved stroke services in the country.Recent data from the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), had given the Princess Royal University Hospital stroke service a Level A ranking. This is the highest possible rank and only eight per cent of stroke units in the country currently achieve it. This is a significant achievement as the hospital was previously rated as Level D and has risen to level A in just 18 months, making it one of the most improved stroke services in the country.

Summary of findings

- Pets As Therapy (PAT) dogs is an initiative to help patients who may be feeling low after suffering a disability following a stroke, or who may have been in hospital for a long period of time. The stroke ward had introduced pet therapy and a dog and their owner visited the ward weekly. They visited patients who were unable to communicate and found they often made huge efforts to communicate with the dog. The stroke ward had introduced pet therapy and a dog and their owner visited the ward weekly. They visited patients who were unable to communicate and found they often made huge efforts to communicate with the dog.

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

Importantly, the trust must:

- Continue to work to improve the availability of medical records in the outpatients department and medical care wards.
- Work with key stakeholders to improve patient flow throughout the hospital to reduce waiting times in the ED, cancellation of operations and delayed discharges.
- Improve the system for booking and managing waiting times in outpatient clinics to reduce delays for patients and clinics running over time.
- Improve the environment in the surgical assessment unit.
- Review and improve record documentation to ensure it is fully completed and in line with national guidance including DNACPR orders.

In addition the trust should:

- Continue to recruit to substantive posts and ensure that there is always an appropriate skill mix of staff on duty
- Continue to embed the processes for monitoring and improving the quality and safety of care provided including incident reporting and learning from incidents
- Continue to improve the rate of staff appraisal and attendance at mandatory training
- Ensure all medicines are stored and secured in line with trust policy
- Improve the monitoring of hand hygiene in services for children and young people
- Ensure all equipment (including resuscitation trolleys) is cleaned, maintained, checked and secured in line with trust and national policies
- Continue to work to resolve the problems with IT system to ensure patient information is managed effectively and safely.
- Improve multidisciplinary working in medical care and services for children and young people.
- Improve staff awareness and understanding of their role and responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
- Continue to work with commissioners to ensure there is adequate funding and resources for the End of Life service

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The Emergency Department provided effective care and patients were positive about the care they received. However, some aspects of the service required improvement. Staffing levels, both medical and nursing, need to be improved. The children's ED did not comply with the Royal College Paediatrics Child Health (RCPCH) guideline's as they did not always have two paediatric trained nurses on duty twenty four hours seven days per week. The ED was not meeting the national standard to see, treat and discharge 95% patients within four hours. Between January and December 2014 the weekly performance ranged between 45% and 91%. Patients waiting to be admitted to the wards frequently waited longer than 12 hours for a bed to become available. Care was evidence based and the ED participated in national audits. Despite the long waiting times patients spoke positively about the care they received and said their dignity and privacy was maintained. Leadership in the ED had improved and there was good teamwork and an open culture. It did not have a written strategy and the problems with long waiting times remained even though senior management arrangements had improved since the merger with Kings College Hospital NHS Foundation Trust. This was mainly due to difficulties in admitting patients to wards leading to slow patient flow and a crowded department
Medical care	Requires improvement 	Patients receiving medical care were treated with dignity and respect. They told us they were treated with kindness and compassion, and most were involved in decisions about their care. Many improvements had been made since our last inspection in December 2013 but some aspects of safety required further work; patient records we reviewed did not always include information about the risks and treatment that patients had received and and were not always available.

Summary of findings

Wards generally had sufficient staff, but were sometimes staffed by newly qualified nurses and less experienced nurses. There were not always enough competent staff to undertake tasks such as phlebotomy and administer chemotherapy. This caused delays with admissions and impacted on patient care and treatment.
Stroke care for patients had improved and the performance in the Sentinel Stroke Audit Programme (SSNAP) was particularly praised as the hospital had significantly improved its rating over the past year.
The hospital was able to meet the needs of individual patients including those living with dementia but there were some delays with discharges. performance in the Sentinel Stroke National Audit Programme (SSNAP) was particularly praised as the hospital had significantly improved its rating over the past year and was now rated twelfth nationally.The hospital was able to meet the needs of individual patients including those living with dementia. However, some patients experienced a delay with their discharge.

Surgery

Requires improvement

Surgical services were well led and patients received effective care. Staff reported incidents and there were processes in place to monitor the quality of care provided.
Surgical procedures were sometimes cancelled and not rescheduled within 28 days; some cancellations were due to the lack of available medical records. Some patients had to wait too long from when they were referred to when they received treatment. Due to a lack of beds on the wards some patients were nursed in recovery areas overnight. Patient records were not always complete and medical equipment had not always been checked to ensure it was fit for use. Space in the admissions unit was limited and did not provide privacy and dignity for patients.
Anaesthetic medicines were stored in unlocked rooms and an audit of controlled drugs had found areas which required improvement.

Summary of findings

Patients had their nutritional needs assessed and met and effective management of their pain. They told us that they were involved in discussions about their treatment and relatives were informed of their progress.

Critical care

Requires improvement

Critical care services provided effective evidence based care and patient mortality outcomes were within the expected range.
Staff were caring and feedback from patient surveys was positive about staff. They were described as "friendly, kind, thoughtful and so attentive". People felt that their friend/family member had been treated with dignity and respect.
The service experienced problems with receiving and transferring patients due to capacity issues and a lack of available beds on wards for patients once they were well enough to leave critical care. The hospital had taken some action and was using two 'satellite' critical care beds but his had not resolved the problem. .
Information in some patient records was incomplete and some notes lacked sufficient detail. There were also problems with ventilators and the blood gas analyser, although steps were in progress to address these concerns.
Learning from incidents was variable despite staff having a proactive approach to reporting.
Senior staff, nurses, managers and consultants, told us they envisaged the service would be expanded but there was no plan or strategy to support this.
Staff were positive about the support they received from their line managers and were engaged in clinical governance activities.

Maternity and gynaecology

Good

Women and their families received good care in the maternity and gynaecology services. They told us they received good care and felt staff listened and involved them in decisions about their care.
The hospital had effective systems to respond and minimise risks to women. Since our last inspection more midwives had been recruited and support and leadership has been strengthened with the appointment of two senior midwives. Consultant cover over the weekend had improved and more consultants had been recruited.

Summary of findings

Women received evidence based care and clinical audits were carried out in both maternity and gynaecology. The number of women having caesarean sections had been reduced; information at the time of the inspection showed that the rate was 23% compared with the England average of 26%.
The number of births had decreased and the unit had not had to close or cap the number of deliveries since December 2013.
The gynaecology service was not meeting the referral to treatment time for 12% of women. A one stop clinic had recently been introduced where women could receive diagnosis and treatment of common gynaecological conditions.
Becoming part of King's College Hospital NHS Foundation Trust had resulted in significant change and improvements. Governance and risk processes had improved and matrons and managers were more visible. The clinical director for maternity and gynaecology had spent much of the working week at the hospital leading the changes.
While most staff were positive about the changes some administrative staff felt their job had become more difficult due to the incompatibility of some of the IT systems and difficulties in sometimes obtaining notes.

Services for children and young people

Good

There had been significant progress in how the trust delivered services to neonates, children and young people since our last inspection. Some improvements were still required to ensure that nursing levels were aligned to national standards and that all staff complied with trust-wide policies regarding infection prevention and control practices including the screening of patients for MRSA.
The majority of care and treatment was provided in line with evidence based practice but some improvements were required in areas such as the management of children presenting with asthma.
Clinical outcomes for children with diabetes was better than the national average in a number of areas.

Summary of findings

Staff had fully embraced the concept of family centred care. All members of the family played pivotal roles in the care and treatment of neonates and children. Children and parents spoke positively about the care they received.
Access into children's services was generally good. There had been a reduction in the number of surgical cases being cancelled and children and young people who presented to the hospital requiring surgical intervention were appropriately managed in a safe and effective way.
Local leadership at ward level was considered to be good. Staff were complimentary about their direct ward leaders who were seen to be working at ward level, supporting staff.
The service had a specific child health strategy that was aligned with the trust-wide strategy. The strategy was driven by quality and safety, and took into account the requirement for the service to be fiscally responsible.
Governance arrangements were in place for which a range of healthcare professionals assumed ownership. There was evidence that risks were managed and escalated accordingly. However, there were a small number of examples where risks that might have an impact on the clinical effectiveness of the service were not recorded on the divisional risk register.
Since our previous inspection in December 2013, the service had introduced a quality measurement scorecard; however, there was a lack of information for some metrics, which meant that the scorecard was not being used to its optimum.

End of life care

Requires improvement

The end of life care service was underfunded and under resourced. The service was not commissioned and although the trust had submitted a business case to the clinical commissioning groups it had not been approved. However, despite this the end of life care team, where possible, provided an effective service and were caring and compassionate.
There was no consultant cover on Fridays and staff worked long hours to meet the needs of patients. They were just below their targets for responding to routine and urgent referrals.

Summary of findings

The clinical nurse specialist met with bereaved relatives and offered support by referring them to community services.

Outpatients and diagnostic imaging

Requires improvement

The outpatients and diagnostic and imaging departments were caring and well led. Some aspects of safety including learning from incidents, IT problems availability of medical records needed to be improved.

Staff were reporting incidents but learning from never events that had happened at the Denmark Hill site had not been shared with staff at the PRUH.

Problems with the compatibility of some IT systems meant that some patients attended their outpatient appointment on the wrong day.

Availability of medical records was an on going problem although some improvements had been made including a medical records library at Orpington Hospital. The department had introduced an on-going programme of audit and root cause analysis for when notes were missing. This resulted in additional medical records staff been recruited and standard operating procedures being implemented.

Staff told us that patients were experiencing longer waiting times in most clinics. There was no system to ensure there were sufficient nurses and doctors to see patients. This resulted in longer waits for initial appointments and over-booking of clinics, leading to longer waiting times.

The radiology department was able to provide reports electronically within the trust reporting protocol of 24 - 48 hours for most of the time.

Patients were positive about how the staff communicated with them and the care they received. They were involved in discussions about their care and their privacy and dignity was maintained.

Staff were proud of their services and felt supported by their managers. The told us they were able to raise concerns and there was good communication between staff. Both departments held were monthly governance meetings and team meetings where information about incidents and complaints were shared with staff, although some staff told us they did not receive this information.

Princess Royal University Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Princess Royal University Hospital

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

The Princess Royal University Hospital has over 500 beds. It serves a population of approximately 300,000 in the borough of Bromley.

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Alan Thorne, CQC

The hospital was visited by a team of 56 people including CQC inspectors, analysts and a variety of specialists. There were consultants in emergency medicine, medical care, surgery, haematology, cardiology and palliative care medicine; an anaesthetist, and two junior doctors. The team also included midwives, nurses with backgrounds in surgery, medicine, paediatrics, critical care and palliative care, board-level experience, a student nurse and two experts by experience. Experts by experience are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care services.

How we carried out this inspection

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

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

The inspection team always inspects the following core services at each inspection:

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

Detailed findings

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

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

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

Facts and data about Princess Royal University Hospital

Context

- The Princess Royal University Hospital (PRUH) is located at Farnborough Common and is in the London Borough of Bromley. It serves a population of approximately 300, 000 in Bromley and Bexley and employs 2,572 whole time equivalent (WTE) staff.
- The hospital offers a range of local services including a 24 hour emergency department, medicine, surgery, paediatrics, maternity and outpatient clinics.
- In the 2011 census the proportion of residents who classed themselves as white British in Bromley was 77.6%.
- Bromley ranks 203rd out of 326 local authorities for deprivation (with one being the most deprived).
- The life expectancy for women in Bromley is 84.5, which is slightly better than the England average of 83, and it is also slightly better for men, at 81 compared with 79.2 for the England average.
- In Bromley, the rates of obese children, acute sexually transmitted infections, smoking-related deaths and incidence of tuberculosis are all better than the England average.

Activity

- The hospital has approximately 455 beds including 40 maternity beds and 10 critical care beds.
- The hospital employs 2,326 FTE staff.
- There are approximately 42,344 inpatient admissions, including day case activity, per annum.
- There are approximately 233, 644 outpatient appointments per annum.
- There are approximately 67,591 urgent and emergency care attendances per annum.
- There are approximately 5,000 births per annum.
- There were 1148 deaths between April 2014 - March 2015.

Key intelligence indicators

Safety

- There was one 'never event' between February 2014 and January 2015.
- The Strategic Executive Information System (STEIS) recorded 102 serious untoward incidents between February 2014 - January 2015.
- Between April 2014 to March 2015 there were no cases of MRSA.
- Overall, between April 2014 - March 2015 there were 6.4 cases of C. difficile (against a target of 4.8)

Effective

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

Detailed findings

Caring

- The NHS Friends and Family Test for urgent and emergency care (January 2015) showed the percentage of respondents who would recommend the emergency department was 78%, which was worse than the national average of 88%. The response rate was 15%, which was below the national average of 20%.
- The NHS Friends and Family Test for inpatients (January 2015) showed the percentage of respondents who would recommend the inpatient wards was 93%, which was just below the national average of 94%. The response rate was 36%, which was in line with the national average.
- The NHS Friends and Family Test for maternity (January 2015) showed the percentage of respondents who would recommend the antenatal service was 94%, which was just below the national average of 95%. Response rate figures were not available. The percentage of respondents who would recommend giving birth at the hospital was 92%, which was below the national average of 97%. The response rate was 26.9%, which was better than the national average of 22.9%. The percentage of respondents who would recommend the postnatal service was 87%, which was worse than the national average of 93%. Response rate figures were not available.
- The Cancer Patient Experience Survey for 2013 showed the trust as a whole was amongst the bottom 20% of trusts for the majority of the questions in the Cancer Patient Experience Survey. The trust as a whole had an 83% rating for 'Patient's rating of care' as 'excellent'/'very good' in the survey. This was lower than the 92% rating for the top 20% of trusts.
- The CQC Adult Inpatient Survey 2013/14 showed the trust performed about the same as other trusts for all indicators in the survey.

Responsive

- Between April 2014 - March 2015 the hospital had not met the cancer two-week standard for nine months. The percentage of patients who were seen within two weeks ranged from 82.56% June to 95.95% in October against a standard of 93%.
- Between April 2014- January 2015 the hospital improved its performance in relation to the breast symptom two-week wait. For the first three months the hospital did not meet the standard of 93% (82-88.96%). From July onwards the hospital achieved above the standard of 93%.
- Between April 2014 - March 2015 the hospital did not meet the emergency department four-hour waiting time standard of 95%. Performance ranged from 45-91%.
- Between April 2014 and March 2015 the hospital did not meet the referral to treatment times (RTT) for inpatients and for non admitted patients it did not meet RTT for three months during that period.

Well-led

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

Inspection history

- This is the second comprehensive inspection of the Princess Royal University Hospital. The previous inspection was carried out in December 2013.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

The emergency department (ED) at the Princess Royal University Hospital (PRUH) is open 24 hours a day seven days a week. It treats people with serious and life threatening emergencies and those with minor injuries which need prompt treatment such as lacerations and suspected broken bones. Between April and December 2014 there were 67,591 attendances in the ED. Around 20 % of patients were aged 0-16 years old.

Patients presented at the department by walking into the reception area or arriving by ambulance at a separate entrance. If a patient arrived on foot, they were initially registered to be seen by a nurse from the Urgent Care Centre (UCC) who carried out an initial clinical assessment (streaming). If patients needed to be treated by the ED rather than the UCC they were required to re-register at the ED reception and be seen by a triage nurse. (Triage is the process of determining the priority of patients' treatments based on the severity of their condition). The UCC is managed by a different provider.

If the patient arrived by ambulance, they were initially assessed by a senior nurse in an assessment area before being taken to the most appropriate area in the department to receive their care and treatment.

The ED was divided into different areas depending on the acuity of patients. The resuscitation area had four trolley bays. There were eight cubicles and four rooms including the plaster room in Majors 'A'. There are eight cubicles including the isolation room and two rooms in Majors 'B'. One of the rooms was used as an ambulatory area which had chairs and the other for patients who required mental health assessments[

The children's ED had four trolley bays, one cot cubicle, one seated cubicle and one high dependency unit (HDU). There was also a designated children's play room. One bay in the resuscitation unit was designated for children.

We visited the ED over two days during our announced inspection and returned unannounced during a weekday evening. We observed care and treatment and looked at 24 sets of patient records. We spoke with 24 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We also spoke with 11 patients and nine relatives who were using the service at the time of our inspection. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also used information provided by the organisation and information we requested.

Urgent and emergency services

Summary of findings

We have rated the ED as requires improvement.

The ED was not meeting the College of Emergency Medicine (CEM) recommendation that an emergency department should provide medical emergency cover 16 hours a day. The ED department was reliant on using agency staff. Between July and December 2014 the ED used an average of 30.5% of bank or agency staff per month. In the children's ED the staffing levels did not comply with the Royal College Paediatrics Child Health (RCPCH) guideline's as they did not have two paediatric trained nurses in the ED 24 seven days a week.

Between January and December 2014 the ED consistently failed to meet the target to see, treat and discharge 95% patients within four hours. The 95% target was not reached during any week in this period; weekly performance ranged between 45% and 91%. The average for the period was 70.3%. Patients waiting to be admitted to the wards were frequently waiting longer than 12 hours; on the morning of one of our inspection days there were 20 patients with a decision to admit (DTA) waiting for a bed on a ward and 14 of these had been waiting more than 12 hours. The DTA was often delayed so there were many more patients spending excess time in the ED. It was trust policy for a DTA to be made by speciality teams and not by Emergency Medicine Consultants. This further delayed patients' moving through the hospital.

Training opportunities were limited at this hospital for nursing staff because most were provided at the trust's other site at Denmark Hill. The appraisal rate for nursing staff was very low. A low number of nursing and medical staff had completed training to support their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Policies and procedures were developed in conjunction with national guidance and best practise evidence from professional bodies such as the College of Emergency Medicine, the National Institute of Health and Care Excellence (NICE) and the Resuscitation Council UK. Multi-disciplinary working was in evidence so that the needs of each patient were prioritised.

Staff told us that the ED was developing an open and honest culture and excellent teamwork. There was a shared vision for the future of patient care and treatment. The strategies developed by the leadership team were driving improvement, but were on a pathway from a low trajectory. For example, it had not been possible to mitigate all the risks associated with delays to patient treatment.

There were positive comments from patients about the care received and the attitude of motivated and considerate staff. Patients and their relatives and families were kept informed of on-going plans and treatment. They told us that they felt involved in the decision making process and had been given clear information about treatment options.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

At the time of our inspection the nursing vacancy rate was 29.31% at the PRUH. The ED department was reliant on using agency staff but was staffing over its establishment. Between July and December 2014 the average use of bank and agency staff was 30.5% per month.

The PRUH was not meeting the College of Emergency Medicine (CEM) recommendation that an emergency department should provide emergency consultant cover 16 hours a day, 7 days a week. The Emergency Medicine Consultants were on duty in the department between 8am and 10pm daily with 'on-call' cover outside of these hours seven days a week.

In the children's ED we found that the staffing levels did not comply with the Royal College of Paediatrics and Child Health (RCPCH) guideline's as they did not always have two paediatric trained nurses on duty twenty four 24 days a week. Nursing staff told us that the twilight shift (6pm – 6) am was primarily covered by agency staff and the night shift was not always covered by two trained children's nurses.

Medicines were stored, recorded and administered safely to protect patients from the risk of medicine misuse. However there was no fridge in the children's ED for the safe storage of medicines and local tropical anaesthetic creams were not being stored appropriately.

Staff demonstrated an open and transparent culture as regards incident reporting and patient safety; staff understood their roles and responsibilities; they were empowered to raise concerns and to report incidents.

Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children, although some improvements were required in documentation related to safeguarding and staff training.

Staff we spoke with told us that they were unable to access mandatory training at the PRUH and had to attend training at the Denmark Hill site.

Incidents

- There were no never events reported between February 2014 and January 2015. (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented).
- There were two serious incidents (SIs) in the emergency department (ED) in 2014/15. The department has investigated the serious incidents. Learning points from the incidents were described in the governance meeting minuets and reports into the two serious incidents were presented to the trust's serious incident committee in February 2015.
- For the period July 2014 – December 2014 there were 386 adverse incidents in the ED. The largest number of incidents reported (62) related to appointments, admissions, transfer and discharge. Minutes of the governance meetings demonstrated that trends were being monitored and that learning points were identified.
- Learning from adverse incidents was shared with the staff through a bi monthly "Tackling Risk in the ED" newsletter which was available on staff notice boards and emailed to all ED staff. Staff confirmed that they received the newsletter.
- Nursing staff told us that they reported incidents through an IT system and would report incidents such as when patients who were admitted with pressure ulcers or when they had safeguarding concerns. Staff we spoke with told us they would occasionally get feedback.
- Mortality and Morbidity meetings were held monthly to review the care of patients who had complications or an unexpected outcome and to share learning and inform future practice.
- Training records provided by the trust showed that none of the ED staff had attended training sessions in complying with the Duty of Candour.

Cleanliness, infection control and hygiene

- Fifty seven per cent of nursing staff and 13% medical staff working in the ED and acute medicine had received training in infection prevention and control (IPC) against the trust's target of 80%.
- The ED was visibly clean and tidy. We observed support staff cleaning the department throughout the day. Information supplied by the trust through the infection control score card showed that environmental audits of

the cleaning by a contractor and nursing staff were below the trust targets of 95% for the period December 2014 to February 2015. Over the three month period the nursing targets fluctuated from 73% in December, 65% in January and 85.7%in February. For the same period the contractor's performance fluctuated from 91% in December, 86%in January and 84.2% in February.

- In majors B we observed that some of the equipment had green labels stating that it had been cleaned two days before. We spoke with a staff member who told us that the equipment wasn't always cleaned on a daily basis. This meant the patients were at risk of infection as equipment was not being cleaned on a daily basis.
- Personal protective equipment (PPE) such as disposable apron and gloves, hand washing facilities and hand cleaning gels were available throughout the department and we saw good examples of hand hygiene by staff..
- Monthly audits of hand washing showed that compliance with good practice was below the trust target of 95% for the 2 month period January (53.4%) and February 2015 (58.9%). In November and December 2014 no hand hygiene audits were under taken.
- The IPC scorecards did not record avoidable infections such as MRSA, C difficile (C.Diff), Methicillin-sensitive Staphylococcus aureus (MSSA) or Escherichia coli.
- We observed that trust policy was followed for the management of a patient presenting with a risk of viral haemorrhagic fever (VHF).

Environment and equipment

- The physical environment did not enhance patient safety as the lay out of the ED had been altered to try and accommodate increasing numbers of patients.
- There waiting area was bright and clean with sufficient seating; there was a trolley with jugs of water and cups available for patients. The ED's waiting times were displayed on a large screen.
- The ED was divided into different areas depending on the acuity of patients. The resuscitation area had four trolley bays. There were eight cubicles and four rooms including the plaster room in Majors 'A' and eight cubicles including the isolation room and two rooms in Majors 'B'. One of the rooms was used as an ambulatory area with chairs and the other for patients who required mental health assessments.
- The department had a separate children's ED. The department had four trolley bays, one cot cubicle, one seated cubicle and one HDU. There was also a designated children's play room. One bay in the resuscitation unit was designated for children.
- There was adequate resuscitation and medical equipment in the adult ED. This was clean, regularly checked and ready for use. Each bed space within the resuscitation area was designed and configured in the same way, which allowed staff working within that area to be familiar with the bed space and which in turn contributed to improved efficiency during trauma and resuscitation events.
- The children's resuscitation equipment in the children's ED and the children's resuscitation cubicle were checked daily and ready for use.
- The department had a separate contamination treatment area, that could be utilised in the in the event of a patient presenting with a highly infectious disease such as Ebola. This consisted of three rooms; a room for putting on protective clothing, the treatment cubical and a further room with shower to remove decontaminated personal protective clothing.
- The ED's risk register had identified that the computerised tomography (CT) scanner was some distance from the department which meant that the PRUH needed to further develop its intra-hospital transfer/transfer to CT policy .
- We found that call bells were in each room and within easy reach of patients. However the call bell in the plaster room was not working.
- The department was secure and had the facility to 'lock down' the department to isolate it in the event of an untoward incident.

Medicines

- Locks were installed on cupboards and fridges containing medicines and intravenous fluids. Keys were held by nursing staff. In some areas of the department, such as resuscitation, cupboards and fridges were left open to facilitate access to medicines in emergencies (such as Rapid sequence intubationrapid sequence intubation (RSI). Risk assessments had been undertaken for these.
- Controlled drugs (CD) were checked on a daily basis by staff working in the department. We audited the

contents of the CD cupboard in the resuscitation area against the CD registers and found they were correct. The CD register was completed fully, with two signatures for each drug administered.
- Patients' allergy status was recorded in three of the 24 records we reviewed.
- Prescription charts and medicine administration records were completed accurately in the patient records we looked at.
- Medicines management training was part of the mandatory training programme for nursing staff. Information supplied by the trust confirmed that 46% of ED adult nurses, 88% of paediatric nurses and 35% of ED emergency nurse practitioners at the PRUH had completed the training against the trust's target of 80%.
- There was no fridge in the children's ED for the safe storage of medicines. We found that local tropical anaesthetic creams were not being stored appropriately in a fridge which would reduce their effectiveness.

Records

- Health record keeping training is part the mandatory training programme. Information supplied by the trust confirmed that 68% nursing staff at the PRUH and 51%of medical staff working in the ED and acute medicine at the PRUH had completed the training against the trust's target of 80 %.
- Patients were registered on the ED computer system which tracked the patient journey through the department and highlighted any delays. The patient record detailed the time when patients where first registered onto the system, when patients were triaged, seen by a clinician, diagnosed and when a decision to admit the patient had been taken.
- A paper record was also generated by reception staff registering the patients' arrival in the department and to record patients' personal details, initial assessment, and treatment. All healthcare professionals recorded care and treatment using the same document.
- We looked at the care records of 24 patients which included six children and five patients in the clinical decisions unit (CDU) and found that they were clear and easy to follow.

Safeguarding

- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns. One nurse we spoke with told us that they had recently reported concerns about an older person who was living at home and who had ulcers on their hand. They were concerned that this had not been identified earlier.
- The children's ED had a safeguarding flag system in place. The 'At Risk' register was also checked for all children and updated weekly.
- ED records prompted staff to screen for vulnerable adults so that any action necessary to safeguard these patients could be made.
- Safeguarding concerns were also discussed as part of the PRUH high frequent ED attenders meetings.
- Fifty two per cent of nursing staff and 20% of medical staff working in trauma, emergency and acute medicine at the PRUH site had attended training in safeguarding vulnerable adults against the trust's target of 80%.
- All of the paediatric nurses had received Level 3 safeguarding children training.
- Seventy six per cent of nursing and 18% of medical staff working in trauma, emergency and acute medicine at the PRUH site had received training in safeguarding children at level 2 against the trust's target of 80%.

Mandatory training

- Mandatory training included aseptic non touch technique (ANTT), blood transfusion, mentorship in professional practice, medicine management and Sepsis. For the ED, 46% of adult nurses, 88% of paediatric nurses and 35% ED emergency nurse practitioner's had completed mandatory training.
- Staff had also received training in health and safety: 93% nursing and 52% medical staff working in the ED and acute medicine against the trust's own target of 80%.
- Seventy two per cent of nursing and 35% of medical staff working in trauma, emergency and acute medicine at the PRUH site had received resuscitation training against the trust's target of 80%.
- Seventy per cent of ED adult nurses and 69% of ED emergency nurse practitioner's had completed immediate life support training against the Trust target of 80%.
- Twenty four per cent of adult ED nurses had completed advance life support training (ALS) and 11% of ED paediatric nurses had completed advanced paediatric life support (APLS) training against the trust's target of 80%.

- A total of 35% of medical staff had completed training in resuscitation against the trust target of 80%
- Thirty two per cent of adult ED nurses and 11% of ED paediatric nurses had completed team based trauma life support (TTLS) training at the PRUH against the trust's target of 80%.
- Staff we spoke to told us that they were unable to access mandatory training at the PRUH and had to attend training at the DH site. Nursing staff told us they had to pay for their own travel and 10% of training fee. However the trust advised that nursing staff pay their own travel expenses but can claim this back through the division. Training fees are only incurred for longer courses, for example an MSc which is not considered to be mandatory training.

Assessing and responding to patient risk

- Patients arrived at the ED either independently or by ambulance the latter of which utilised a separate entrance.
- Patients who arrived by ambulance were taken to the resuscitation area or an allocated cubicle space. If patients required immediate treatment calls were phoned through in advance so that an appropriate team could be alerted and prepared for their arrival.
- Other patients arriving by ambulance were assessed by a nurse who took a 'handover' from the ambulance crew. Based on the information received, a decision was made regarding which part of the department the patient should be treated.
- Data provided by the trust for the period April 2014 to October 2014 showed that ambulance patients were triaged before registration. The ED was piloting a system to monitor the flow through the department. On 16th April three patients waited for over 35 minutes, including one patient who had been waiting for one hour and 23 minutes, to be triaged.
- Between April and December 2014 there were 288 black ambulance breaches. A black breach is when an ambulance has to wait over 30 minutes to hand over a patient to the ED.
- Patients were initially registered to be seen by a nurse from the Urgent Care Centre (UCC) who carried out an initial clinical assessment (streaming). If patients needed to be treated by the ED rather than the UCC they needed to re-register at the ED reception and be seen by a triage nurse. The UCC was managed by a different provider.
- Triage was undertaken in accordance with the Manchester Triage System (MTS). This is a tool used widely in ED to determine the priority of patients' treatments based on the severity of their condition. Trained triage nurses followed a pathway or algorithm and assigned a colour coding to the patient following initial assessment. Red being the label assigned to those patients who needed to be seen immediately through to orange (very urgent), yellow (urgent), green (standard) and blue (non-urgent). The MTS was on the PRUH's risk register as the version that was on the ED's database was out of date and there were plans place to upgrade to a later version.
- There was an adult triage cubicle adjacent to the main reception area and waiting room. Once triaged, patients were prioritised for treatment and clinical intervention in the most appropriate area within the department for their on-going management.
- Children attending the ED were streamed at the main reception and whilst this was not undertaken by a paediatric nurse, children were directed to the children's ED where triage was undertaken by a paediatric nurse if they were available. Not all children were assessed by a paediatric nurse. During the visit, while the sister was on her break, the children's ED only had one adult nurse present.
- The records reviewed in the CDU used the patient at risk (PAR) system to detect deterioration in adult patients. However, the children's department did not have a scoring system in use to monitor deterioration, but depended on clinical judgement.
- Risk assessment tools were used for patients in the CDU. Risk assessments for pressure sores, nutrition, falls and manual handling were completed in the five patient records we reviewed in the CDU.

Nursing staffing

- The ED department was currently staffed above their established staffing level. Information supplied by the trust showed that since November 2014 the department had increased its nursing allocation to19 nurses for the day and night shifts. This had been increased since the merger with King's College Hospital NHS Foundation Trust from 13 nurses during the day and nine nurses at night.

Urgent and emergency services

- The nursing vacancy rate at the PRUH was 29.31%. Nursing staff told us that they were actively recruiting but it had been difficult, and they were waiting for six overseas nurses to start shortly. There was also difficulty in recruiting to band 7 staff.
- The ED department was reliant on using agency staff. When we visited the department it had six agency staff on duty. Nursing staff spoken with told us that a number of the agency staff had worked in the department for some time and that on average 50% of the agency staff who were used worked full time in the department. We saw evidence of an induction process for agency staff.
- Between July and December 2014 the ED used an average of 30.5% of bank or agency staff.
- In the children's ED we found that the staffing levels did not always comply with the Royal College of Paediatrics and Child Health (RCPCH) guideline's; it did not always have two trained children's nurses on duty 24 hours, seven days a week. Whilst there was always at least one children's nurse on duty, it was unclear how managers ensured the safety of children when two paediatric nurses were not on duty.
- Nursing staff told us that the twilight shift (6pm – 6 am) was primarily covered by agency staff and the night shift was not always covered by two trained children's nurses.
- During our visit we were advised that following the ED clinical governance meeting in April 2015 the staffing levels of the adult and paediatric ED's and the skills mix in the resuscitation area were added to the department risk register. Minutes of the meeting in April 2015 were not available.
- Between August and December 2014 the sickness rate was 4.9% among nursing staff .
- The turnover rate was 11.45% among nursing staff in the ED at the PRUH between April and December 2014. There was an upward trend of 4.92% in turnover among nursing staff; in 2013/14 it was 6.53%.

Medical staffing

- There were Emergency Medicine Consultants on duty in the department between 8am and 10pm daily with 'on-call' cover outside of these hours seven days a week. The PRUH was not meeting the College of Emergency Medicine (CEM) recommendation that an emergency department should provide emergency consultant cover 16 hours a day, seven days a week .
- In the children's ED a junior doctor was available from 8am – midnight seven days a week. The children's ED was covered by doctors from the adult ED outside of these hours.
- A total of 35% of medical staff had training in resuscitation against the trust target of 80%
- Information from the trust showed a medical vacancy rate of zero in the ED at the PRUH.
- Information from the trust showed a sickness rate of 0.77% among medical staff at the PRUH for August to December 2014.
- Information from the trust showed a turnover rate of 70.4% amongst medical staff in the ED at the PRUH between April and December 2014. There was an upward trend of 55.5% in turnover amongst medical staff; in 2013/14 it was 14.9%.
- Between 1st September and 31st December 2014 the average locum usage in the ED was 23.4%.

Major incident awareness and training

- The hospital had an up-to-date major incident plan (MIP). The MIP provided clinical guidance and support to staff on treating patients of all age groups and included information on the triage and management of patients suffering from a range of injuries.
- Staff spoke with were knowledgeable about the process and action cards were on display in the ED seminar room.
- Decontamination equipment was available to deal with casualties contaminated with chemical, biological or radiological material, or hazardous materials and items (CBRN).
- In the ED staff allocation book we observed that the major incident team was identified so staff on duty knew what their responsibilities and tasks were in the event of a major incident.
- Eighty four per cent of nursing staff working in trauma, emergency and acute medicine at the PRUH site have received training in major incident and CBRN measures against the trust's target of 80%.
- All of the nursing staff working in trauma, emergency and acute medicine had received training in conflict resolution against the trust's target of 80%.
- Contracted security staff were on duty in the department. Their presence was calm and reassuring. We spoke with a member of the security staff who

described the 'guarding' or 'doorperson' training they received under their Security Industry Authority (SIA) licence. They did not receive specific training for healthcare settings.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Pain scoring tools were not consistently used to monitor the efficacy of patients' pain control. The administration of analgesia was delayed because there was no group directive agreed for nurse prescribing.

Training opportunities were limited at this hospital for nursing staff because most were provided at the trust's other site at Denmark Hill. The appraisal rate for nursing staff was very low.

A low number of nursing and medical staff had completed training to support their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Patients were offered food and drink at meal times and the trust told us snack boxes were available outside of set meal times.

Policies and procedures were developed in conjunction with national guidance and best practice from professional bodies such as the Royal College of Emergency Medicine, the National Institute for Health and Care Excellence (NICE) and the Resuscitation Council UK.

Multi-disciplinary working was in evidence. Staff we spoke with were clear about their responsibilities in relation to obtaining consent from people, including those people who did not have capacity to consent to their care and treatment.

Evidence-based care and treatment

- Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the College of Emergency Medicine (CEM), NICE and the Resuscitation Council UK.
- Guidelines were easily accessible on the trust intranet page and were up to date. Junior doctors were able to demonstrate ease of access and found them clear and easy to use.
- Clinical guidelines were accessible electronically.
- Adherence to guidelines was encouraged through the development of illness specific proforma to prompt use of best practice guidelines. For example, we saw evidence of the use of both the fracture neck of femur and sepsis guidelines.
- Comprehensive antimicrobial guidelines were available.

Pain relief

- The notes we reviewed did not demonstrate consistency with the recording of pain scores.
- We observed that nurses who triaged walk-in patients to the ED had to get a doctor to prescribe analgesia as there were no patient group directives (PGD) in place to enable nurses to prescribe pain relief.
- The trust scored about the same as other trusts in the A & E survey 2014 for being for patients not having to wait long to receive pain relief if requested and for patients feeling that hospital staff did all they could to help control their pain

Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed and administered and recorded when clinically indicated.
- The department had a hostess service offering food and drinks to patients which were offered regularly to patients. Patients we spoke with told us that they had been offered food and drink whilst in the department. One relative told us that food and drink was not available outside of the meal times and they had to buy biscuits for their elderly relative. However, the trust has told us that snack boxes are available at all times.
- We observed staff offering patients food and drink, and water was available in all areas.
- We observed that a patient who had been in the department in excess of six hours did not have access to a jug of water and cup.
- The trust scored worse than other trusts in the A & E survey 2014 for patients being able to access suitable food and drink while in the ED.

Patient outcomes

- The ED at the PRUH had mixed results in the College of Emergency Medicine (CEM) audit for the fractured neck

of femur audit published in 2013. The ED performed above the national average for analgesia being provided in accordance with local or national guidelines and given promptly on arrival. The ED was in the lower quartile for pain re –evaluation and for the time that patients waited for x –ray's.
- The ED was between the upper and lower England quartiles for the majority of standards in the CEM audit for the treatment of renal colic published in 2013.
- In the CEM audit for Severe Sepsis and Septic Shock published in 2013 the ED was between the upper and lower England quartiles for the majority of criteria audited.

Competent staff
- Information provided by the trust showed that 2% of nursing staff in the ED had an appraisal between April and December 2014. In 2013/14, 4% of nursing staff had had an appraisal.
- Junior nursing staff spoken to told us that they felt supported in their role and were able to access training via e-learning which they completed mostly in their own time. They were also able to access group sessions to discuss practice issues.
- Junior doctors we spoke with told us that they felt supported in their roles by the ED consultants and had regular teaching sessions.
- Nursing staff were supported by an ED practice development nurse who was a senior member of staff who also worked clinically. Their role helps to develop the competency assessments for qualified staff.
- The lack of training facilities in the ED has been identified as a risk on the ED risk register. Some nursing staff felt that all the resources were at the Denmark Hill site especially with regards to teaching, training and education.

Multidisciplinary working
- There was effective multidisciplinary working in the emergency department. This included effective working relations with speciality doctors and nurses, and GP's.
- Medical, nursing staff and support workers worked well as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- In the children's ED a patient transfer policy detailed how children should be transferred to the Denmark Hill hospital and the grade of nursing and medical staff required.
- The monthly PRUH high frequent attenders meetings had representation from speciality teams and community stakeholders including Bromley Clinical Commissioning Group (CCG), social services and mental health partners.
- The children's department did not have its own waiting area and did not employ a play therapist to distract children while they were receiving treatment.

Seven-day services
- All areas of the ED were open seven days a week. Support services were also available seven days a week including for example X-ray, scanning and pathology.
- The ED consultants were not present in the department 24 hours a day. They were however present seven days per week from 8am to 10pm and provided cover 24 hours a day, either directly within the department or on-call. Middle grade doctor cover was available at all times.

Access to information
- The department had a computerised system that showed how long patients had been waiting as well as their location in the department and what treatment they had received.
- A paper record was generated by the reception staff registering the patient arrival in the department to record the patient's personal details, initial assessment and treatment. All health care professionals recorded care and treatment using the same document.
- Staff could access records including test results on the trust computerised system.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)
- We observed that consent was obtained for any procedures undertaken by staff. This included both written and verbal consent.
- Staff we spoke with were clear about their responsibilities in relation to gaining consent from people, including patients who lacked capacity to consent to their care and treatment.
- Staff told us that no Deprivation of Liberty Safeguards applications had been made through the ED in the last 12 months or for the year to date by the trust. However, the trust has advised that a DoLs application would be made by the ward once a full assessment of the patient is made. This is in line with the MCA 2005 Deprivation of Liberty protocol.

Urgent and emergency services

- Thirty one per cent of nursing and 17% medical staff working in trauma, emergency and acute medicine had received training in DoLS and the MCA against the trust's target of 80%.

Are urgent and emergency services caring?

Good

The ED provided compassionate care and ensured that patients were treated with dignity and respect despite the challenges provided by patients spending long periods of time in the ED before they were transferred to the wards.

Patients spoke positively about the care they received and the attitude of motivated and considerate staff. Patients and their relatives and families were kept informed of on-going plans and treatment. They told us that they felt involved in the decision making process and had been given clear information about treatment options.

Compassionate care

- During our inspection we saw many examples of patients being treated with compassion, dignity and respect. Staff introduced themselves by name and explained treatment plans in terms that were easily understood**.** We observed clinical staff exploring patient's social circumstances as well their presenting medical concerns.
- In the bays we saw that patients preferred name were written on a white board together with the name of the nurse responsible for looking after each patient. We observed screens being put around a patient when they were transferred to a hospital bed to protect their dignity; staff explained that the bays were small and the nursing staff needed to create extra space for the nurses and the bed.
- We spoke with 12 patients and several family members. Their experiences were mixed. One patient was unhappy about being discharged and felt they had been rushed through and should have been kept in longer. Another patient who was waiting for a bed told us that the last time they had been in the ED they had spent 24 hours in the plaster room. One patient told us that 'you can't fault this hospital' they had seen two doctors from the stroke unit and they had explained everything.
- Another patient told us that they were happy with the care and that the doctors and nurses had answered all their questions and a further patient told us the junior nursing staff were fantastic.
- The trust scored about the same as than other trusts in the A & E survey 2014 for ensuring that patients had enough privacy during examination and treatment.

Understanding and involvement of patients and those close to them

Understanding and involvement of patients and those close to them

- The trust scored about the same as other trusts in the 2014 A&E survey for giving patients the right amount of information about their condition or treatment.
- Patients we spoke with told us they had been involved with the planning of their care and had understood the information provided to them.
- The trust scored about the same as other trusts in the 2014 A&E survey for patients being one thing by a member of staff and something quite different by another. It also scored the same as other trusts for involving patients as much as they wanted to be in decisions about their care and treatment.

Emotional supportEmotional support

- **We observed staff provide emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible.** There was a relative's room where distressed relatives could sit in a private space.
- We observed staff provide emotional support to patients and their families. They gave open clear answers to questions and provided as much reassurance as possible.
- The trust scored about the same as other trusts in the A & E survey 2014 for patients feeling reassured by staff if they were distressed while in the ED. ED.

Urgent and emergency services

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

Inadequate

The flow of patients in the ED was often blocked by internal capacity issues in the hospital. The hospital held four bed meetings four times per day to look at the flow of patients across the hospital. The bed state across the hospital was "black" alert (black alert is a hospital's most severe status level, on the apex of a "traffic light system" of green, amber and red, when a hospital is at full capacity and has no beds available). We found that whilst staff were aware of the issues and the hospital had a bed capacity escalation plan this was not referred and no action was taken to address the issues.This meant that patients waiting in ED had to wait in the department until beds on the wards could be found.

The ED at the PRUH consistently failed to meet the target to see, treat and discharge 95% patients within 4 hours between January and December 2014. The 95% target was not reached during any week in this period; weekly performance ranged between 45% and 91%. The average for the period was 70.3%.

Patients waiting to be admitted to the wards were frequently waiting longer than 12 hours; on the morning of one of our ione day of our inspection days there were 20 patients with a decision to admit waiting for a bed on a ward. Of these, 14 of the patients had been waiting for more than 12 hours. The DTA was often delayed so there were many more patients spending excess time in the ED. It was trust policy for DTA to be made by speciality teams and not by Emergency Medicine Consultants. This further delayed patients' pathway through the hospital.

Staff responded well to patients individual needs, patients were transferred from trolleys onto beds and pressure relieving mattresses were available. Patients spoken with told us that they had been assisted with their personal care and that they had been offered food and drink. Patient observations were being checked regularly. Relatives were encouraged to stay with patients whilst they were in the department.

Service planning and delivery to meet the needs of local people

- The ED served a population of approximately 300,000 in the boroughs of Bromley.
- The PRUH introduced streaming of all walk in patients at reception to include screening for patients with suspected viral haemorrhagic fever. The ED had good facilities for isolating these patients, which we saw in use during our inspection.
- Patient information and advice leaflets were available in English, but were not available in any other language or format. Telephone translation services were available for patients for whom English was not their first language and some staff spoke more than one language.

Access and flow

- Walk- in patients reported to a reception desk at the back of the waiting room which was behind the ED reception. Patients were initially registered to be seen by a nurse from the UCC who carried out an initial clinical assessment (streaming). If patients needed to be treated by the ED rather than the UCC they would need to re-register at the ED reception and then be seen by a triage nurse. Two patients' we spoke with were confused and annoyed about this. One patient said" I have been asked the same questions three times".
- The ED Quality Indicators Scorecard showed that between January and December 2014 782 patients waited in the ED (trust wide) for 12 hours or more after a decision was made to admit (DTA). The 12 hour breaches are measured from the time of DTA. However, we found that a DTA was often delayed and this increased the number of patients and delays in the ED. It was trust policy for the DTA to be made by speciality teams and not by Emergency Medicine Consultants. This further delayed patients' pathway through the hospital. On one day of our inspection there were 20 patients with a DTA waiting for a bed on a ward; of these,14 of the patients had been waiting for more than 12 hours. One patient, an 82 year old male, had been registered on the computer system at 5.57pm the previous evening, the decision to admit (DTA) has been taken at 9.20pm. The patient was transferred out of ED the following afternoon at 2.55pm having spent 21hours and 26 minutes in the department.
- Of the 20 patients with a DTA, 15 were waiting for medical beds to become available on the wards. A

consultant told us that they had been to assess patients waiting to be admitted and that as patients were discharged later in the day, patients waiting in the ED would be transferred to the wards.

- PRUH had bed management meetings four times a day to look at the flow of patients across the hospital. We observed two bed meetings at lunch time on the days we inspected. The bed state across the hospital was black (most serious) as there was a lack of beds across the hospital. We found that whilst staff were aware of the issues and the hospital had a bed capacity escalation plan this was not referred and no action was taken to address the issues. This meant that patients waiting in ED had to wait in the department until beds on the wards could be found.
- Nursing staff took action to mitigate risks associated with long stays in the ED. Patients were transferred from trolleys onto beds and pressure relieving mattresses were available. Patients spoken with told us that they had been assisted with their personal care and that they had been offered food and drink. We saw that patient observations were being checked regularly.
- We looked at data supplied by the PRUH covering a 48 hour period from midnight on 2 of April to midnight on 3 April 2015 about the length of time patients spent in the ED. During that period 751 patients attended the ED. Of these, 68% of patients spent less than 4 hours in the department. The longest delays were from the DTA to actually admitting a patient to a ward. 38% of admissions waited more than two hours for a bed and 10% waited more than 6 hours.
- Between January and December 2014 the ED consistently failed to meet the target to see, treat and discharge 95% patients within four hours. The 95% target was not reached during any week in this period; weekly performance ranged between 45% and 91%. The average for the period was 70.3%.
- The total time in A&E the ED (average per patient) for the trust was consistently significantly higher than the national average. In the 12 months up to September 2014, patients spent an average of between 150 and 180 minutes in the department. The national average for the same period was less than 140 minutes.
- The percentage of patients who left the department before being seen was recognised was recognised as potentially being an indicator of whether patients are dissatisfied with the length of time they have had to wait. The trust had consistently performed worse than the national average in the 12 months up to September 2014. Between 2.9% and 3.9% of patients left without being seen compared to between 0.2 and 3% nationally.
- The ED was piloting a system to monitor the flow of patients through the department, this was undertaken over a 24 hour period on 24 and 25 March and again during the days of our inspection. A safety board was used to highlight potential trigger points for the department and safety huddles (meetings) were held at two hourly intervals to monitor what was happening.
- Between April and December 2014 there were 288 black ambulance breaches at the PRUH site. When we inspected we found that two patients who had arrived by ambulance had been waiting for over an hour to be admitted. The ambulance staff told us that they frequently had to wait for over an hour before they could hand patients over to the ED.

Meeting people's individual needs

- There were 3105 people with dementia admitted to the trust last year. On average, there were approximately 78 inpatients with dementia at any one time. The trust did not have an electronic flagging system for people with dementia.
- The children's ED were able to access the children's and adolescent mental health services (CAMHS) for children and young people at during the day, at weekends and out of hours.
- The hospital held a high frequent attenders meeting on a monthly basis to identify individual patients who had a high number of attendances at the ED and co-ordinate their management plans.
- There were 538 patients with a learning disability admitted to the trust last year. On average, there were approximately seven or eight inpatients admitted with a learning disability at any one time across the PRUH and the Denmark Hill site..
- There was no universal flagging system in place for patients with a learning disability (LD). There was a dedicated learning disabilities coordinator based at the PRUH and all patients presenting in the ED with a learning disability had a 'Special Case' notification registered on Symphony (the electronic system for monitoring the progress of patients through the ED).
- The trust employed one LD nurse at the Denmark Hill Site. Clinical staff sent an alert whenever an adult with a

learning disability was admitted or attended the ED. Referrals were sent either for a safeguarding concern with the safeguarding adults team or as a routine notification that a person with LD had been admitted.
- Adjustments for patients with learning disabilities varied but could include: increased visiting hours, extended ward rounds or specific MDT meetings in addition to the usual clinical discussion, the use of a health passport to aid handover from carers to clinical teams and joint working with community LD teams.
- The department did not have a room specifically identified for patients who presented with mental health needs. Staff showed us a cubicle where patients with mental health needs could be interviewed or assessed. The cubicle was configured for patients with physical ill health and was not an appropriate area for interviewing patients with mental health needs as it presented several risks such as ligature points and potential missiles and weapons.
- Staff also told us that they sometimes used the relatives' room and patients would not be left alone in the room.
- Patient information and advice leaflets were available in English, but were not available in any other language or format. Telephone translation services were available for patients for whom English was not their first language and some staff spoke more than one language
- Children's needs were met by the provision of age appropriate toys and activities.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make a formal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally patients were referred to the Patient Advice and Liaison Service (PALS) who would formally log their complaint and attempt to resolve their issue within a set period of time. PALS information was available in the waiting room.
- One patient told us they had raised complaints through PALS and they thought the PALS had improved since the PRU had become part of King's College Hospital NHS Foundation trust
- Formal complaints were investigated by a consultant or the nurse manager and replies were sent to the complainant with an agreed timeframe.
- For the period 1 January to 31 March 2015 the ED received 24 complaints of which eight were upheld, three were partially up held, four were not upheld and for nine the outcome was not known or did not relate to the ED.
- Information provided by the hospital showed that as part of monthly clinical governance meetings complaints were discussed and learning from the complaints was shared with the staff through a bi monthly "Tackling Risk in the ED" newsletter which was available on staff notice boards and emailed to all ED staff. We found that when we were talking toN nursinges staffwe spoke with they were not aware of the complaints that had been made.

Are urgent and emergency services well-led?

Requires improvement

Staff told us that the ED was developing an open and honest culture and excellent teamwork and improvements had been made since our last inspection. There was a shared vision for the future of patient care and treatment. The strategies developed by the leadership team were driving improvement, but were on a pathway from a low trajectory. For example, it had not been possible to mitigate all the risks associated with delays to patient treatment.

Medical leadership was constantly visible in the clinical environment. Nursing leadership was shared with other areas of the trust which left little time for visible clinical leadership. This weakness had been recognised and there were plans to resolve it in the near future. The leadership team demonstrated the skills, knowledge and experience needed for their roles.

Governance arrangements had improved and risks and issues around the quality of care provided were being monitored and addressed or escalated.

Staff were engaged in the service but engagement of the public in developing or improving the service was limited.

Vision and strategy for this service

- Although the ED did not have a written strategy all staff we spoke with understood the vision for the

department. They wanted to rapidly assess and treat all patients presenting to the department in a safe and effective manner. They were clear about what the department did well and where it could improve.

- Senior staff told us that there was a strategy for achieving the vision. However, it had proved difficult to implement. Although senior management arrangements had improved since the merger with Kings College Hospital NHS Foundation Trust they had not yet been able to reduce the long delays experienced by many patients. This was mainly due to difficulties in admitting patients to wards leading to slow patient flow and a crowded department.

Governance, risk management and quality measurement

- Governance mechanisms had been established to monitor and improve standards of patient care. Monthly governance meetings were held within the directorate and all staff were encouraged to attend, including junior members of staff. Complaints, incidents, audits and quality improvement projects were discussed. Attendance was good.
- The ED maintained a risk register which fed into the hospital risk register. We saw that the two top risks were using an out dated version of the Manchester triage system (MTS) and operational blockages in the PRUH admissions emergency pathway which could lead to ED overcrowding and may impact on patient safety. We were told that changes had been made to mitigate these risks; for example there were plans to upgrade the MTS to version 3 along with staff training and a review of the discharge planning process at the PRUH. However, it was felt that full mitigation of the admissions emergency pathway was outside of the remit of the ED.

Leadership of service

- Leadership and management of ED had changed in the eighteen months since the merger with Kings College Hospital NHS Foundation Trust. It is now shared between a clinical lead, head of nursing and a general manager.Governance mechanisms had been established to monitor and improve standards of patient care.r.
- Staff told us that the leadership team had the skills, knowledge and experience required to carry out their roles. Initially, senior staff had divided their time between the two EDs; at PRUH and the Denmark Hill Hospital. However, this had sometimes resulted in fragmented and confusing working patterns and practices. A number of consultants now devoted all their time to the PRUH ED which had improved continuity. The only consultant who worked between the two departments was the clinical lead. Staff told us that this worked well and they felt it was appropriate.
- Nursing leadership had been shared between the PRUH and the Denmark Hill Hospital ED. This had proved difficult from a time management point of view and led to a fragmentation of leadership. It left little time for direct patient care or clinical leadership. These difficulties had been recognised and the trust had recruited to a new post of Deputy Head of Nursing dedicated to the PRUH ED.

Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED. Junior and middle grade doctors we spoke with told us that they felt supported by their consultants whom they described as 'inspirational leaders' and they were able to access on-going training.
- There was a strong sense of teamwork which encouraged candour, openness and honesty. Staff told us the support they received from their colleagues in the department helped them to cope with the pressure which resulted from a crowded department.
- The Deputy Head of Nursing for the ED told us they were proud of the passionate and caring staff, the 'can-do' attitude amongst staff and the multi-disciplinary team (MDT) working.
- The culture within the department was centred on the needs and experience of people who used the service.

Public and staff engagement

- Staff felt engaged by the ED leadership in the planning and delivery of service. However, since the merger with Kings College Hospital NHS Foundation Trust some staff felt that they had lost their autonomy. Various staff quoted it was "the Denmark Hill way or the highway".
- There was limited evidence of public engagement specific to the PRUH ED other than posters and family and friends test cards.

Innovation, improvement and sustainability

- The ED at the PRUH was piloting a system to monitor the flow through the ED department, this was over a 24 hour period on 24 and 25 March and again during the

time of our inspection. . A safety board was used to highlight potential trigger points for the department and safety huddles (meetings) were held at two hourly intervals to monitor what was happening.

Medical care (including older people's care)

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

Information about the service

The care of patients with medical needs was coordinated across the King's College Hospital NHS Foundation Trust sites at the Denmark Hill hospital, the Princess Royal University Hospital, Orpington Hospital and Beckenham Beacon. At the time of our inspection, the Princess Royal University Hospital (PRUH) had 13 medical inpatient services. These included general medical wards, care of frail and older people, stroke, cardiac and endoscopy services. The hospital also provided additional Level 1 support for patients who required increased short-term care or monitoring in the hyper-acute stroke ward and the Acute Medical Unit.

During our inspection of the medical services undertaken at the PRUH, we visited the majority of medical wards and day care areas. We also visited Ontario Ward at Orpington Hospital that provided rehabilitation for neurology patients.

We spoke with 17 patients currently undergoing treatment on the wards and those close to them. We observed the care and treatment of patients, attended ward multidisciplinary meetings, ward board rounds, and looked at patients' nursing and medical records, including medicine administration charts. We also visited patients who were being looked after by medical consultants on other specialty wards, such as surgery, due to lack of capacity on the general medical wards.

We spoke with a wide range of staff, including all grades of nursing staff, healthcare assistants, domestic staff, consultants, junior doctors, pharmacists, allied healthcare professionals (AHP), discharge coordinators and hospital-based social workers. We held focus groups for various grades of staff, and spoke with managers and senior trust staff.

Before our inspection, we took into consideration the views of people who contacted us through our listening events, and from people who contacted us to tell us about their experiences. We reviewed performance information about the King's College Hospital NHS Foundation Trust and the PRUH.

Medical care (including older people's care)

Summary of findings

We found medical services at the Princess Royal University Hospital (PRUH) had made improvements since our last inspection, in December 2013 and this progress needs to continue. Areas that required more work include medical and nursing records. Medical records were not always available when needed, and there was an issue with the coding, which meant that patients may have more than one set of records. The nursing care plans and risk assessments were not always completed or updated. This meant that patients were at risk of receiving inappropriate or inadequate care.

We found that the trust was actively recruiting to the vacancies in the medical division. However, the wards were relying heavily on agency, bank and newly qualified staff. Medical staff vacancies were covered by locum doctors and consultants. This meant that patients care and treatment was, on occasions, postponed or delayed, whilst waiting for staff with the competencies or experience to undertake more involved nursing procedures. Training and formal supervision were available, but the shortage of staff meant that they could not always be released from the ward to attend. The computer system for recording training and appraisals was new, and not all training undertaken had been recorded.

There were security issues with medicines management, and the resuscitation equipment, which were not always kept secure. Although the hospital was clean, bright and well maintained, the design of many of the wards was not conducive to good infection prevention and control, or the care of confused or vulnerable patients. There were wards which could only be accessed through other wards, a long narrow ward where staff had little direct vision of the patients, and wards with no rest areas for patients or staff, and a lack of storage facilities.

However throughout all the medical services we inspected we noted there had been considerable improvement since our last inspection. The additional resources provided since the hospital was acquired by the Kings College Hospital NHS Foundation Trust had helped the PRUH to prioritise quality of care and patient safety. In particular the nursing establishment has improved and although there remained vacancies and there was an issue with the skill mix, the improved staffing levels have had a positive effect throughout the medical directorate. An example of this was the improved stroke service at the PRUH. In 2013 the service scored a 'D' in the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP). In 18 months the stroke service at the PRUH has risen to one of the top eight per cent in the country. The trust told us that the improvements were due to a number of changes, such as filling key nursing positions including a matron, clinical nurse specialist and full-time psychologist.

Care and treatment was provided in line with best practice guidance, and there were monitoring systems in place. Results from the most recent audits indicated that patients care and treatment was improving. There was a good reporting culture, with staff learning from accidents, incidents and complaints. There were robust clinical governance strategies in place. Staff demonstrated a good understanding of infection control procedures, with robust monitoring of their effectiveness. We saw that patients were treated with dignity and respect. There was good leadership of the wards and departments within the medical division, with staff taking responsibility for their areas of influence, and pride in the staff working there. Staff felt engaged and supported by their managers.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We found that some of the safety aspects of the medical care provided at the Princess Royal University Hospital (PRUH) required improvement. Patient records did not always document details of the risks to patients or the treatment they had received. On occasions medical records were not available, which meant that doctors may not have all the information to hand to enable them to treat the patients appropriately.

Wards generally had enough staff on duty; however, this was often made up of bank and agency staff. We found that the skill mix was not always appropriate, with the nursing numbers made up of newly qualified staff and junior nurses. This meant that on occasions, patients had to wait for procedures or tests that required the skills and competencies of a more senior and experienced nurse, or a junior doctor. Front-line ward staff told us how the staffing of the medical wards and departments had improved over the past 18 months, and how they now felt able to increase their staffing numbers should the acuity of the patients increase.

Resuscitation equipment was not kept secure, as tamper-proof tags were not in place. This meant that there was a risk of unauthorised access, as there were no means of identifying if the resuscitation trolley had been used, or if drugs, stock or equipment had been removed from the trolley between checks.

Medicine storage on the wards was not always secure. This meant that there was a risk of unauthorised access.

Patients were protected from avoidable harm and abuse through staff being encouraged to report incidents and 'near miss' events. Incidents were reported, learnt from, and fed back to the staff. The trust was proactively working to address those areas identified as high risk, such as the prevention of pressure sores and falls.

Although the general environment was visibly clean, bright and modern, the basic design of many clinical areas presented problems with regard to infection control, restricting access and the care of unwell or confused patients. Although at the time of our inspection there was an outbreak of norovirus (Winter vomiting virus), we found that staff knowledge and the application of infection control measures were outstanding. All grades of staff actively challenged infection prevention and control practice that did not comply with national and local guidelines.

Incidents

- The rates of incidents reported to the National Reporting and Learning System (NRLS) was higher than the England average per 100 admissions.
- Throughout the hospital we found that there was a positive incident reporting culture. Staff we spoke with were clear about their reporting responsibilities and told us they were encouraged to report all incidents and near miss events.
- We spoke with staff who told us how patient safety was the top priority for the trust. All grades of ward staff, from consultants to ancillary staff, were able to give examples of where they had reported an incident and changes were made as a result.
- Staff told us that they usually received feedback, directly or through staff meetings, memos or bulletins. For example, a consultant told us how discharge information had been changed following an incident involving a patient's anticoagulation therapy. A junior doctor told us of how, following a patient's fall, actions were taken to help prevent a reoccurrence.
- All staff told us that they would feel happy to speak out about any concerns, and would be confident that they would be addressed.
- The only group of staff who told us that they rarely received feedback following the reporting of incidents, were some of the therapists.
- Between February 2014 and January 2015 there had been no medical 'never events' reported. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between February 2014 and January 2015, there were 103 serious incidents at the Princes Royal University Hospital. Included in these were 11 falls with significant injury and six grade 3 pressure ulcers. There were no grade 4 pressure ulcers acquired during this period.
- We spoke with consultants and senior managers, who told us about the clinical governance and risk meetings, which were held monthly by directorate. Junior doctors confirmed how they received feedback from the

monthly Mortality and Morbidity meetings. All incidents, including feedback from mortality and morbity meetings, were discussed, and information disseminated.

- We spoke with staff and they told us of the positive changes that had been made to help reduce falls. For example, on the Stroke Unit, the manager told us that there was now 'zero tolerance' for falls. It was no longer accepted that patients may fall, and every incident was analysed.
- Staff told us about the Falls and Continence project, which identified that more falls occurred when patients were not helped to the toilet regularly. Action on this had helped staff to change their attitude to falls. Staff showed us the data, which confirmed the improvement.
- We saw from various clinical governance meeting minutes that the Duty of Candour was discussed, and staff were made aware of the new requirements relating to the new legislation. When we spoke with staff, including junior doctors, they were all aware of what the Duty of Candour meant for them. For example, both nurses and doctors told us how they would discuss matters with patients when things went wrong.

Safety Thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter associated urinary tract infections (CAUTIs), urinary tract infections (UTIs), falls with harm to patients over 70, and venous thromboembolism (VTE).
- We found that the NHS Safety Thermometer information was available on each of the medical and elderly care wards that we visited. The information was updated monthly, and clearly displayed for patients, visitors and staff to see.
- The results of each wards performance were presented at the monthly departmental meetings, and to the board in the clinical governance reports.
- The Safety Thermometer information for the past year indicated that pressure ulcer rates were variable, with improvement noted from October 2014 onwards.
- The rates of patients' falls were variable between December 2013 and December 2014. As a result of the analysis undertaken following each fall, staff told us that changes had been implemented, such as ensuring that there was always a member of staff available in each bay, and providing a desk and chair in each bay for staff to work from. This was helping to reduce the incidents of falls.
- We noted that there was a slight fall in catheter associated urinary tract infections (CAUTI) rates between January and September 2014, followed by an increase.
- Staff told us that they were confident in using the tool, and were able to demonstrate to patients and the public that the ward was delivering safe and consistent care.

Cleanliness, infection control and hygiene

- All of the medical areas of the hospital we inspected were visibly clean and tidy. However on some of the wards, we noted that the furnishings, such as bed lockers, were damaged, tired and required replacing. This presented an infection control hazard as damaged furniture is difficult to clean effectively.
- At the time of our inspection, there was an outbreak of norovirus (winter vomiting virus). Several wards had bays where visitors were restricted and barrier nursing precautions were in place. There was appropriate signage in place to inform visitors and staff of the precautions to take to reduce the spread of infection, with sufficient disposable aprons, gloves and hand-washing soaps and gels available.
- We found that staff were aware of the principles of knowledge about the prevention and control of infection (IPC). The application of infection prevention and control measures throughout the hospital was outstanding. All grades of staff actively challenged infection prevention and control practice. We observed healthcare assistants cleaning beds, lockers and hard surfaces thoroughly. They told us "we've had infection here and we don't want it back".
- We saw that staff regularly washed their hands with soap and water, and used hand gel between patients. The 'bare below the elbows' policy was adhered to.
- We noted that the hospital's infection rates were around the national average for MRSA, C. difficile and MSSA (between April 2013 and November 2014).
- All of the patients we spoke with told us that the hospital was always kept clean and tidy. They told us "the cleaners do it [clean the ward] every morning and again in the afternoon". They told us that they noticed the nurses were always washing their hands.

- The cleaning of the hospital was undertaken by an outside contractor. Ward staff told us there was usually no problem with the cleaning of the wards. However, on one ward we visited, the housekeeper told us that there had been no additional cleaning staff put on duty following the infection outbreak. They told us that although they were coping, this was putting a lot of pressure on the domestic staff, who were unable to empty waste bins and clean as often as was required, especially in the afternoon and evening. We mentioned this to the senior nursing team, who told us that additional cleaners should have been allocated, and rectified the situation immediately.
- We spoke with infection control link nurses, who told us how they undertook regular hand hygiene audits in order to make sure all staff were compliant with hand washing.
- Endoscopy decontamination at the PRUH was on the trust's risk register. The endoscopy suite was not fully compliant with Department of Health decontamination guidance (HTM 2030) and was not JAG (Joint Advisory Group) accredited. JAG accreditation demonstrates that the endoscopy service has met nationally-recognised endoscopy standards. The endoscopy manager told us that there were plans in place for a central decontamination unit to be built, and to achieve JAG accreditation by the end of the year.

Environment and equipment

- Although the general environment was bright, clean and modern, there were clinical areas where the ward layout made the nursing of unwell or confused patients difficult. For example the basic design of accessing one ward through another did not allow for isolation and robust barrier nursing procedures. This became apparent during the inspection, as there were areas where visiting was restricted due to a viral outbreak.
- We found that Farnborough Ward consisted of 25 side rooms in a long, narrow corridor, making staff observation of unwell patients a challenge. Although a day room was built this year, it did not have a call bell system.
- Staff told us that structural improvements had been identified; however, because the hospital was constructed using a public finance initiative (PFI), any alterations took a long time to approve and put into place.
- In the meantime, the hospital worked around the limitations of the building by providing extra staffing, and ensuring staff had sight of vulnerable patients in wards, bays and in corridors.
- Across the hospital there was little space for storage which meant equipment was often found in corridors where it restricted access and created potential hazards.
- We reviewed the testing and maintenance of equipment across wards and specialist medical units, such as resuscitation trolleys, hoists and slings, medicine trolleys and fridges, etc. Equipment was labelled following cleaning to indicate that it was fit for use.
- We found that although the resuscitation equipment was usually checked daily, the drugs and equipment were not kept secure, as tamper-proof tags were not in place. This meant that there was a risk of unauthorised access, as there were no means of identifying if the resuscitation trolley had been used, or if drugs, stock or equipment had been removed from the trolley between checks. We raised this concern with the resuscitation officer, who told us that they were unaware that the trolleys had the ability to be made secure with tags.
- We found that the hospital had recently implemented an equipment library, which staff told us had greatly improved the availability and reliability of the equipment.
- We spoke with the member of staff responsible for the equipment library, and they told us how each piece of equipment was now logged in and thoroughly checked to ensure it was clean and fit for use before being made ready to be loaned out again. Managers told us how this had greatly improved equipment availability, as before, each ward held their own equipment and there were no verified checks undertaken as to maintenance and cleaning.
- Staff we spoke with on the wards told us that there were now no concerns about the availability of equipment, such as pressure relieving equipment for patients assessed at risk of developing pressure ulcers, or pumps for giving intravenous fluids.
- However, some of the junior doctors told us there was still an issue with some pieces of equipment and stock, and gave examples where they had to visit three wards before they found a blood gas machine that was available and working. They told us there was also sometimes a problem with replacing stock, such as tourniquets to take bloods. They told us that this could potentially impact on patient safety.

Medical care (including older people's care)

Medicines

- The handling, administration and storage of medicines was reviewed across the medical wards and specialist medical units we inspected.
- There was a Medicines Safety Committee that sat within the clinical governance structure where medicine safety issues were identified and discussed. Communications were sent to the relevant areas in the form of alerts, emails, bulletins or posters, to raise awareness and ensure that key messages were received.
- We saw that although there were security measures available, there were occasions when staff had not secured the medicine storage rooms, or tethered the medicine administration trolleys to the wall after use. This meant that there was a risk of unauthorised access.
- Medicine storage usually met best practice guidelines; however, we noted that controlled drug liquids were not always labelled with an expiry date when opened.
- There was named pharmacy support for each ward. We found that by having ward-based pharmacy staff and drug 'listing', the pharmacy department was able to support patient flow and the management of medicines onwards.
- We saw that the PRUH had a well organised pharmacy department. Staff told us that the availability of drugs and medicines was rarely a reason why discharge was delayed as, where possible, take home medications were pre-ordered in advance; for example, in the discharge lounge the wait for medicines was observed to be less than 30 minutes.
- We spoke with PRUH and trust-wide pharmacy leads, who told us that electronic prescribing and medicines administration were not implemented on the PRUH site. They said that this increased the likelihood of prescribing and administration errors when compared with the Denmark Hill site.
- The pharmacy department did not have automated dispensing machines, which also increased the risk of dispensing errors, and reduced the efficiency of the dispensing process, adding to the trust's issues of delayed discharge. We were told of a recent serious incident where palliative care drugs were dispensed to the wrong patient. The patient subsequently deteriorated and was admitted to the intensive care unit.
- Pharmacy staff told us of the measures that had been taken to align the pharmacy and medicines management across the trust. This included supporting the trust with the challenges of bed capacity and extended pharmacy opening times, providing additional staff and systems to help with the timely processing of discharge prescriptions.
- We spoke with the clinical nurse specialists, and they told us of the problems they encountered with being able to use their prescribing qualification. This was a source of frustration, as it inhibited their practice and impacted on the care they could offer patients.

Records

- The hospital was using a mainly paper-based record system, with standardised care plans in place that tracked the patient's journey through the hospital. The care plans included risk assessments, such as the risks of falls, pressure ulcers and malnutrition.
- On each ward or specialist unit we reviewed a small sample of nursing and medical records. We found that few of the nursing records had been fully completed. Risk assessments were not always completed, nor a reason given as to why it had not been done.
- Care plans were not always in place and routine observations not always recorded. For example, on Med 5 we found a patient who had been admitted with tissue damage for wound care, who did not have a care plan in place to guide staff on how to care for their wound. On Med 3, one patient's visual infusion phlebitis score had not been undertaken for the three nights that they were in hospital.
- We examined the medical and nursing records of medical patients admitted as outliers to non-medical wards. We found incomplete documentation and poorly completed assessments. For example, a medical patient admitted to a surgical ward, who was a planned discharge, had no assessment of their social status on admission. There was no indication of any multidisciplinary involvement, such as a dietician, occupational therapist, or social worker, or any assessment of their home circumstances. When we spoke with the patient and their family, they had concerns that the patient would be able to cope at home, as they were also a carer for their bed-bound spouse. None of this information was recorded in the nursing or medical records. We spoke with the doctor responsible for the patient's discharge and they were unaware of the patients' home circumstances, and how this may impact on their ability to cope at home without additional support in place.

- Another medical outlier on Chartwell Ward had had a urinary catheter removed in the emergency department prior to admission to the ward. There was no information, continence risk assessment or observations relating to this in the nursing records.
- Allied healthcare professionals usually documented the patients' treatment in the medical notes.
- On the Acute Medical Unit (AMU) not every patient had an escalation plan. Of the five sets of records we looked at, only two had completed escalation plans.
- The medical notes were paper-based and mostly legible. Although the notes were usually well filed, we found several examples where it was not easy to locate the most current period of treatment, or to quickly identify any tests or investigations undertaken.
- Consultants told us that it was difficult to locate any summary of the patients' conditions. For example, the consultant on a care of the elderly ward told us that a patient was living with dementia. This was not easily apparent from looking at their medical records.
- We looked at a set of medical records on the endoscopy unit, and found that although a consent form had been signed, the procedure, risks and benefits were illegible. This meant that there was no record that the patient knew and understood what the procedure was that they had consented to, or that the risks and benefits had been explained to them. There were no formal audits of records or consent forms undertaken, apart from the staff who coded the medical records for billing purposes.
- We found that poor record-keeping may have impacted on patients' health and well-being. For example, in November 2014, a medical inpatient fell on the ward. It was noted that the falls risk assessment had not been completed on admission, and that two other opportunities for completing an assessment had been missed, such as on transfer to a new ward, and following an earlier fall.
- We spoke with the doctors, who told us that there were sometimes difficulties in locating the medical records for new patients. Across the medical directorate doctors told us that the current IT systems were 'challenging and difficult', but they envisaged that once the PRUH had access to the electronic patient record system, this would become improve.
- The hospital's Patient Advice and Liaison Service told us that there had been numerous problems with lost notes – with over 80 cases noted. There were particular problems for Liver and Ophthalmology patients, to the extent that the Patient Advice and Liaison Service team were advising patients to go back to their GP for a referral to a different hospital.
- They told us that the trust's electronic-based system was very efficient with information, regarding viewing tests and investigations which were available online. They said that the cross-site diagnostic information was available and usually worked well.
- Staff working in the endoscopy unit told us that the availability of medical records prior to endoscopy procedures was sometimes an issue, and that this was always reported as an adverse incident.
- The divisional team report 2014/15 indicated that patient records could not be found for three patients for participation in a national confidential enquiry relating to a NCEPOD (National Confidential Enquiry into Patient Outcome and Death) sepsis study.

Safeguarding

- The trust had a safeguarding vulnerable adults and children policy, and guidelines were available on its intranet.
- We spoke with the safeguarding lead, who told us that all staff had a good understanding of safeguarding children. They knew the process, and made their own referrals, although support was available if required.
- We were told by the safeguarding leads that there was little safeguarding supervision across the trust, as it was not part of the trust's culture. They told us that they received supervision from their manager at the Denmark Hill site, which was not best practice. They told us that peer review felt like a 'one way process' and didn't feel comfortable. However, we were told they were very experienced and received little support from the safeguarding nurse at the Denmark Hill site.
- A designated safeguarding nurse from the local CCG (clinical commissioning group) had responsibilities for supervising the PRUH safeguarding leads as they had local knowledge and a good governance system in place. However, we were told that although they had been in post for six months, they had not yet met with the safeguarding nurses at the PRUH.
- The safeguarding manager from the Denmark Hill site visited the PRUH every six weeks, and the PRUH safeguarding nurses attended the Denmark Hill site for monthly steering group meetings.

Medical care (including older people's care)

- The safeguarding nurses told us that Level 3 training took place at the Denmark Hill site, although there was a good training room at the PRUH.
- The safeguarding leads voiced their concerns about support available for the newly appointed safeguarding nurse who worked two days a week.
- They told us that there was a designated safeguarding doctor, who had held the post for many years, and was described by staff as supportive, knowledgeable and helpful.
- Across the medical directorate, we saw that safeguarding training was included in the trust's mandatory training programme. The results of the training were displayed on each ward.
- We saw evidence that staff had attended dementia awareness training. This was supported by the changes staff had made to the wards, where patients living with dementia received care and treatment.
- Dementia champions were available to support patients and other members of the care team to care for patients living with dementia. We saw evidence in two patients' records of the completion of the dementia care plans, together with completed 'This Is Me' documents, which were individual care plan for vulnerable adults.

Mandatory training

- The trust had put in place a new electronic system for recording staff training. The system highlighted when training was undertaken, due or urgently required.
- However, we were told that there was a delay in inputting recent training and in updating records with any past training.
- We looked at the electronic training records and identified many gaps. However, the managers assured us that staff training was improving since they had become part of King's College Hospital NHS Foundation Trust. They gave examples where staff had attended the training, but this was not yet on the system; for example, on the stroke ward at Orpington Hospital 75% of staff had completed their mandatory training, but this was not reflected in the electronic records.
- We spoke with consultants and doctors of all grades. They told us that mandatory training, such as safeguarding and infection control, was available, although it was not always easy to find the time to attend.
- Junior doctors, new nursing staff and agency nurses told us about their induction training, which they had all completed when starting work at the trust.

Assessing and responding to patient risk

- The trust used the National Early Warning Score (NEWS). This scoring system enabled staff to give early identification of patients who were becoming increasingly unwell, and provide increased support.
- We saw good examples of staff in the Acute Medical Unit using the NEWS system to identify deteriorating patients and ensure that they were seen quickly by a doctor.
- Staff told us that there had been some issues with implementing the early warning system, with some staff being 'complacent' about slight elevations or small deviations, and the records not reflecting the elevation scores. This impacted on the overall efficiency of the system for identifying vulnerable patients. This was being rectified by additional training and support.
- The hospital operated a medical outreach team called i-Mobile, who were called when there were concerns about a patient's condition. We spoke with the i-Mobile nursing staff, who told us how they were helping to prevent admissions to the intensive care units. They gave the example of the previous month, where they were called to 10 patients, and only two subsequently required admitting to the intensive care unit.
- Staff told us how the i-Mobile team offered good senior support to the junior doctors on the ward. The team gave one-to-one care on the wards for patients identified at risk, although this was limited, with one band 7 nurse per shift.

Nursing staffing

- We spoke with nursing staff from across the medical and specialist units, and reviewed nursing rotas. We saw that nursing numbers, both planned and actual, were displayed on most of the wards and services we inspected.
- Monthly nursing performance reports were presented to the board of directors, and provided them with information on the details of the actual hours that registered nurses and clinical support staff worked on the wards, versus the planned staffing levels. For example, in January 2015, the overall fill rate for registered nursing shifts was 97%, and for other care

staff against planned levels was 116% during day shifts. The actual fill rate for shifts for registered nurses against planned levels was 100% during night shifts, and for other care staff the actual fill rate was 144%.

- Ward managers told us that they usually worked to a nursing ration of 6:1 or 8:1 depending on the acuity of the patients.
- Throughout the hospital, staff told us how the staffing establishment had improved since the hospital became part of the King's College Hospital NHS Foundation Trust. They told us that there was an active recruitment drive in place across the trust and, although many wards remained understaffed and relied heavily on agency and bank staff, there was now no compromise in the staffing numbers. Staff told us that even when they were understaffed according to the rota, it still felt better than previously.
- We saw that agency staff underwent a structured induction to the trust and to the wards they were allocated. Senior nurses and managers told us that the same agency and bank staff were used where possible, which helped with continuity of care for patients.
- We spoke with agency and bank staff, who confirmed that they usually worked on the same wards and felt very much part of the nursing team. One agency nurse told us how they were involved in training and team meetings, and had worked on the same ward for over a year. Another told us how they had access to the reporting system, and gave an example where they had reported an incident.
- Staff told us that although the nursing numbers had improved, the skill mix was sometimes an issue. Managers told us that there were never shifts with 100% trust staff. They gave examples of shifts with only one permanent member of staff, and the rest bank or agency. We found this on the day of our inspection, where Med 1 Ward was staffed by two regular agency nurses and two healthcare assistants. We found that there was also a high ratio of newly qualified nurses on many wards. Although they told us that they felt well supported by the more senior staff, this still meant that they did not have the skills or competencies to undertake many nursing tasks, which put additional strain on the more senior nurses and junior doctors.
- Managers told us that staffing the wards was their biggest worry. Although the trust was actively recruiting, there just were not enough applicants.
- They told us that compliance with the expected ratios was assessed and fed back daily to senior managers. They told us they felt well supported when asking for additional staff to support the increased acuity of patients. One manager told us "it's never a problem when justifying the need for additional staff – patient safety comes first". We saw an example on Med 7 where the Matron completed a form which documented the extra support needed for confused patients, and which was used to provide evidence for extra staff.
- However, we noted that there were instances where there were insufficient staff or an inappropriate staffing skill mix on duty. For example, between September to December 2014, there were four instances when insufficient staffing numbers were reported on Chartwell Ward. Staff reported that insufficient staffing or an inappropriate skill mix had an adverse effect on patient care; for example, with patients' blood tests not being undertaken, or treatment being delayed.

Medical staffing

- We saw that the proportion of consultants was slightly lower than the England average, with a higher number of middle grade doctors.
- We spoke with all grades of doctors and medical consultants, who told us that there was a shortage of medical staff across the medical directorate. Although these were usually covered by locum doctors, this put additional pressure on all grades of medical staff working in the hospital. For example, they told us that where consultants had retired, their post was being covered by various other consultants, which led to a lack of ownership. Where middle grade doctors were not available, out of hours cover was provided by the emergency department. They gave examples where the consultants had to cover and be 'hands on'.
- Junior doctors told us that the safety systems had improved over the past year. One doctor told us that "patient safety was my first concern when I started here, but with 'King's' input the checking and double checking has improved safety over the past year".
- In the hyper-acute stroke unit (HASU) we were told that there were four senior house officers on fixed-term contracts.

Medical care (including older people's care)

Major incident awareness and training

- The trust had business continuity plans in place for all hospitals, including the PRUH. These included communications and useful telephone numbers. Staff were aware of these, and knew how to access them.
- The trust had a major incident policy and procedure, which was available on the trust's intranet. The staff we spoke with knew their responsibilities in the event of a major incident and how to access the policy.
- There were arrangements in place to deal with the Winter pressures arrangements, including proactively planning for additional bed space and staffing.

Are medical care services effective?

Requires improvement

Medical services at the PRUH were rated as requires improvement in terms of delivering effective care.

Although training and development opportunities were available for medical, nursing and ancillary staff, there were logistical issues with finding the time to release staff for training. There were not always sufficient staff skilled to undertake tasks such as phlebotomy and chemotherapy; this was causing delays to admission, and impacting on patient care and treatment.

We found that although the recording of staff appraisals was an issue, the majority of the staff we spoke with had received an annual appraisal. There were few opportunities for formal supervision, but staff were supported through team meetings and peer support. There was evidence of good multidisciplinary working across the medical division, with strategies in place for working with partner agencies to access hard-to-reach communities.

The hospital had relevant policies and procedures available regarding consent, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, we found that staff although staff had attended training on this, their understanding varied between wards and departments.

The hospital was progressing towards seven day working; however, this was hampered by lack of staffing resources.

Patients nutritional and hydration needs were met, because there were systems in place to assess their nutritional needs and provide the necessary care and treatment. Although we found that the nutritional documentation was not always complete. Special diets were catered for, and dieticians were available if required.

There were systems in place to monitor compliance with national guidance and best practice. There were systems in place to monitor patient's experience of pain, and to provide appropriate care and treatment. The hospital performed well in the majority of national audits it took part in. Performance in the Sentinel Stroke National Audit Programme (SSNAP) was particularly good, as the hospital had significantly improved its rating over the past year and was now rated twelfth nationally.

Evidence-based care and treatment

- The trust audited the hospital's compliance with NICE (National Institute for Health and Care Excellence) guidelines. From the 2014/15 Team Divisional report, we saw that the PRUH was 95% compliant with NICE guidelines.
- Staff were able to access national guidelines through the trust's intranet, which was readily available to all staff. The medical staff demonstrated the ease of accessing the system to look for the current trust guidelines on the management of anticoagulant therapy.
- The trust audited the hospital's compliance with NICE (National Institute for Health and Care Excellence) guidelines. From the 2014/15 TEaM Divisional report, we saw that the PRUH was 95% compliant with NICE guidelines.
- Staff were able to access national guidelines through the trust's intranet, which was readily available to all staff. The medical staff demonstrated the ease of accessing the system to look for the current trust guidelines on the management of anticoagulant therapy.
- The policies and procedures at the PRUH were not yet fully reflective of the Kings College Hospital NHS Foundation Trust policies. Junior doctors told us there were sometimes differences in the policies found at the Denmark Hill site and those at the PRUH. For example, the guidelines for the administration of vitamin D were different across the two hospitals. Although this had not had an impact on patient care the junior doctors who worked across the two sites told us that they found this confusing.

Medical care (including older people's care)

- We saw examples of 'best practice' guidance being followed in practice. For example, on the hyper-acute stroke unit we observed staff ensuring that high risk patients were wearing pressure stockings to reduce the risk of thrombosis.
- Staff on the stroke unit told us that having a full-time clinical nurse practitioner available, helped to ensure that NICE guidance was embedded in the care they gave to patients.
- We saw that nursing and medical staff were involved in local audit programmes to monitor the quality of care and treatment. Junior doctors gave examples of where they had been involved in audits, which had resulted in a change in practice or had raised awareness of issues. For example, 51 sets of notes had been reviewed on the Acute Medical Unit, looking at how conversations with patients were documented when making resuscitation decisions. On Chartwell Ward, nurses were assisting in an audit of neutropenic sepsis, measuring the time from admission to the first dose of antibiotics.

Pain relief

- There were systems in place to monitor patient's experience of pain, and provide appropriate care and treatment. For example, on Chartwell Ward, the doctors told us about the 'Pain Team' and how they made referrals to the specialist pain management nurse.
- Patients on the general medical wards told us that staff frequently asked patients if they were in pain, and told us that they were given analgesia if required.
- On the Acute Medical Unit a patient told us "as soon as I'm allowed pain killers they give them to me, they are all very good at that".

Nutrition and hydration

- We saw that nutritional assessments using the Malnutrition Universal Screening Tool (MUST) were included in the basic care records which should be completed for each patient on admission. However, in the records we reviewed, these were not always completed, or a reason why not, recorded.
- On the general medical wards, completion of the risk assessments was inconsistent, with some fully completed and reviewed with referrals to a dietician, and others left blank. On the Acute Medical Unit, two of the three patients admitted the previous day had their nutritional and hydration needs assessed, but none of the patients reviewed, who were medical outliers, had their 'MUST' assessments completed.
- We spoke to patients about their experience of food in the hospital. They told us that "the food is good". Another told us that the food was always served attractively.
- A patient on Chartwell Ward told us "there is a different choice every day and I've eaten well. I lost weight when I was admitted to the other hospital but I don't think I have here". One patient told us that they were on a special diet and there was no problem with getting suitable food.
- Another patient on the Acute Medical Unit told us how they had lost weight and the hospital was providing nutritional supplements to build them up.
- Staff told us that they ordered special diets from the kitchen, and there was usually no problem in organising these.
- We heard from staff in the discharge lounge, of how meals were ordered for patients waiting to go home. This included a packed lunch if they were discharged in the morning, or a hot meal if they were discharged after lunch.
- On Dawson Ward, staff offered drinks hourly, to ensure patients were hydrated.

Patient outcomes

- There were no risks identified in regard to the hospital's mortality rates.
- The 2014/15 team divisional report indicated that the PRUH participated in 11 of the 12 applicable national audits that it was eligible for. The trust was taking action to enable the hospital to submit data for the outstanding audit.
- The hospital also performed well in the National Heart Failure Audit and the National Diabetes Inpatient Audit.
- The Myocardial Ischaemia National Audit Project (MINAP) and the Lung Cancer Audit also gave areas where the hospital could improve, although the results were close to the national average.
- We noted the stroke and hyper-acute stroke unit (HASU) at the PRUH performed exceptionally well in the Sentinel Stroke National Audit Programme (SSNAP). The unit scored highly in a number of areas, including timeliness of admission to the HASU from the Emergency Department, and patient reviews by a stroke consultant. The trust told us that the improvements were due to a number of changes, such as filling key nursing positions including a matron, clinical nurse specialist and full-time psychologist.

- The average length of stay was higher than the England average for most of the elective and non-elective procedures at the two main sites including the PRUH.
- We noted that the risk of readmission for elective general medicine was noticeably worse than the England average at the PRUH.

Competent staff

- Throughout the hospital, and on the stroke ward at Orpington Hospital, we found that the majority of staff had received their annual appraisals; at Orpington Hospital 97% of staff had been appraised. Some wards told us that since September 2014, the IT system had had problems with recording appraisals.
- Nursing staff in general told us that training and support were improving; however, there were wards which had particular problems with maintaining staff competencies, such as the oncology ward, Chartwell Ward. Here, staff told us that nurses skilled and trained in administering chemotherapy were hard to recruit, and although funding for the training was available, it was difficult to find suitable staff. We were told that the lack of suitably trained staff had led to delays in admission.
- There were few opportunities for formal supervision; however, staff were supported through other means, such as team meetings and peer support.
- The staff we spoke with told us that they used a lot of agency and bank staff, and that although they always tried to use the same agency staff, there was no robust system in place for checking their competencies. For example, staff at Orpington Hospital told us that although most agency staff were 'regulars', there was no assurance around their drug administration competencies, unlike the bank staff who had comprehensive clinical competency framework documents.
- We spoke with agency staff, who told us that they had completed training and undertaken competencies through their agencies, although this was not verified.
- The trust employed practice development nurses (PDN) to provide training and support to the nurses on the wards. Staff were positive about their input. We saw the PDNs relieving staff of their ward duties, so they could be free to do training.
- We spoke with the doctors, who told us that training opportunities were limited because of staff shortages. They said that education and training was more service-focused, with educational and clinical supervision. The junior doctors told us that the shortage of middle grade doctors meant that it was difficult to get appropriate supervision, and gave examples of when they could not get competencies signed off.
- Consultants told us that time was allocated for study leave and it was funded.
- All the doctors we spoke with told us that they had undergone an induction programme when starting work at the hospital. The junior doctors told us that they felt valued and well supported due to good team working. They told us "it's pretty good here".
- All the medical staff we spoke with were aware of their revalidation dates, and told us that they had had appraisals in the past year.

Multidisciplinary working

- We saw that there was generally evidence of good multidisciplinary working across the medical division. We joined several ward rounds, where the doctors, nurses, allied healthcare professionals and social workers met to discuss the care and treatment of each patient at the patient's bedside. We noted that these were conducted in a respectful and professional manner, between all grades of staff and specialties.
- The doctors told us that the nurses were "excellent – really good and very supportive". For example, on Chartwell Ward, we were told that the nurses ensured that blood tests were taken as early as possible, to ensure the results were ready for the ward round. They told us that the specialist nurses were always contactable, along with the pharmacists.
- However, on M3 and the Acute Medical Unit, we were told that genuinely multidisciplinary working was more of a challenge. Staff felt this was because the focus was on discharging patients quickly, and little attention was paid to concerns raised by other healthcare professionals. We were given examples where patients at risk of falls were discharged home as they were 'medically fit'. We were told that the ward rounds could be very "intimidating" and the therapists felt their opinion was not always valued by certain members of the nursing and medical team. Staff who had worked across the trust, told us that it was different at the Denmark Hill site, where everyone's opinion mattered and was taken into consideration.
- We saw there were strategies in place for working with partner agencies to access hard-to-reach communities,

such as the homeless partnership project, which was a multi-agency, multi-professional pathway, providing patient-centred, integrated care, across physical and mental health providers, drug and alcohol services, and hospital and community care.
- The hospital-based social workers told us that although joint health and social care posts had been discussed, this had not happened. We were told that the relationship between health and social care colleagues had improved, but there were still cultural barriers that prevented a truly integrated service.

Seven-day services

- Consultants we spoke with told us that there was a consultant-led ward round each morning, including at weekends. The junior doctors we spoke with told us that there was never any issue in contacting the consultants for advice, and they felt well supported.
- There was pharmacy cover for each of the wards on weekdays and Saturdays, with a pharmacist on duty in the pharmacy on Sundays.
- However, we found that not all of the support services offered a comprehensive seven day service.
- The staff in the cardiac care unit (CCU) told us that if a patient required pacing out of hours they would need to be taken to the Denmark Hill site.
- We spoke with the therapists, who told us that it was difficult to run a seven day service with limited resources. They told us that until more therapists had been recruited they could not offer a full seven day working service.
- The physiotherapy service operated an on-call rota at weekends. Staff told us that this was a gap in being able to offer a truly seven day service.
- The physiotherapists could only offer seven day working for the acute and rehabilitation teams, while although the speech and language therapists had put in a business case for more staff, they currently could only offer a basic weekday service to the hospital.
- The junior doctors told us that although the radiology service offered an out-of-hours service, in reality, it was very difficult to get clearance for treatment, as the department could be quite obstructive. They gave examples of where patients' treatment had been delayed because of this, and told us it was very frustrating.
- We spoke with the social services support in the hospital, and they told us that they offered seven day support to the wards to help facilitate discharge.

Access to information

- We found that there was not always prompt access to medical records. This impacted on the care and treatment patients received. Some procedures, such as endoscopy, were cancelled or delayed.
- Information was readily available throughout the hospital in the form of leaflets, booklets and posters.
- Each ward we inspected had a range of information leaflets available in accessible locations. These included general information on the ward, information on various conditions, and support groups in the community, together with public health information.
- The hospital's website also provided information, and signposted to further sources of information and helpful advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent policy in place, which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent, details on the Mental Capacity Act 2005 (MCA) guidance, and checklists.
- Staff told us that training on the MCA 2005 and DoLS was available. Although there were IT problems with accessing the online training and updating the system, managers told us that they were confident that the majority of their staff had undertaken training on the MCA. This was verified by looking at the staff training information available on the wards.
- The staff we spoke with were able to describe incidents where patients' capacity to consent was questioned, and appropriate action taken to ensure their rights were upheld.
- The majority of staff were able to describe the process of obtaining valid consent, but were less familiar with the Deprivation of Liberty Safeguards (DoLS).
- Some of the ward managers we spoke with did not understand the MCA 2005 and had not attended the training. They told us that they would ask the trust's adult safeguarding lead, who assumed overall responsibility for the process. They told us that the

doctors were the principal leads for capacity assessments, but the nursing staff may be involved by raising concerns, discussion of issues and assisting with the process.
- The hospital-based social workers told us that there was a lack of understanding on the wards about DoLS, and ward staff struggled with the DoLS referral process.
- In the records we looked at, we saw evidence that patients capacity was taken into consideration. For example, one patient had refused treatment, and it was clearly noted that they had the capacity to make this decision. We looked at a sample of capacity assessments, and saw that they were well completed and met the MCA 2005 Code of Practice.
- On the Acute Medical Unit we saw an example of where a patient had been identified as requiring screening for dementia. A mental capacity assessment had been undertaken and an application for DoLS completed.

Are medical care services caring?

Good

We rated the medical services at the PRUH as good for caring, because the majority of patients we spoke with, or who contacted us, were positive about the care provided to them, and told us they were treated with kindness and compassion. We observed staff being friendly towards patients, and treating them and visitors with understanding and patience, and that treatment was provided in a respectful and dignified manner.

Patients told us that they were usually involved in decisions about their care, and were kept up to date with their progress. Emotional support was provided by staff in their interactions with patients, volunteers and clinical nurse specialists, who visited the medical wards regularly. Most patients and their relatives were positive about their experiences, with comments such as "staff are very nice, very kind", "they are always ready to help, and nothing is too much trouble", and "they take good care of you – it couldn't be better".

Compassionate care

- We spoke with 17 patients and two relatives, who all told us that the care at PRUH was "excellent". Comments included "staff are very nice, very kind", and "they are always ready to help, and nothing is too much trouble".
- The patients who contacted us prior to the inspection, and through our various listening events, told us that the care was usually very good and the staff were excellent. We heard some patient's stories where care was less than ideal, but when reported, the issues were always dealt with promptly and appropriately.
- During our inspection, we overheard a patient who was worried about ringing their bell being told by a healthcare assistant to "press your buzzer if you need to, that's what we are here for. Is there anything I can get you?"
- On the hyper-acute stroke ward we saw staff talking with patients in a respectful and caring manner, taking time to explain treatment and options to patients.
- We noted that the interactions between care staff and patients were kind and friendly, and it was evident that staff listened to patients concerns, and patients trusted the care staff.
- Patients told us that they were treated with dignity and respect by all members of the care team. We observed patients being asked how they wanted to be addressed, staff knocking on doors before entering, and curtains being pulled around beds before treatment or private conversations took place.
- However, on Med 1 a relative of a patient told us that their parent had not had a shower in three weeks. When this was raised with the staff, they told us that they now made sure they had a shower most days. They told us that although the staff were caring, they were very busy and this impacted on the care.
- We noted on the Patient Choices website that the number of negative comments was high relative to positive comments, and the hospital scored three and a half out of five stars for dignity and respect. This was based on 193 ratings. We noted that over the past six months concerns had been raised about the attitude of some of the staff, doctors and administrative staff, which was less caring and helpful than expected.

Medical care (including older people's care)

- Patients were asked to complete a 'How Are We Doing?' patient survey prior to discharge. Recent results indicated that patients were happy with how they were treated, but felt improvements were needed with patients experience of the neuroscience service.
- The average response rate for the Friends and Family Test was low, at 15.1%. However, on reviewing the evidence, this was caused by several months without any responses. Since June 2014, the response rates had been improving.
- Out of 239 responses, 87% of staff said that they would recommend the PRUH for care, and out of 416 responses 93% of patients would recommend the hospital.

Understanding and involvement of patients and those close to them

- Patients told us that they usually felt involved in their care. They told us the staff nearly always checked with them before providing care, and they always listened to what they said. Some patients told us that the staff were too busy to let them know what was going on, and others said "if you ask a question they will tell you or find out for you".
- We spoke to patients on the general medical wards, and they told us that sometimes the doctors talked over you. One patient told us "it's 50:50 if they talk to you and involve you".
- On Chartwell Ward patients told us "lovely, really nice", "staff are always cheery". One patient told us "I wouldn't be worried about coming here again, I have nothing but admiration for the staff, they are so professional".
- The patients we spoke with tended to know what was in their plan of care. For example, they knew when they could ask for pain relief, or when their dressings were due to be changed.
- Another patient told us how they had been fully involved in their discharge planning. They told us that the staff explained everything in 'easy speak' so they could understand.

Emotional support

- Patients received emotional support from various sources during their stay in the hospital.
- There were specialist nurses available to offer support, counselling and advice for patients with many of the long-term conditions on the wards.
- On the stroke ward we saw a pet therapy dog and their owner, who visited the ward weekly. They told us they had visited patients who were unable to communicate and seen them 'come to life', and how people with speech difficulties often made huge efforts to communicate with the dog. They told us how they had joined the ward rounds on occasions, and the doctors had seen the different response that patients gave to the dog. Pets as Therapy (PAT) dogs were an initiative to help patients who may be feeling low after suffering a disability following a stroke, or who may have been in hospital for a long period of time.
- Patients we spoke with on the general medical wards were unsure of who they would talk to if they were worried. One patient told us "I suppose I'd talk to my wife".
- The trust employed a wide range of clinical nurse specialists who supported patients and their families with specific needs and long-term conditions; they included the Parkinson's, respiratory, tissue viability and diabetes nurses.
- Staff on Chartwell Ward told us there was a counselling service available for patients, although they felt this could be improved.

Are medical care services responsive?

Requires improvement

We found that some of the responsive aspects of the medical care provided at the Princess Royal University Hospital (PRUH) required improvement. The pressures on beds in the hospital meant that there were usually medical patients admitted to non-medical wards, and patients were sometimes moved several times during their stay, sometimes late at night. Bed occupancy had been consistently above 90% since April 2013, which meant that the hospital was under significant pressure when admitting and discharging patients.

Discharge planning was not always effective. Although there were established medical pathways of care through the hospital, the discharge plans were not always realistic resulting in patients not being discharged in a timely fashion. The barriers to quick and effective discharges were mainly external and the hospital was actively looking at means of improving the discharge pathway.

Medical care (including older people's care)

The lack of experienced nursing staff and phlebotomists meant that junior doctors spent much of their day taking bloods which meant less time to spend with patients or attending consultant ward rounds.

Although the general environment of the PRUH was bright and modern, with wide open corridors, there were few amenities for patients, such as quiet rooms for visitors or patients.

We found that the needs of local people were taken into consideration when planning services. The trust actively canvassed the views of the local community when acquiring the PRUH, and worked proactively with commissioners and stakeholders in developing services.

Peoples' individual needs were met, as clinical nurse specialists were available to support patients with long-term conditions, or particular nursing needs. Complaints and concerns were managed appropriately, with any lessons learnt fed back to staff.

Service planning and delivery to meet the needs of local people

- The trust's acquisition of the PRUH and Orpington Hospital was in response to a number of Trust Development Authority recommendations.
- The facilities at the PRUH were being reviewed in order to increase services. These included more inpatient beds, and the development of specialist services, such as invasive cardiology, colorectal and neurology.
- The trust met with the commissioners, public and other stakeholders, in order to inform the planning and delivery of local services.
- We found various initiatives taking place to meet local needs; for example, senior nurses in the cardiac care unit (CCU) told us how the specialist nurses worked with patients in the hospital and with the community nurses. They gave examples of exercise classes held both in the hospital and out in the community.

Access and flow

- We saw evidence of effective care pathways across the medical division. For example, in the stroke units, we saw that the patient's treatment started in the emergency department, and continued through the inpatients units until discharge, where there was close liaison with community services.
- We saw similar co-ordinated intervention in the other services, such as in elderly care wards, endoscopy services and the medical wards.
- Bed occupancy had been consistently above 90% since April 2013. The England national average was 88%. This meant that the trust was under significantly more pressure when admitting and discharging patients.
- Bed meetings were held three times a day to discuss discharge planning. The meetings were multidisciplinary, and involved social service representatives, where possible. In addition, a weekly meeting was held, where bed management across the hospital was reviewed and discussed.
- The hospital-based social workers told us that they worked with the discharge planners, but tended to deal with more complex cases. They said it was the out-of-area discharges that caused the greatest delays in discharge.
- An analysis of delayed transfers between April 2013 to November 2014, indicated that more than half of the delayed transfers of care within the trust were due to patient or family choice. Delays in funding or community placements were a contributory factor with only 4.5% awaiting assessment.
- The hospital had a discharge lounge, which staff told us was well used. Staff from the discharge lounge visited the wards, and helped staff there to prepare the patients who were ready for discharge, and brought them back to the discharge lounge, where they were given meals and drinks.
- Discharge planning was included in discussions during the ward rounds. For example, on the Acute Medical Unit, 12 patients were identified as fit for discharge earlier in the week, but only five were achieved. Staff told us that this was 'usual' because planning was 'over optimistic'.
- We spoke with two of the eight discharge co-ordinators, who told us that when families were 'stalling' for whatever reason, and the patient was ready to go home, they received a letter documenting the agreed discharge plan. If there remained problems, then legal letters were sent. Patients who were transferred to continuing care facilities, such as nursing homes, received a pack outlining the discharge time frame. The discharge planners and managers were undertaking a rolling programme of training for ward staff to improve the discharge process.

Medical care (including older people's care)

- On the Acute Medical Unit a patient told us that they had been readmitted following discharge earlier in the week. They told us they had been sent home half an hour after having a procedure, which they felt was too soon. They had been readmitted the following day, with an infection in the wound site.
- On Med 7 staff made post discharge telephone calls to patients to check on their progress.
- We noted that the hospital's referral to treatment (RTT) performance has been getting worse since October 2013; it was below the England average but above the 90% standard. The gastroenterology specialty, in particular, was not meeting the standard.
- We spoke with the junior doctors and senior nurses, who told us that a lot of their time was taken up with taking bloods, as there were few phlebotomists, and the wards were staffed with a lot of inexperienced, newly qualified nurses, who did not have the competencies to take bloods. They told us that they spent so long taking bloods each day that often there was not time to spend time with patients or attend consultant ward rounds. One junior doctor gave an example of that day, when of the four junior doctors on duty, two had spent their time taking bloods. They told us, "this really isn't the best use of my time". We spoke with the phlebotomists, who told us that the phlebotomy service was being withdrawn.
- During our inspection, there were a number of medical patients who had been admitted to non-medical wards because of a lack of appropriate medical beds. We were told that this was usual for the hospital, and systems were in place to ensure such patients received appropriate medical care. Consultants told us that there were, on average, four to five medical outliers; however, this increased to around 10 during the Winter months. They told us that although it was an 'inconvenience' to staff, there were no concerns about patients receiving appropriate care and treatment.
- We spoke to medical patients who were not on the appropriate medical wards. One patient told us, "it was very frustrating as staff didn't know how to use my cannulas and the first one got infected".
- Consultants told us that each non-medical ward had an allocated physician. The medical outliers were seen daily by the ward medical teams, and patients were 'repatriated' to a medical ward as soon as possible.
- Patients were often moved between bays or wards during their stay, according to the needs of the individual patients, and the needs of the ward. We spoke with one patient and their relative, who told us that they had been moved four times within a six week stay. The relative said "every time I came in Mum had been moved to a different ward. No one explained why".
- Staff told us that on occasions, patients were moved between wards late at night. The hospital designated these as 'Red Transfers' and maintained a log for any that occurred after 10pm.

Meeting people's individual needs

- We saw that patients were referred to specialist nursing services when appropriate. For example, we saw that patients were referred to the falls team or tissue visibility nurses, if they sustained a fall or developed a pressure ulcer. There was a learning disability nurse attached to the safeguarding team.
- On the Acute Medical Unit we saw that the specific needs of a bariatric patient were discussed and taken into consideration.
- On the stroke unit, we saw that simple measures, such as making sure male patients were appropriately dressed by providing pyjama tops, had increased their dignity.
- On Dawson Ward, we saw that patients' individual needs were assessed and met where possible. For example, a married couple who were admitted together, were distressed at being separated. Staff had moved two beds together in a side room and they were now settled and happy.
- Staff told us that translation services were available, although none of the staff we spoke with had accessed them. They told us they usually worked with the family, unless there were known tensions. Using a relative is not good practice, unless the patient specifically requests it, as there are issues of confidentiality. It is not always possible to be certain that the interpretation is correct and unbiased.
- Staff on the stroke wards gave examples of accessing support for a patient who used sign language, and also gave examples of how a patient who belonged to the travelling community, was supported during a stay in hospital.
- We saw that on the care of the elderly wards, people living with dementia were supported by dementia champions.

Medical care (including older people's care)

Learning from complaints and concerns

- The complaints process was outlined in information leaflets, which were available on the ward areas. We saw information on raising complaints readily available on all the wards and departments we inspected.
- The senior nursing staff and managers told us that complaints were discussed at clinical governance meetings, and we saw evidence of this in the minutes of meetings. In the minutes of the haematology governance meeting we saw that complaint response times were improving. For example, three of nine complaints were outstanding, which demonstrated an improvement during 2014. The stroke unit gave an example of where action was taken following complaints about meals being cold. It was identified that the soup and the rest of the meals were being delivered to patients at the same time; a delay of half an hour was put in place between the soup being served and the rest of the meal, so that both were served hot.
- The staff we spoke with were aware of the trust's complaint policy and how to facilitate patients if they wished to raise a concern or a formal complaint. For example, the junior doctors we spoke with told us how they would signpost patients to the Patient Advice and Liaison Services office. They told us that they usually received feedback from any complaint they had been involved with. The ward staff told us they rarely received complaints. They told us that feedback was usually positive.
- Patients we spoke with told us they would raise any issues or concerns with the ward staff in the first instance, but they knew there was a formal complaints process available if needed. We spoke with patients who had raised concerns, and they told us they felt listened to and their concerns addressed. We spoke with a patient on the Acute Medical Unit, who told us they had made a verbal complaint about a member of staff, and it was dealt with promptly and appropriately.
- We spoke with the Patient Advice and Liaison Services manager at the PRUH. They told us that the number of contacts with Patient Advice and Liaison Services had increased from 200 to 400 (November 2014) following the implementation of the PIMS (Patient Information Management System). The problem was a connectivity issue, where the system generated multiple numbers and did not recognise when a patient may already be on the system. Staff are aware that patients may have more than one number, and reports were generated highlighting the patients. The medical records department was going through the system and merging patient records, but this was an on-going problem.

Are medical care services well-led?

Good

We rated medical services at the PRUH as good for well-led. The medical directorate was well-led because there were strategic objectives in place, together with a publicised trust vision and values. There were robust clinical governance and reporting arrangements in place. Risks were identified and acknowledged, and action plans put into place to address them. Action plans were constantly reviewed. There was clear leadership, and staff knew their reporting responsibilities and took ownership of their areas of influence.

We found that medical services at the PRUH had improved considerably since our last inspection. The additional resources provided by the Kings College Hospital NHS Foundation Trust had helped the PRUH to prioritise quality of care and patient safety. An example of this was the improved stroke service at the PRUH. In 2013 the service scored a 'D' in the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP). In 18 months the stroke service had risen to one of the top eight per cent in the country. The trust told us that the improvements were due to a number of changes, including filling key nursing positions such as the matron, clinical nurse specialist and full-time psychologist.

All staff spoke with pride about working at the PRUH, and the majority were full of enthusiasm and hope for the future. Managers were passionate about their ward or department, and were proud of the teams they had working with them. The trust actively engaged with the public and staff through meetings, surveys and communications. There were systems in place to ensure the patients voice was heard and listened to. Local initiatives to improve the patient experience, care and treatment were encouraged.

Medical care (including older people's care)

Vision and strategy for this service

- The trust had strategic objectives in place, together with a vision and values to act as a guide for staff in expected behaviours.
- Staff we spoke with told us that board level visibility was variable. For example, on the cardiology ward, staff told us that the chief executive (CEO) visited the ward monthly, but they had not seen the director of nursing. They told us "I wouldn't know her name".
- Staff from other wards told us that they regularly met with the deputy director of nursing. On the Stroke Unit at Orpington Hospital staff told us they did not often see senior members of the trust, but they had received feedback from the head of nursing on any board level issues.

Governance, risk management and quality measurement

- The trust provided detailed information regarding the governance and reporting arrangements in the medical directorate. We saw that there was a robust reporting system, with final accountability at board level.
- The exception to this was with the management of medicines, where the board level accountability, and clinical and nursing engagement were unclear. Where audits were undertaken and actions identified, there was little evidence that action had taken place, such as in medicine security and the timely approval of patient group directions.
- We saw from the minutes of various governance and risk management meetings that a range of patient safety and quality issues were reviewed monthly, including clinical effectiveness, reports from other sub committees such as mortality and morbidity meetings, health and safety, audits, quality and performance data, and infection control. Patient experience, training, HR, compliance with NICE, trends from complaints, patient surveys, cardiovascular risk and governance committee details were also reviewed monthly. Action logs detailed what should be done, by whom, in order to improve the service.
- For example, the cardiovascular risk and governance committee met monthly, and the terms of reference included overseeing all aspects of the management of governance and risk within the relevant specialty.
- We saw from the haematology risk and governance committee minutes that the safety of the thrombolysis service was regularly audited, and demonstrated that the service was comparable to other stroke units in Europe and the UK. This provided assurance that patients were being appropriately thrombolysed without contraindications.
- Incidents were monitored, trends analysed and actions identified to improve patient care and safety. For example, a rate of falls was identified in the stroke unit, where two significant incidents had occurred. A further audit was identified to look for trends outside of the single root-cause analysis. Following this, improvements to the falls prevention plan, with increased training of nurses and healthcare assistants, was identified.
- We saw from the 2014/15 quarterly neurosciences reports into clinical effectiveness that the PRUH participated in all three of the audit programmes that they were eligible for. Areas were highlighted for action, including the NICE technology appraisals that were required.
- Information regarding outliers and bed move staffing were discussed and included on the medical risk registers.
- Cross-site risk registers were maintained according to speciality. We reviewed the Cardiac Risk Register, where seven of the 22 entries related to the PRUH. We saw that staff detailed issues where risks to patients were identified for action, such as the lack of consultant cover, which was managed through the use of locums or agency staff. The transfer of patients to PRUH out of hours was identified as a risk, and a 'cut off' time for transfers from the Denmark Hill site to the PRUH was discussed, with an escalation pathway for deteriorating patients. Staff were reminded to raise late transfers as incidents, to enable more thorough investigation of the issues.
- Staff on Med 7 showed us the 'Commit to Care' initiative board, which closely monitored the quality of care. They told us how proud they were of their team improving the wards score to a 'silver' rating, which demonstrated a substantial improvement in the quality of care offered.
- Nursing and medical staff told us how proud they were of the care they delivered. In particular staff on the stroke wards told us about the zero tolerance for falls and how root cause analysis investigations were undertaken to learn why a fall had occurred and to put measures in place to prevent it happening again. Actions taken included increasing staff presence in the bay areas of the wards and reducing clutter on the wards.

Medical care (including older people's care)

Leadership of service

- The trust established clinical and managerial leadership teams across the hospital. These included medical and nursing leadership, and clinical leads across the medical division, with the aim of encouraging local ownership whilst maintaining board level oversight. Staff have been encouraged to work across the trust sites, with the aim of spreading good practice and learning across the organisation.
- Managers told us that they had been through four or five years of poor management, with lack of resources and support. They said there had been such an improvement since they became part of the King's College Hospital NHS Foundation Trust, and although there were budget constraints, it was not as bad, as now they felt supported and listened to by the senior management team. One manager said simply "we're not alone any more". They told us of the support structures, such as the Ward Sister's Forum, regular planned meetings with the directors' of nursing team, and directorate meetings.
- All of the ward managers and matrons we spoke with from the medical division and endoscopy services were enthusiastic and passionate about the care and treatment their unit provided.
- Throughout the hospital, managers told us that they were most proud of their staff and the team they worked with. We heard how staff were proud to be working at the PRUH, and because of the challenges of the past few years, strong teams had been forged. One manager told us "my team is amazing – I've never seen anything like this before in any hospital I've worked in". Another told us how two members of staff had achieved 'Nurse of the year' and 'Healthcare Assistant of the year' awards; they told us they were so proud of all the team but "it's nice to get recognition".
- The medical staff in the hyper-acute stroke unit told us how supportive the head of nursing had been in improving the service at the PRUH without compromising the service at Denmark Hill. For example, there was now a dedicated pharmacist and specialist nurse. They told us that this had led to significant improvements to patient care, which was reflected in the SSNAP audit results.
- Staff on the wards told us that their managers were very 'hands on'. They said that if they were short-staffed or they saw a need, they would join them on the ward to support them.

Culture within the service

- The trust was still very early in the process of bringing together the various hospitals under the King's College Hospital NHS Foundation Trust umbrella, and there remained cultural elements to be addressed. Staff at the PRUH told us they often felt overlooked and disregarded by the more 'famous' and well known 'King's' Hospital at Denmark Hill. They gave examples where the brand 'King's way' was used to make them feel inferior, when the work they were doing was either different, or of a comparable or better standard.
- Some staff told us "it feels like a 'take over' not an 'acquisition'". They told us that there was good work happening at the PRUH, but it was not acknowledged because it was not Denmark Hill. The Patient Advice and Liaison Service team told us that staff had come to them, telling them that they felt undervalued.
- We noted that although some services, such as the stroke units, had embraced the changes and were working together to improve services overall, other areas, such as therapies, were still operating as separate entities.
- However, we noted that the PRUH documented low sickness absence rates. This indicated better health and well-being for the staff who worked at the PRUH than that of the average NHS workforce in England.
- All the staff we spoke with told us they felt engaged in the trust's plans for the future of the hospital.
- Medical staff of all grades were positive about the clinical leadership in the trust.
- Doctors gave us examples of the changes in culture over the last 18 months. They told us that previously there was a reluctance to report incidents, but now that everyone has access to the reporting system, incident reporting had improved, together with all the governance structures around it. This made for a more open and accountable culture. They told us that although it was very much a 'work in progress', they were very optimistic for the future.
- The junior doctors told us that following the hospital being acquired by the King's College Hospital NHS Foundation Trust, there had been a change in the culture, which although it had been embraced by most of the staff, had led to difficulties where some staff remained unconvinced.

- Duty of Candour training was delivered by the trust and monitored during departmental risk and governance meetings; implementation of the Duty of Candour was evidenced as being discussed in the haematology clinical governance committee minutes.

Public and staff engagement

- The trust had various means of engaging with patients and their families. These included various surveys, such as the Friends and Family Test, inpatient surveys and the 'How Are We Doing?' initiative.
- Feedback and comments from patients were also shared with patients and the public on posters around the hospitals, and in monthly updates available on the trust's website.
- There was a patient feedback forum for stroke patients, where former patients shared experiences of their care with the stroke team.
- The new 'How Are We Doing?'/Patient Experience survey questionnaires were now in use at all trust locations.
- On Med 7 staff told us about the 'Gold Fish bowl exercise', where patients were invited back to the hospital to discuss any problems they had had during their stay. The nurses turned away from the patients, enabling them to say how they felt without intimidation. There was then an honest and open discussion about how the patient experience could be improved.
- The results of the surveys, feedback from complaints and the Patient Advice and Liaison Service, as well as patient comments, were reported back to staff, the trust board and commissioners, in order to inform priorities for improvements.
- We saw that the trust held regular seminars for Foundation Trust members on various aspects of clinical care, such as speech and language therapy, continence management, and food and nutrition. This was an opportunity for trust members to ask questions of staff, and understand more about the work that they do.
- We were told how the clinical nurse specialists liaised with community support groups and the community nursing services to help patients once they returned home. For example, we heard how the cardiac nurses supported exercise programmes in the hospital and in the local community.
- The consultants told us of the good links that the respiratory nurses had with the community teams.
- The trust held discussions with staff and patients at various events, such as the 'King's in Conversation' listening events.
- Staff surveys were undertaken to examine the cultural differences across the trust, and a three year plan started to address the differences identified.

Innovation, improvement and sustainability

- The hospital was proactively looking for ways to improve the service it offered to the people of South London and North Kent. For example, we noted that the trust was working with partner agencies and other health and social care organisations, to improve healthcare for hard-to-reach groups, such as the homeless and alcoholic communities.
- Care of the elderly was being promoted through integrated working with local health and social care providers.
- Within the hospital, there was assessment and liaison between medicine, surgery, orthopaedics and therapies, to provide proactive care of older people undergoing surgery.
- We were told about many initiatives to improve practice, including information that stroke patients at the PRUH could participate in clinical research, in order to further improve care, and the respiratory team was working on a project to improve the mental health care of people with physical health problems.
- Recent data from the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), has given the PRUH stroke service a Level A ranking. This is the highest possible rank and only 8% of stroke units in the country currently achieve it. The stroke service at the PRUH is composed of the hyper-acute stroke unit (HASU), providing rapid initial stroke care, and a medical ward specialising in stroke aftercare and rehabilitation. This is particularly noteworthy, as the hospital was previously rated as Level D, and has risen to Level A in just 18 months, making the stroke service at the PRUH one of the most improved stroke services in the country.

Surgery

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

Information about the service

The surgical division incorporates a range of services, including trauma and orthopaedics, urology, general surgery and gastrointestinal. There are 110 beds for surgical patients.

On the second floor in the north wing, there are six main operating theatres, including one theatre dedicated to treating emergency patients.

Day surgery patients are treated in a separate stand-alone building on the hospital site, where they are assessed, operated on and discharged on the same day. The day surgical unit has six operating theatres and 30 beds.

The majority of surgical activities at the PRUH were day case procedures, which contributed 61% of activity between July 2013 and June 2014. Elective surgery made up 13% of the work and emergencies contributed 26% to activity. The main speciality was general surgery, which made up 36% of surgical procedures in this period.

During our inspection we visited the Day Surgical Unit, main operating theatres and surgical wards, 4, 6, 7 and 8. We made observations of staff interactions with patients and one another, and spoke with seven patients receiving care, and one relative. We reviewed 16 patient records and other electronic and documentary information provided to us. We spoke with 28 staff across the departments we visited.

Summary of findings

Many aspects of the hospital's surgical services had improved since our last inspection, in December 2013, but more work was still required.

During the inspection, we followed up on the areas which resulted in compliance action as a result of the last inspection. We found some of the required actions had been met, and improvements were seen with respect to others.

Technical medical equipment was not always checked to ensure it was fit for use and medicines were not always managed safely.

Staff did not always receive the required mandatory safety training and some did not routinely have an annual performance review.

Referral to treatment times (RTT) had not been met in a number of surgical specialties. Surgical procedures were sometimes cancelled and were not always re-scheduled and undertaken within 28 days. Patient records were not always completed to the required standard and the lack of availability of patient notes contributed to cancellation of operations.

Whilst clinical staffing levels presented a challenge in some areas, the risks had been mitigated by the use of bank and agency staff.

Patients received consultant-led treatment and the multi-disciplinary team (MDT) contributed to the delivery of this. Patient's individual needs were

Surgery

assessed, and they were cared for safely and in accordance with professional practice guidance. Staff were observed to be, and were reported by patients, as kind, caring and compassionate.

Effective systems and processes were in place for reporting different types of incidents, for reviewing these, and learning from the outcome. The governance arrangements ensured that senior clinical and medical staff were fully involved in reviewing incidents, risk registers and surgical related performance outcomes. Information was shared with staff and communicated to the trust board.

There was proactive leadership within the surgical division and at departmental levels. Leaders fostered an open and honest culture, which was aimed at delivering good outcomes for patients.

Are surgery services safe?

Requires improvement

Technical medical equipment was not always checked to ensure items were fit for use, and medicines were not always managed safely. There were gaps in patient records with respect to safety checks and dementia screening.

Staff had not received all the mandatory safety training required to support the delivery of safe care and treatment to patients.

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

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

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

There were effective arrangements in place to minimise risks of infection to patients and staff.

Arrangements were in place to ensure staffing numbers and skill mix were appropriate to support the delivery of patient care safely.

Incidents

- There were arrangements in place for reporting incidents, accidents, errors or near misses. Physiotherapy and clinical staff were able to describe the reporting process, and said they received feedback from their line managers via emails and at ward/ departmental meetings. The detail was said by one nurse to include the event, the actions required and what 'we can do to prevent' the situation from happening again.

- Staff told us that learning meetings took place once a month, but urgent communication of information happened sooner if needed. An example of learning from reported incidents related to improved pre-operative checks for patients having eye surgery.
- A 'Safe Anaesthetic' monthly web page was produced, and this was seen to be a good source of information to staff. We saw the 'Safety In Anaesthesia and Learning from Incidents' (SALI) newsletter produced in April 2015. This provided information and feedback arising from incidents.
- Medical staff spoken with in a focus group reported having used the incident reporting system, but they had not received any feedback. They also said they were not aware of any changes as a result of incidents having been reviewed.
- Clinical care forums, attended by the head of nursing, ward managers, the risk manager and matrons, took place monthly. Incidents, along with root cause analysis and actions, were discussed at these meetings.
- We saw from information provided that serious incidents (SI) had been investigated within the governance and risk management processes. Information was detailed and demonstrated a thorough process from start to end. Themes and learning from such reviews included, for example, the care of patients having eye surgery and the marking of operation side
- The PRUH reported one 'never event', which occurred in general surgery during October 2014. This was under investigation and was to be presented at the Serious Incident Committee in May 2015. Some medical staff were not aware of any 'never events' having occurred, whilst others were aware of an incident at the Denmark Hill site and an incident at the Princess Royal University Hospital (PRUH). With respect to the latter, medical staff said the protocol had been redesigned and the World Health Organization (WHO) five steps to safer surgery checklist and surgical count process had changed to address the matter.
- Although the hospital was using the WHO checklist we were not provided, when asked, with information related to compliance with the checklist including audits.
- Theatre staff had reviewed 12 adverse incidents (AI's) in January 2015, and 19 AI's which occurred in March 2015. These types of incidents were considered to be less serious and included for example, near misses. We saw from information provided that of the March incidents, three had been rated as amber, ten as yellow and six as green. Trends were identified with respect to allergies, equipment and bed availability. Actions had been identified for each AI, with a view to avoiding recurrence.
- Mortality data was reviewed by the Mortality Monitoring Committee. We saw information had been reported and reviewed by speciality. In addition to this, we saw that mortality was included in discussion at the Combined Anaesthetic, Surgical and ICU clinical governance meeting. This included key actions to be taken, such as having a standardised integrated care pathway, and patients having an anaesthetist review on the day of admission. These actions were seen to have been put in place.
- A mortality outlier alert investigation into fractured neck of femur at the PRUH was noted to be in progress, and had been discussed at the Patient Outcomes Committee in March 2015. Possible quality of care issues had been identified in 14 out of 50 cases; there were minimal coding issues and the case mix was similar to peer services. Recommendations had been made and actions were said to be in progress to improve care.
- Duty of Candour was understood by some of the nursing staff we asked, but not by other staff, including a physiotherapist. On one ward we observed a good example of the process of obtaining statements and heard about the process staff followed to ensure that the patient and relevant family were informed.

Safety thermometer

- The NHS Safety Thermometer was used to collect local data on specific measures related to patient harm and 'harm free' care at a particular point in time. The trust also collected data on all incidents of harm free care and reported on this monthly via the divisional score cards and other reports.
- Data was collected with respect to hospital-acquired pressure ulcers. We saw, for example, that on the trauma and orthopaedic ward (7) there had been three such ulcers acquired in the three months prior to our visit. Nursing staff had guidance from tissue viability nurses, and aids were available to reduce the possibility of acquiring such ulcers.
- The February 2015 metric report viewed for main theatres indicated there had not been any slips, trips or falls. Similarly, there had not been any falls reported

within the surgical division in December 2014, or in January and February 2015. The surgical division at the PRUH reported three hospital-acquired pressure ulcers in both January and February 2015.

- We noted there was no recorded data on the performance metrics provided for January and February 2015 to indicate that venous thromboembolism (VTE) assessments were being monitored, although there was a target set at 95% compliance. We did see in ward nursing records reviewed that the required assessment had been carried out in the majority of cases.

Cleanliness, infection control and hygiene

- At the time of our inspection there was an outbreak of norovirus (Winter vomiting virus) and some wards were not accessible because of this. We saw there was signage in place and instructions for staff and other people to follow when visiting open wards. Theatre staff were made aware of the norovirus update at the morning 'huddle' meetings, which we observed taking place at 10.30am.
- There were infection prevention and control (IPC) link nurses on wards, one of whom spoke to us about their role. Their role was said to include attending IPC meetings and ensuring staff followed policies and procedures. In addition they undertook IPC checks such as hand hygiene monitoring and checks on the cleanliness of the environment. We saw that action plans were developed in response to monitoring IPC outcomes in theatre. We also saw hand hygiene results on display. For example, on the ambulatory emergency care ward for March 2015, results indicated 84% compliance. Surgical performance metrics for January and February 2015 did not include any details on hand hygiene audits, despite there being a target of 95% compliance set.
- We observed that there were dedicated staff for cleaning ward areas and they were supplied with and used nationally recognised colour- coded cleaning equipment. This enabled them to follow best practice with respect to minimising cross-contamination.
- The surgical wards we visited were clean and patients were satisfied with the cleanliness. Operating theatres were found to be clean on inspection. There were separate clean preparation areas and facilities for removing used instruments from the operating room ready for collection for re-processing by the internal decontamination service.
- Theatres were cleaned at night, and theatre staff cleaned theatres between cases during the day. Technical theatre equipment was cleaned by staff and we saw items were clean and recorded as ready for use. Equipment used by patients on wards, including commodes and raised toilet seats were inspected and found to be clean. Labels had been attached to items indicating when they had been cleaned and by whom.
- We saw there was access to personal protective equipment (PPE), including gloves and aprons, in all areas visited, and staff used these during the course of their activities.
- Compliance action had been previously taken in relation to staff not always following infection control procedures, and there being a lack of alcohol dispensers in patient areas. We found that action had been taken to rectify these matters.
- There was access to IPC policies and procedures via the trust intranet, and we sampled these, and found they were up to date.
- Staff were observed to comply with local infection control policies, such as 'bare below the elbows', to enable thorough hand washing and disposal of different types of waste. The exception to staff compliance was when we observed a nurse practitioner enter an unaffected ward directly from a ward which had norovirus. They did not wash their hands or use hand gel until they left the ward.
- Staff had good access to hand-washing and drying facilities, and were particular in taking time to wash and dry their hands in order to minimise risks of spreading norovirus.
- We observed staff complying with a local policy with respect to the handling and management of clinical and domestic waste. We observed bed linen was handled in accordance with best practices, and sharps were disposed of safely.
- Surgical staff working in theatres were seen to follow the National Institute for Health and Care Excellence (NICE) guidelines CG74, Surgical site infection: prevention and treatment of surgical site infections (2008). We observed theatre operating staff washing their hands prior to preparing instrumentation, using an aqueous antiseptic surgical solution, and donning a sterile gown.

Surgery

- Staff had a sepsis pathway to follow where patient's needs indicated that this was needed.
- Patients were seen to have been screened pre-operatively for Meticillin Resistant Staphylococcus Aureus (MRSA) in line with local policy. In the December 2014 performance metric for surgery, we saw that no data had been collated with respect to compliance with this, despite there being a target of 100% set.
- Data reviewed on the December 2014 performance metric indicated that in surgery there had been no MRSA bacteraemias, two Vancomycin-resistant enterococci (VRE) and one Clostridium difficile Toxin (CDT) case in the month, which was the same as the previous month. No target was specified.
- Performance metrics for January and February 2015 were reviewed, and these indicated for both months that there had been one VRE and five CDT cases.
- Wards displayed information, which indicated the number of infections. For example, on the ambulatory emergency care ward (ward 4) there had not been any MRSA or CDT. On the trauma and orthopaedic ward (ward 7) they had had one CDT case in the previous three months.
- Infection prevention and control (IPC) training was part of mandatory training for nursing staff. Infection control training attendance rates for theatres were provided to us during the visit. We saw 77% of the main theatre staff and 76% of day surgical unit staff had completed this training.
- Theatre staff also undertook aseptic non-touch technique (ANTT) training with respect to wound management. Although we did not identify a specified target for this training, we saw that 72% of main theatre staff and 82% of day surgical unit staff had completed the training.
- A brief summary of IPC was seen to be included in the annual report and accounts for 2013/14.

Environment and equipment

- The admissions unit was found to be unsuitable for its intended purpose. The area was cramped and afforded little privacy. We observed patients having blood taken, anaesthetic assessments and surgical consent all within public view and hearing. There were two changing rooms for patient use, and two patients could often by present in the waiting area. Confidential information could be heard when staff went through the theatre checklist with patients.
- Ward areas were generally accessible to patients and were gender separate. There were shower/bathing and toilet facilities, and these afforded privacy when in use. Curtains were in used around beds in bay areas to ensure privacy. Side rooms were available in limited numbers, for patients who needed isolation, or if their care needs indicated specific requirements for their own room.
- There were six main operating theatres, including an emergency theatre under the auspices of the national 'Confidential Enquiry into Perioperative Deaths' (CEPOD)arrangements. Associated anaesthetic rooms were also available. (One theatre was closed at the time of our visit due to staff shortages). The trauma and orthopaedic theatre had laminar flow ventilation in place. The recovery area had 11 bays, two of which were used for paediatrics. Four bays in recovery were used as day case beds, from which patients were directly discharged home.
- The separate Day Surgery Unit (DSU) had 30 beds, six operating theatres, five anaesthetic rooms, two pre-assessment rooms and an area used for walk-in and out eye procedures. There was also a six bay recovery area and a discharge lounge. Patients were treated and cared for on trolleys suitable for operating upon. The exception to this was for ear, nose and throat (ENT) procedures and patients having pain management procedures, who were moved onto general operating tables.
- Staff in DSU anaesthetics were not adhering to the Association of Anaesthetists of Great Britain and Ireland (AAGBI) safety guidelines Safe Management of Anaesthetic Related Equipment (2009). Anaesthetic equipment was not always being checked on a regular basis. There was an absence of signatures to indicate checks on two anaesthetic machines in the DSU, despite there being a logbook at each anaesthetic machine.
- Emergency equipment, including resuscitation trolleys on wards and in theatres, had been checked, and were ready for use. The security tabs on resuscitation trolleys were not always present, which could pose a risk of accessibility to drugs. Oxygen and suction equipment was accessible and in date. Emergency intubation equipment checks had been carried out regularly. In the recovery area we saw that there were no dates on suction filters, so it was not clear when they had been changed.

- Surgical instruments were processed in-house, with a turnaround time of eight to 12 hours and a fast track rate of four hours for emergencies. Shortages of staff in the sterile services department was said to impact on achievement of the turnaround times, on occasion.
- A designated member of staff was responsible for checking that equipment was within the safe period of use. Despite having this role, we found three out-of-date sterile instrument kits, and one orthopaedic drill set, which were found to have exceeded the expiry date in theatres, including one that had expired on 3 March 2015. The member of staff could not explain the reason for this to us, but removed the items to prevent possible use.
- Staff in theatres said that if they needed to borrow operating kit from Denmark Hill, this was identified two days in advance. Issues with lack of kit for gynaecology procedures had almost been resolved, by standardising and buying new items.
- The hospital had an equipment library, which was the central place for staff to obtain items to support patient treatment and care. Items were routinely collected from the ward by staff from the library after use, and they were responsible for servicing and maintaining such items.

Medicines

- We made observational checks with respect to the ordering, storage, administration and disposal of medicines on surgical wards and in theatres. Staff on wards told us there was regular contact with pharmacy, with twice weekly stock checks and top-up supplies. Pharmacy staff, including technicians, were said to attend the multi-disciplinary team (MDT) meetings on the acute surgical ward, which took place daily.
- Medicines audits were carried out on wards, and we saw results for the audit carried out in March 2015 on the urology ward (6), which indicated satisfactory results.
- Medicines were stored safely and appropriately on wards, including items which needed to be stored in refrigerated conditions. Temperature checks had been carried out on fridges on wards and in theatres. Temperature checks on warming cabinets used in theatres were not being routinely taken. We noted an absence of dates on some of the fluids in the warming cabinet.
- Medicine trolleys were locked securely and could not be accessed by anyone other than staff. Controlled drugs (CD's) were stored in locked cupboards, which were secured to the wall within a locked room. We checked CD registers on wards and did not identify any poor record-keeping regarding checks and administration.
- Rooms storing anaesthetic medicines were unlocked when theatre lists were running, and were, therefore unsupervised when staff were not present. No access control measures were in place for these rooms, which increased the risk of unauthorised access to medicines. We observed prepared drugs set out on the sideboard in an anaesthetic room within the DSU, which was not occupied at the time. We also saw intravenous fluids hung on the back of a door with the giving set (infusion device) already attached.
- We saw a pharmacy audit for February 2015 with respect to CD's and noted that whilst wards two and three complied with all applicable standards, there were areas of non-compliance identified elsewhere. Theatres had also been included in the audit, and the results also identified concerns in relation to a number of areas. The audit concluded with recommendations, and a memorandum was circulated to areas, with information aimed at improving practice.
- Prescribing, including regular medicines, as required, and take home items, was undertaken by medical staff. Reasons for the prescribing of antibiotics were not always recorded in notes where relevant.
- We saw medicines were given to patients by nursing staff in accordance with the prescription, and that safety checks were carried out during the administration process.
- Staff had access to up-to-date guidance on medicines, and received advice from pharmacy, as well as newsletter information.
- Medication errors were reported as part of the incident management system. For example, we were told that the acute surgical ward had reported and followed-up one error, where the nurse had not checked the patient allergy status before giving take home medicines. On the urology ward, there had been some issues with staff mixing up a form of a controlled medicine, which was available in either modified or immediate release formulas. This had resulted in a discussion with the matron, and additional training was to be put in place. We saw that information to alert staff had been placed in the drug cupboard.
- We were informed by an overseas nurse that they were required to complete medicines competencies before

they could administer medicines. They advised they would be doing this once they had received confirmation that they were registered with the Nursing and Midwifery Council (NMC). All newly employed or newly qualified nurses were expected to complete a competency assessment in relation to medicines.

- The Theatre Users Medicines Management Group meeting, held on 2 February 2015, indicated that medicine stock had been discussed, along with risk reports, trends and action plans. It was noted that adverse incidents related to medicines had been discussed at the clinical governance and risk meeting held on 4 February 2015.

Records

- The surgical areas used paper documentation for recording patient information. In general, nursing and medical records were completed to a good standard, although there were some gaps, such as the name of the admitting consultant, and the preferred name of the patient, which were not included on four records. Of the five sets of patient records we reviewed on the acute surgical ward (ward 4), we found there was multi-disciplinary input where required, which included entries made by allied health professionals, including physiotherapists and occupational therapists, and dieticians.
- Risk assessments, such as assessment of moving and handling, skin integrity, nutrition, use of bed rails, and venous thromboembolism (VTE), had been completed in patient records reviewed on wards, and where interventions were required, this was in evidence. For example, the prophylaxis treatment for prevention of VTE. However, we noted in records reviewed in the admissions lounge that the VTE records had not been completed fully. In one case, there was missing information, although the patient had the correct prophylaxis prescribed. In two other records, the VTE had not been completed, and staff were having to chase this up with the consultant.
- Progress notes had been recorded for each patient, and care plans were individualised or based on a surgical pathway, such as the hip fracture pathway. However, where care plans were not following a specific pathway, they did not always have identified goals set for the patient to achieve.
- We noted 'Intentional rounding' took place at regular intervals, during which nursing staff checked the well-being and status of the patient, and updated risk assessments if needed.
- Record keeping was part of mandatory training, and was completed on a once-only basis. Of the 835 surgical staff requiring this, 418 had completed it in 2014/15, representing 50% of staff.
- We observed theatre staff following the five steps to safer surgery procedure, which included team brief, sign in, time out, sign out and debrief. Evidence of staff completing documentation, to reflect the World Health Organization (WHO) safety procedures, were seen in most of the notes reviewed. However, in one patient record there was no WHO documentation, despite the patient having had orthopaedic surgery.
- We noted that operation site safety check-lists were not completed for all surgical patients. Two site safety checklists on patients from ward 4 had not been completed fully. This presents a risk for individuals who are having an operation on a specific limb. A patient record in the admissions unit had the check-list ticked as having been completed, but the checks had not been carried out as per the list. The check-lists are part of the pre and post-operative patient journey from ward to theatre and back. The completion of the check-list related to marking of the patients body in relation to the limb or area to be operated on.
- Patient records contained evidence of attendance at the pre-operative assessment, where relevant. Information included, for example, patient demographics, previous medical and surgical history, allergies and medicines, along with baseline observations. Anaesthetic risk scores were used to ensure that only those patients suitable were booked for day surgery.
- We reviewed an audit of the completion of patient records, which included a lower than expected compliance rate of 64% for consent documentation at the PRUH. The results were reported on 23 March 2015, and indicated that there were aspects of record completion which had not been recorded to a consistent standard. Conclusions and recommendations were identified within the report, which were to be shared with the Patient Safety Committee and the Medical Director's office.
- At the previous inspection, which took place in December 2013, concerns were identified with respect

to the management of medical records and their availability to support in-patient care episodes. During the current inspection, we were told by staff that the provision of patient notes had improved; however, there were still occasions when notes did not always arrive in time in the DSU, resulting in the cancellation of patients procedures. Staff in the admissions unit said that they generally received the proper patient notes for admission on the day before the procedure.

Safeguarding

- Clinical staff told us they had access to link nurses for safeguarding. During our discussions, clinical staff and allied healthcare professionals demonstrated a good level of understanding and knowledge around this subject. Staff were clear about the escalation process, and accessibility of the safeguarding team. They were able to describe the referral process, and were satisfied they had support and advice from the safeguarding team, as well as access to a safeguarding protocol.
- Medical staff confirmed their understanding of safeguarding, and the principles of safeguarding vulnerable adults.
- Staff were required to complete refresher training on adult safeguarding every three years. Level 2 training had been completed by 94% of in-patient theatre staff, and by 97% of day surgical unit staff. Children's Level 1 safeguarding training had been completed by 100% and 87.5% of these staff respectively. Level 2 children's safeguarding had been completed by 98% of staff in the DSU. Ward staff training for adult safeguarding ranged from 42% on ward 6, up to 88% on ward 4. With respect to children's safeguarding there were four members of the nursing staff who were yet to complete the training.
- Medical staff training in relation to children's safeguarding ranged from 31% in general surgery, up to 75% in urology. Adult safeguarding training ranged between 23% for general surgical doctors, and 50% for trauma and orthopaedic, and ENT doctors.

Mandatory training

- We were told staff in the admissions unit were up to date with their mandatory training. The acute surgical ward provided figures which indicated that they were up to date with 98% of mandatory training. Staff who spoke with us said they had attended mandatory training, or they were able to identify which sessions they needed to complete.
- Mandatory training days were advertised via the trust intranet. We saw from information provided that subjects included; moving and handling, resuscitation, slips, trips and falls, and venous thromboembolism (VTE).
- Training figures for theatre department staff indicated that 75% of main theatre staff and 91% of day surgical unit staff had completed resuscitation training. There were lower levels of staff having completed training for VTE, with 74% and 53% of these staff groups having completed this. Information governance had only been completed by 63% and 46% respectively.
- We saw information that outlined mandatory training for consultant orthopaedic surgeons, which included, VTE, basic life support and blood transfusion.

Assessing and responding to patient risk

- Nursing staff described the use of an early warning scoring system to monitor patients' condition following their surgery. The scoring system enabled staff to identify concerns before they became serious, and to get support from medical staff. We saw the early warning system in use in the patient notes we reviewed.
- We observed that staff in the admissions unit had been proactive in identifying a risk related to a patient who had skin ulcerations and varicose veins. They had contacted the tissue viability nurse, who had arranged for a practice nurse to see the patient at home. We saw too that the medical staff had assessed the patient with a view to consideration of postponing their surgery.
- On the trauma and orthopaedic ward we saw evidence of physiotherapy assessments with respect to patient mobility, displayed in each patient bed area. This ensured that staff were aware of mobility risks.

Nursing staffing

- As a result of the findings in the previous inspection, carried out in December 2013, compliance action was served with respect to the inadequacy of staffing levels and skill mix. We found, during the current inspection, that improvements had been made and that mitigation of risks related to staffing vacancies had been managed to ensure patient safety.
- Staffing figures were displayed on each ward. These indicated the optimum levels and the actual levels for each part of the day and night shifts. For example, on the trauma and orthopaedic ward (ward 7), it was

indicated on 15 April 2015 that they should have five trained nurses and four healthcare assistants (HCA) on the morning shift, and four of each during the late and night shifts. Actual levels were said to be five trained and five HCA on the early shift, with the required numbers on the late and night shifts. The ward manager reported that the staffing establishment had doubled to 42 whole time equivalent (WTE), and there were eight overseas nurses due to join them. The increase in staff had been welcomed as a result of the acquisition by King's College Hospital NHS Foundation Trust. However, staff recognised the challenge of supporting staff in such a large number.

- A member of staff on ward 7 said that staffing levels could sometimes be a problem, with 28 beds, often occupied by elderly patients, some of whom were living with dementia and fractured neck of femurs. As such, their needs were often greater, and additional time was required to provide the level of care and support.
- On the 20 bed urology ward (ward 6), daytime staff ratios were said to be based on one trained nurse to five patients with support from two healthcare assistants (HCA). For patients who were at risk of falling additional staff were used to 'special' them, which they felt was appropriate.
- All surgical wards at the PRUH were noted to be dependent on the use of agency nursing staff for each month during 2014. Figures supplied to us indicated that there was significant use on a number of wards. Significant use of agency staff was also seen on wards 5 and 7. Agency staff usage on surgical wards varied: from 60% on ward 5 and 52% on ward 7. Bank staff usage on surgical wards varied from 40% to 56%, as a percentage of temporary staff.
- Vacancy rates provided to us for the surgical directorate at the PRUH location indicated these to have been 23% throughout 2014.
- Turnover rates were provided, and these indicated an 8% turnover of nursing staff in surgery between April and December 2014.
- In main theatres, we were told there were 101 WTE established staff and 38.88 WTE vacancies at band 5. There were 10 overseas staff, who were supernumerary at the time of our visit, whilst they completed their adaptation courses and obtained a professional registration number. This would reduce the overall vacancy rate and a further eight overseas staff were due to join the team in September this year.
- Agency staff were used routinely in main theatres, with five or six agency staff working per day, and an additional seven or eight bank staff to supplement substantive staff. Duty rotas reviewed confirmed the arrangement for staff, by area, skill mix and time period.
- There was an induction and orientation programme for agency staff to complete, and such staff were said to be used for a trial period before more regular long-term bookings were made.
- Sickness rates in main theatre were said to have improved, down from 9% in September 2014 to 3% in January 2015.
- Staffing levels in the Day Surgery Unit (DSU) indicated there were sufficient staff for five theatres, but not to facilitate the functioning of the sixth. There were 67.47 WTE staff. The bank staff were made up of substantive staff who did extra work on their days off. Agency staff were used when needed, and they were said to be regular and therefore familiar with the ways of working. We spoke to an agency nurse, who confirmed they had worked at the location for in excess of a year and that they had had an induction.
- Staff were said to be multi-skilled in the DSU, with the ability to be in theatre or look after patients in the ward area.
- Handovers took place between ward staff at shift change. Whiteboards above the patient beds were updated with the name of the nurse responsible for the patients care during the shift.
- Huddle meetings in theatres and DSU were used to identify problems with staffing levels or skill mix, with respect to the day's activity, and for the following day.

Surgical staffing

- Duty rotas viewed demonstrated the arrangements for medical staffing in the surgical division.
- Medical staff confirmed that there was a consultant surgeon presence seven days a week, and on-call for each 24 hour period; and during the on-call period, they were free from undertaking elective work. The registrar

was usually on-call at the same time as the consultant for the specialty. There was a consultant anaesthetist available 24/7, and medical staff reported that there were no issues in getting a consultant opinion for any of the specialities.

- There were 10 Specialist Registrars (SpR), three of whom were training grades. A middle grade doctor was on duty between 8am and 2pm, and they saw urgent care referrals. A SpR was on duty between the hours of 12:30pm and 9pm, and one at night. In addition, there were two senior doctors on duty at night for all of surgery, and one senior doctor, plus one junior doctor for general surgery.
- SpR's undertook ward rounds in the morning and there was a regular Friday morning ward round by consultants, although some saw their patients daily. At weekends, the consultant saw, as a minimum, the post-take admissions, and some were said to see all their inpatients, as well as emergencies.
- Information on the use of locum medical staffing was provided for the PRUH, and this indicated that during October 2014, 21% of medical staff were locums. The highest locum usage was in September 2014, at 25%.
- Junior medical doctors reported that they had to undertake routine bloods for testing, because the phlebotomy service was inefficient and unreliable.

Major incident awareness and training

- We did not identify any major incident training within the mandatory programme.
- There was a local policy for the Major Incident and Mass Casualty Incident Response Plan, which included, cascade, patient flow and internal support services.
- There was a protocol in place for managing in-patient theatre emergency bookings through the CEPOD theatre.

Are surgery services effective?

Requires improvement

Patients had been assessed, treated and cared for in line with professional guidance. Patients reported that their pain was assessed and treated.

The nutritional needs of patients had been assessed, and patients were supported to eat and drink where their needs indicated. There was access to dieticians and to the speech and language therapy team. Special medical or cultural diets were catered for.

Patients surgical outcomes had been monitored and reviewed through formal national and local audit.

Staff caring for patients had undertaken training relevant to their roles, and completed competence assessments to ensure safe and effective patient outcomes. Many ward staff had received an annual appraisal, and had opportunities to discuss and identify learning and development needs through this, as well as during supervision meetings. However, documentary information for theatre staff indicated that some had not had an appraisal since 2012 and for others no previous appraisal could be found

Consultants led on patient care, and there were arrangements in place to support the delivery of treatment and care through the multi-disciplinary team (MDT) and specialists. There was access to allied healthcare professionals during out-of-hours.

Evidence-based care and treatment

- Medical staff said they followed local guidelines and policies, based on National Institute for Health and Care Excellence (NICE) and Royal College guidelines. For example, they had guidelines for dealing with upper gastro-intestinal bleeds, a local antibiotic prescribing policy, and for enhanced patient recovery. They also followed national guidelines for the management of colorectal cancer.
- We reviewed data and patient notes during our inspection, which indicated that patient's treatment and care complied with National Institute for Health and Care Excellence (NICE) guideline CG124: Hip fractures – The management of hip fractures in adults. This included for example, patients being operated on the day of, or day after admission, and having a bone health assessment.
- We saw from care records reviewed, and in our discussions with staff that they were following NICE guidance on falls prevention, the management of patients with a fractured neck of femur, pressure area care, and venous thromboembolism. We saw that

anti-coagulant therapy was prescribed for patients at risk of the latter, and anti-embolic stockings were measured and fitted to respective patients, where relevant.

- We observed that patients who had attended pre-admission assessments, had pre-operative investigations and assessment carried out in accordance with NICE clinical guidelines. This included following guidance regarding medicines and anaesthetic risk scores.
- Within anaesthetics, an audit had been carried out as part of the Sprint National Anaesthesia Project (SNAP). This was done to profile compliance with standards for peri-operative care described in the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guideline, the Management of Proximal Femoral Fracture. PRUH reported results from the audit, which were below the national average for five areas. An action plan had been developed as a result, and we viewed a copy of this, with targeted action, and dates for achievement to be met in 2014. Progress notes were included for some of the stated actions.
- There were processes in place for patients receiving post-surgical care to be nursed in accordance with the NICE guidance CG50: Acutely ill patients in hospital: Recognition of and response to acute illness in adults in hospital. This included recognising and responding to the deteriorating condition of a patient, and escalating this to medical staff following the early warning alert system.
- Within the theatre areas, we observed that staff adhered to the (NICE) guidelines CG74 related to surgical site infection prevention and nursing staff followed recommended practice with respect to minimising the risk of surgical site infections. There was a sepsis pathway to follow, where patient's needs indicated that this was required. We noted from the Divisional Effectiveness Report for Critical care, theatres and diagnostics (updated January 2015) that action was required with respect to adherence with NICE clinical guidelines CG65, which concerned peri-operative hypothermia (inadvertent). The report indicated that this was in progress, and would be achieved by October 2014. We reviewed an undated audit with respect to this area, which included the results, recommendations and indications for future audit.
- Clinical and medical staff told us they had access to policies and procedures. They said that when these were updated, staff were sent an email to advise them; this included, the falls guidelines, and on the introduction of interventional rounds at regular intervals.
- We observed staff following local policies and procedures with respect to patient manual handling and interventional rounds. In theatres, we saw how staff followed safe practice with respect to swab and needle counts, as well as surgical instrumentation. We observed the patient journey through into the operating theatre, and saw how staff complied with WHO safety checks at each stage
- Staff said there were local audits almost every week with respect to high impact interventions. This included intravenous catheters, cannulation and urinary catheter surveillance
- Daily consultant rounds took place, during which all surgical patients were reviewed, in order to check that expected treatment and care was being effective. We observed a handover meeting with the consultant, the specialist registrar, and the orthogeriatrician, where each patient was discussed, and treatment needs were reviewed.

Pain relief

- Pre-operative assessment included information about the patient with respect to existing pain management, such as the medicines they took. Pain relief was noted to be prescribed for patients.
- Patients confirmed in their discussions with us that they had been asked about their pain, and had been given pain relief. We observed in care records reviewed that there was a pain score assessment in use, and this was generally completed to a good standard, although staff did not always re-assess the pain score after pain relief had been given.
- Staff confirmed there was good access to the pain team, and referral could be made by the nurses or medical staff.
- The trust had conducted an audit of pain management for patients who had a fractured neck of femur between November 2014 and January 2015. The audit looked at compliance with the analgesic proforma, and included a review of the use of facia blocks as pain relief. (This is a peripheral nerve block into the facia iliac compartment, and is an alternative to intravenous pain relief). The results indicated that 36% of patients received such a block, and the report also presented the reasons why

the treatment was not given to the remaining 65% of patients. Of those who had received the block, pain was noted to have improved by between 10% and 25%. Recommendations from the audit included additional teaching to medical staff with respect to facia blocks, and for the anaesthetist to be informed if the block was not done in the urgent care department.

- We saw that the department of Anaesthesia, Intensive Care and Pain Relief held audit meetings on a monthly basis.

Nutrition and hydration

- The nutritional needs of patients were assessed by nursing staff as part of the initial assessment, as well as when their circumstances changed. Malnutrition risk scores were used to indicate the level of support required. Where patients needed help to eat, they had their meals taken to them on a red tray. Staff then assisted patients with eating and drinking.
- We observed that fluid balance charts were used where patients had to have their intake and output monitored and measured. This included for intravenous fluids, or where restrictions were in place.
- Patients in the admissions unit were noted to wait for sometime before going to theatre. There was nothing to drink in the waiting area, which was warm. Delays in going to theatre may have resulted in patients being starved of fluids for longer than would be recommended.
- The food was described by one patient as being "quite good, not a lot but reasonable choice."
- Patients had access to specialist advice from the dietician and members of the Speech and Language Team (SALT), where they had problems, with for example, swallowing. Where there were risks to patients related to eating and drinking, alert signage was seen to be in place, so that staff and visitors were aware. Special diets, such as gluten free, were noted to be available.

Patient outcomes

- Relative risk of re-admission was reported to be less than the England average for the top three elective and non-elective surgical specialties.
- With regard to the responses from Patient Reported Outcome Measures (PROMs), which were responses from a number of patients who were asked whether they felt things had 'improved', 'worsened' or 'stayed the same' with respect to four surgical procedures: the majority of responses indicated the surgical areas to be generally in line with the England averages. The one exception was with respect to knee replacement, were the service performed worse than the England average.
- There was evidence that the surgical division followed the Royal College of Surgeons standards for unscheduled care, which included having consultant-led care, prioritising the acutely ill patient, and ensuring that pre-operative, peri-operative and post-operative emergencies led to appropriate outcomes.
- Information from the National Hip Fracture Database had been communicated to the trust, in which they were informed that they may have been a mortality outlier. The National Hip Fracture Database (NHFD) Annual Report 2014 (published September 2014) showed that PRUH had a crude mortality rate of 9.8% for the period January 2011 to December 2013, compared to 8.4% nationally and a case-mix adjusted mortality rate of 10.4% for the same period.
- During a routine review of mortality rates, these were reported as showing the Summary Hospital-level Mortality Indicator (SHMI) was higher than expected for fractured neck of femur at the PRUH. (The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust, and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated.) An internal review was said to have taken place, and this found concerns in relation to the quality of care, and in particular, to six patient falls in the hospital that had led to a fractured neck of femur. These patients represented 12% of the overall sample of fractured neck of femur deaths, and were considered by the division to have possibly contributed to higher than predicted mortality for fractured neck of femur patients at PRUH. The cases were subsequently under detailed investigation, in accordance with the Adverse Incidents Poli
- The PRUH site participated in the National Emergency Laparotomy Audit 2014. Results from this indicated numerous policies not being available. This included, for example, a policy for location of post-operative care according to risk, a policy for deferment of elective activity to prioritise emergencies, and a policy for radiology involvement for emergency patients. We

reviewed the action plan developed as a result of this, and saw a number of actions were being taken. However, we did not identify any actions related to policy or procedural guidance.

- Surgical site infection data was provided to us, and this indicated for patient having their surgery at PRUH: 86 infections following hip surgery, and 43 following knee surgery, between January 2014 and March 2015.
- The PRUH surgical directorate also participated in National Bowel Cancer Audit and scored better than the England average in relation to three areas, including, 100% of patients having had a CT scan reported on, and their treatment discussed by the multi-disciplinary team (MDT) compared with the England average of 89.3% and 99.1% respectively. Overall, 98.4% of patients were seen by a clinical nurse specialist, compared with the England average of 88%
- The majority of surgical activities at the PRUH were day case procedures, which contributed 61% of activity between July 2013 and June 2014
- We were informed that the PRUH had started submitting data as part of the Trauma Audit & Research Network (TARN) in January 2015; results of which were not yet available.

Competent staff

- As a result of the previous inspection in December 2013, compliance action was served with respect to the arrangements around staff supervision, appraisals and access to training. We found, during the current inspection, that improvements had been made, but there remained areas for further consideration.
- We were told that staff in the admissions lounge were up to date with their appraisals, as were theatre staff. However, documentary information for theatre staff indicated numerous gaps in appraisals; at least 10 staff had not been appraised since 2012, and one not since 2006. There were 31 individuals where it was indicated that no previous appraisal could be found, and the majority of these staff did not have a planned date for a review.
- Annual appraisals of staff on the acute surgical ward were said by the ward manager to be fully up to date. On the trauma and orthopaedic ward we were told appraisals had been completed for 95% of staff, and staff who spoke with us told us they had received their review. All but one staff appraisal had been completed on the urology ward. The appraisal process was said by staff on wards to be much improved, with more discussion and engagement. An example of how this had led to improved staff development was described with respect to the acquisition of improved IT skills for one staff member.
- A student nurse explained that they had been orientated to the ward, including evacuation plans, ward structure and other relevant information. They had a mentor, who they were assigned to work with. They were undertaking various competencies, which had been discussed and agreed for the period of their placement on the ward.
- Newer nursing staff on wards and theatres spoke very highly about the level of support, supervision and mentoring they had received. They reported having opportunities to meet with mentors, and had competencies to be met. A training plan was in place for a newer member of theatre staff, and this included moving into the scrub role once they had completed recovery related competencies.
- Some staff had additional responsibilities as link or champion nurses, such as, tissue viability or infection control link nurses. Information files were available for staff, and these staff also provided updates to the wards after attending meetings.
- The Practice Operating Department Practitioner Developer said they accepted there were problems with staff being able to access training because of staff shortages in theatres. Because of this, they had been running 'drop in' sessions, which ran all day to enable greater access. We saw too that theatre audit days included training, such as the moving and handling of patients, and catheter training, at the 6 March 2015 audit day.
- Junior doctors reported that they were well supported clinically at senior level, and that teaching was good. Time was given to attend training and we saw information, which outlined a programme of development, including simulation training.
- There was an orthogeriatrician employed full time on the trauma and orthopaedic ward, which meant patients had access to specialist care, and staff had access to appropriate skills and expertise.

- Revalidation information provided to us indicated that of the 137 doctors due for revalidation in the trust,18 PRUH doctors had been through the process.
- Comparative outcomes by clinicians for a range of specialties were checked on the NHS Choices website, and no results were identified for orthopaedic, upper gastrointestinal, vascular or urology surgeons.

Multidisciplinary working

- We observed very positive and proactive engagement between members of the multi-disciplinary team (MDT). Staff on the trauma and orthopaedic ward reported having a shared care approach, with input from medical physicians and the orthogeriatrician, plus physiotherapy and occupational therapy. Board rounds took place on week days, and on a smaller scale at weekends, during which all patients on the ward were reviewed. The bed manager was said to be present, so they could be updated progress with discharges, and patients who needed to be repatriated from other surgical wards. (surgical outliers). There was a system in place to ensure that patients on other wards were reviewed by the team. This included 10 patients with a fractured neck of femur and four other types of orthopaedic procedure, who were not on the speciality ward at the time of our initial arrival.
- The urology ward reported that physiotherapists and occupational therapists attended the ward in the morning to be updated on each patient. There were no MDT meetings on this ward, as staff said they had tried to get everyone to be present but this had not happened. The urologists and radiologists met monthly but this meeting did not include nurses.
- Therapists were thought of very highly by nursing staff, and were described as “excellent”, despite being under staffed.
- Medical staff told us there was a MDT meeting, which was held weekly at the Denmark Hill site. This was said to be attended by medical representation from PRUH, including two consultants, three SpRs and two clinical nurse specialist’s. The SpR presented cases at the meeting, and these were reviewed along with special procedures.
- Multi-disciplinary ‘huddle’ meetings took place in theatres each morning, during which performance was discussed, along with problems solving. For example, discharging patients from recovery.

Seven-day services

- There was a consultant presence on site, or via on-call provision for each 24 hour period.
- There was access to one CEPOD theatre and, on occasions when there was availability, a second theatre could be used for emergencies. The main CEPOD theatre was fully staffed 24/7, and the trauma and orthopaedic theatre was staffed by the CEPOD team out of hours.
- Out of hours physiotherapy was available 24 hours a day at weekends, and between 5pm and 8:30am, Monday to Friday.
- There were two radiology SpRs on site for out of hours, and an on-call consultant for both interventional and non-interventional work.
- There was formal guidance in place with respect to out-of- hours pharmacy. However, the information reviewed did not indicate if the arrangement applied to the PRUH. We were unable to obtain clarification on this, despite making a request to the trust following our visit.
- Medical staff reported that it was difficult to get CT scans arranged out of hours, and that a request needed to be made by the SpR or consultant directly to the radiologist if such a scan was required.
- During our review of patient notes, we saw that the medical staff were unable to get an ultrasound of patients' hip joints for one week, as the radiologists were on leave.
- Medical staff reported that there was limited access to the Endoscopic Retrograde Cholangio Pancreatogram (ERCP) service, as it was only available one to two times a week. An ERCP is a test that combines the use of a flexible, lighted scope (endoscope) with X-ray pictures, to examine the tubes that drain the liver, gallbladder and pancreas.

Access to information

- Information to staff was said to be communicated in a monthly briefing on the intranet from the Chief

Executive Officer (CEO). Ward staff said they attended ward meetings when they were able, and that urgent information would be communicated at 'huddle' meetings at the start of shifts.

- Staff reported having access to information and guidance from specialist nurses, such as the tissue viability, and continence nurse.
- Staff were said by a patient on the acute surgery ward to be informative and responsive to questions. The doctor had seen this patient daily, and the patient felt informed and knew where they were up to. Questions had been answered by staff, and the patient's wife had also been kept informed.
- There was access to literature, both on the hospital website, and in departments. This included surgical specific guidance, as well as generalised information.
- A patient in the day case unit confirmed that they had been given sufficient information about their treatment and care by the surgeon.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms sometimes contained abbreviations and jargon, and did not always identify all the risks. For example, a consent form for an elderly patient with a fractured neck of femur did not mention death as a risk, although other risks were identified. A consent form reviewed in the admissions unit indicated that the risks had been written in the benefits section. We noted from information provided that the PRUH had achieved an amber audit rating for consent. Improvement action had been implemented to improve the consent rate, by minimising the loss of consent forms.
- Mental Capacity Act 2005 (MCA 2005) training was mandatory for staff. We saw from training figures supplied by theatres that MCA training had been completed by 97% of main theatre staff, and 76% of the day surgical unit staff.
- Staff who had received MCA 2005 training in the previous year had a good understanding of the issues surrounding consent and best interests. They were aware that there was a separate consent form to be used where the patient did not have capacity to sign their own consent. Staff recognised when they needed to escalate a mental capacity issue, and on the urology ward, they gave an example of when they had had to do this.
- Physiotherapy and occupational therapy staff had a good understanding of mental capacity and how to have this assessed. They were aware of Independent Mental Capacity Advocates (IMCAs).
- On the trauma and orthopaedic ward (ward 7), we saw that there was a designated bed area, where patient who were living with dementia were cared for. A nurse was always present in this bay to ensure patients were safe and had their particular needs addressed.

Are surgery services caring?

Good

Patients were satisfied with the quality and standards of care they received from doctors and nurses. Patients told us their privacy and dignity was respected, and they were involved in decisions about their treatment and care.

We observed staff treating patients with kindness, respect, professionalism and with courtesy. Staff were observed undertaking their duties with enthusiasm and commitment.

Patients reported that their relatives, and those closest to them, were involved and kept informed with regard to their progress.

There was access to counselling and others services, where patients required additional emotional and psychological support.

Compassionate care

- The average response rates from PRUH patients who provided feedback in respect to the Friends and Family Test (FFT) during December 2013 and November 2014, was 34%, which was above the England average of 32% for the same period. Surgical wards: 3, 4, 5 and 6 response score trends ranged from the lowest, at 78 out of 100 on ward 3, in December 2013, up to the maximum score of 100, which was achieved on at least one occasion on each ward.

- February 2015 results for the FFT with respect to five of the surgical wards indicated that more than 90% of patients would recommend the PRUH. Wards 1, 2 and 7 scored less positively, and the overall surgery score was 94% in the FFT.
- We reviewed many positive comments made in relation to care and treatment, and staff attitude, on a 'How are we Doing?' report provided. Negative comments were few, and did not indicate any particular trends.
- Staff were said by a patient on the acute surgical ward (4) to be "very good regarding dignity and respect." This patient added that they were "very pleased, especially as it is my first time." They also told us they were treated very well and the experience had been good.
- A patient in the day case unit told us the staff were "lovely" and treated them not only with dignity and respect, but with a degree of humour, which they appreciated.
- We observed the interactions of staff in all areas visited, and saw they were knowledgeable, competent and compassionate in their exchanges with patients.
- Patients were spoken to in a respectful and caring way, with staff allowing them time to have their questions responded to, or information provided.
- Communications between staff were noted to be open, and enabled discussion of patient needs in order to achieve the best outcomes.
- Patients had call bells, and nursing staff responded promptly to these. One patient told us they had felt "well looked after and safe." They said, "there is always someone here and I never wait for anything."
- In the admissions unit, we observed a doctor speaking to patients in an open room, during which they asked personal questions, which could be heard by a patient of the opposite gender.
- A patient in the admissions unit said they were very pleased with the Enhanced Recovery After Surgery (ERAS) nurse, who provided a focal point to contact with questions.
- We followed a patient journey to the operating room, and observed that the patient's anxiety was alleviated by a medical student, who spoke in a kind and reassuring manner to them.
- We spoke with a patient in recovery, who was waiting to return to the ward. They stated they were not happy with the patient admission area, as they were consented in the waiting area and had no privacy. Other than that, they said they were very happy with the care they had received. Staff were said to be, "very friendly and helpful."
- Wards participated in the 'Commit2Care' Measurement and Accreditation programme. Indicators included patient feedback and observation, which resulted in traffic light scores, and ultimately awards banded from white, through bronze and silver, up to gold. Action plans had been developed where there were areas that needed to be improved. The acute surgical ward had achieved a gold award.
- Care perceptions were monitored as part of the performance metric. We noted in the surgical division December 2014 metric for PRUH that perceptions of positive care had improved, from 85% in November to 87% in December. In the metric for February 2015, care perceptions had dropped slightly to 86%, which was the same as the previous month.

Understanding and involvement of patients and those close to them

- Relatives of an elderly patient were full of praise for the nursing staff. They told us they felt included in decision-making, for example around the discharge plans, and felt "fully informed "about their relatives' progress.
- A patient in the admissions unit told us she knew what to expect, and staff had given them a good explanation, and responded to their questions.
- Patient engagement data collected on the surgical performance metric indicated the target score of 87% had been achieved in January 2015 but fell to 86% in February 2015.

Emotional support

- Staff confirmed there was access to clinical nurse specialists, including the Enhanced Recovery After Surgery (ERAS) nurse, and breast and stoma care nurses, as well as the colorectal nurse and palliative care.
- We saw evidence of behavioural assessments having been carried out, as well as the assessment of individuals psychological and emotional needs, particularly where patients had dementia.
- A mood chart was used for individuals who required monitoring.
- There was access to the Renal Counselling and Psychotherapy Team. Breast care nursing staff provided

a counselling service to women with breast related problems. Patients requiring additional information about their medicines could also be referred to the medicines counselling service.

Are surgery services responsive?

Requires improvement

The arrangements for patients using the admissions unit did not promote a responsive and individualised service. Patient flow through the surgical services was limited by availability of beds, linked at times to delayed discharges. Patients were not always transferred to a ward after their surgery, and were cared for and discharged directly from the recovery area in theatres.

Referral to treatment times (RTT) had not been met in a number of surgical specialties. Surgical procedures were sometimes cancelled, and were not always re-scheduled and undertaken within 28 days. Patient notes were not always available prior to patient admission, resulting in cancellations.

Theatres were not always effectively utilised.

Arrangements were in place to support people with disabilities and cognitive impairments, such as dementia. Translation services were available, and information in alternative languages could be provided on request.

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

Service planning and delivery to meet the needs of local people

- The majority of surgical activities at the PRUH were day case procedures, which contributed 61% of activity between July 2013 and June 2014. Elective surgery made up 13% of the work, and emergencies contributed 26% to activity. The main speciality was general surgery, which made up 36% of surgical procedures in this period.
- Patients' treatment and care needs had been assessed by staff in order that the actions taken were responsive to meeting them.

Access and flow

- We found patients who attended the admissions unit were arriving all at once, which meant upwards of 20 patients arriving at 7.45am for all of the day surgical lists. This resulted in a long queue, and patients having to discuss confidential information in close proximity to others. Patients were not aware, until after their arrival, if they would be operated on in the morning, or be on the 'all day list'. The theatre order for patient procedures was sometimes changed after the patient had been prepared for their surgery.
- Surgeons and anaesthetists visited the admissions unit between 8.15am and 8.30am to see all patients, with a view to starting the operating list at 8.30am, which was impossible to achieve. January figures for theatre start times indicated that the target of 51 had not been achieved, with only 9% of sessions starting right on time.
- We observed one example where the patient journey was not managed well; theatre staff sent for a patient at 11.50am, and just after they had left the admission unit, theatre staff rang through to the department and told staff not to send for the patient as there were no beds.
- Patients in the admissions unit were heard expressing dissatisfaction with the wait; one lady had arrived at 7.30am and was still waiting at midday for their surgery.
- Staff in the admissions unit informed us that there could be numerous patients listed for surgery, of which at least two out of three would be cancelled the day before, with the main reason being lack of beds. At least 25 patients were said by staff to be cancelled the day before their planned surgery. Cancellations usually happened in the afternoons, and sometimes this could be as late as 5pm.The admissions co-ordinator had a responsibility to contact the consultant the day before admissions to discuss priorities.
- During our visit, we saw a patient who arrived at 7.30am who had their surgery cancelled for the third time at 12.30pm, and who was still in the admissions lounge at 4.10pm. Missing notes were said by staff to be a factor for patient cancellations, and there were four such cases on the day of our visit.
- Cancellation of patients going through the DSU was said to happen when notes were not available. This was said by staff to have been a problem in the past, but was less of an issue at the time of our visit. Information provided to us indicated that nine patients had been cancelled due to a lack of records in January, and 11 in March 2015.

Surgery

- As a result of the December 2013 inspection, compliance action was served with respect to ensuring patients were cared for on appropriate wards, and that discharge planning improved. Whilst improvements were seen, we found work was still required to ensure patient flow was responsive to their needs. For example, nursing staff in the admissions unit said that often they did not often know which ward a patient would be going to following their surgery, and this was not always decided until after the admissions unit was closed.
- Main theatre staff said they tried to problem solve, by reviewing delays, and these were assigned to a designated member to review.
- Staff in main theatres said theatre bookings were made four to five weeks in advance. Band 6 specialty leads had a responsibility for reviewing each theatre list, and for checking if there were any issues to manage, such as missing technical kit, skill mix or under-utilisation of the session.
- Theatre utilisation at the PRUH location was provided to us in respect to the periods of October to December 2014. This information indicated that the six day surgery theatres were utilised from 52% up to 80.6%. Utilisation across the other theatres ranged between 64.8% and 75.7%.
- Patients were sometimes kept in recovery overnight if there were no beds, and we were told where this was the case, relatives could not visit them. The number of patients who had been discharged directly from main recovery was monitored, and we saw the lowest number of discharges had been recorded in December 2014 at 21. In January and February 2015 there had been 26 discharges from recovery, and the highest number was 97, in October 2013.
- Medical staff reported that the emergency CEPOD theatre was accessible when required.
- Patients attending the DSU were pre-assessed in accordance with guidelines. Any concerns were identified, and if necessary the patient was referred to the consultant anaesthetist, who reviewed the notes on a weekly basis. There was also a duty anaesthetist on site, who could be approached to review the patient. Patients could be referred back to the GP if necessary, if they needed medicines to be reviewed for example. In this instance, staff said that they informed the GP and gave a copy of the communication to the patient, in addition to letting admissions know what they had done.
- Patient flow was managed through the DSU by scheduling bookings three weeks in advance. A daily 'huddle' meeting took place at 10.30am, during which a range of staff, including the scheduling team discussed day surgery, main theatre activity, and bed availability. Lack of beds on the main wards was cited as a problem at times when patients needed to be admitted and could not be discharged. The department was said to be open officially until 8.30pm hours but stayed open longer if needed. Staff said there was a problem in transferring patients on beds as portering staff were not happy to push beds up a slope outside of the DSU. This meant nursing staff had to do the transfer.
- The number of patients who did not attend the DSU on time accounted for 28 cancellations in January, 39 in February, and 14 in March 2015.
- The number of cancelled surgical treatments that were not then treated within 28 days at the PRUH was 92 for the period April 2014 to March 2015.
- The performance metric for the surgical division in December 2014 indicated 34 inpatient cancellations, which although rated as red, was an improvement on the previous month.
- Staff on the urology ward said they took patients who had previously had their services provided at alternative London hospitals. They said that patients were sometimes sent to them inappropriately from other hospitals. Consultants who were usually based at the Queen Elizabeth Hospital (QEH) Hospital only came to the PRUH when they were on call. This made it difficult for junior doctors to get advice with regard to the management of such patients. However, the patients were said to be reviewed by PRUH consultants, who then fedback to the QEH consultants.
- During the period between June 2013 and July 2014, the average length of stay (ALOS) for the top two elective surgical procedures, was better than the England average. Trauma and orthopaedics patients however, had an ALOS of 4.2, against the England average of 3.5 days. For non-elective surgical procedures, the ALOS was worse than the England average in general surgery, at 5.3 days against England average of 4.3. In urology the ALOS was 4.6 days, compared with the England average of 3.3 days. There was a slightly shorter ALOS in trauma and orthopaedics.
- Discharge arrangements were commenced as soon as possible in the patient journey. Staff reported that the discharge process caused them the most problems,

particularly where a person needed rehabilitation and funding to support their on-going care. One patient had been an inpatient since December 2014, and was still awaiting agreement for funding.
- Repatriation bed day delays at the PRUH were 13 for December 2014, with a worsening trend indicated on the divisional performance metric. For January 2015, the figure was 33, and there were 10 repatriation bed day delays in February 2015.
- The care of surgical outliers was overseen by speciality consultants, and such patients were identified at ward level and within bed management meetings.

Meeting people's individual needs

- The orthogeriatrician reviewed elderly patients on a daily basis. A designated nurse was in place for leading on the pathway for patients who had a fractured neck of femur, and in particular, for facilitating their enhanced recovery.
- Translation services were arranged through the hospital intranet. Newer staff were not aware if patient leaflets could be provided in alternative languages.
- Staff had access to information and a lead nurses with regard to learning disabilities and dementia. Staff who spoke with us about patients with learning disabilities described how they would take care to ensure their communications were appropriate to their needs. They said they would encourage a carer or relative to be present, especially when having to explain treatment.
- Where patients were identified as having become confused, staff said they alerted the manager so that one-to-one care could be arranged.
- There was good ward staff awareness about patients who were living with dementia, and how their needs may require a different approach. For example, a nurse told us how they tended to find such patients to be more alert in the morning, so they planned care around this. They also told us there was a dementia team available to assess individuals, and to provide guidance. A designated nurse was said by staff to see all patients over 75 years of age, in order to assess their needs and mental capacity.
- Discussion with the dementia nurse specialist demonstrated that they saw the admission list of patients for the previous 72 hours. They then visited all non-elective patients over the age of 75 years, and completed an assessment. They also liaised with the GP, and suggested referral to a memory clinic when discharged, if necessary.
- A flower symbol was used to identify patients who had any special needs because of their dementia.

Learning from complaints and concerns

- We observed that information was available to guide patients and their relatives in raising a concern or complaint. There was access to the Patient Advice and Liaison Service (PALS)
- Staff were aware of the reporting process for complaints, and said they had feedback where it related to the ward or their practice. For example on the acute surgical ward, staff said there had been one formal complaint, which indicated a need to improve pain management.
- The divisional performance metrics contained information with respect to complaints. In December 2014 there had been 12 complaints, which was above the previous month and that of the previous year. Figures for January 2015 indicated seven complaints had been raised, and for February 2015 there had been six.

Are surgery services well-led?

Requires improvement

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

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

There were effective governance arrangements to facilitate monitoring, evaluation and reporting back to staff, and upwards to the trust board.

The surgical directorates identified actual and potential risks at a service and patient level, and in most instances

had mechanisms to manage such risks and monitor progress. One area that required further work was in relation to the World Health Organisation safety checklist. No information was available in relation to audits and compliance with the safety checklist.

Staff reported effective leadership, of feeling valued and respected. The culture was of sharing and engagement with staff with openness to feedback and learning.

Patients and staff were encouraged to contribute to the running of the service, by feeding back on their experiences and sharing ideas.

Vision and strategy for this service

- An agency nurse told us the vision was about putting the patient first, transparency and the duty of candour. Other staff told us the vision was to "provide safe care, respect people's needs, be competent and improve health." An overseas adaptation nurse said the vision was to succeed, commitment, teamwork and communication. They added, "this underpins everything."
- We asked members of the senior clinical and medical managerial team if there was an overarching surgical strategy. We were provided with a copy of the 'Liver Services at King's College Hospital Draft Strategy Document 2014-2024'. This contained the broad vision and objectives underpinned by the values and culture needed to meet these. On reviewing the document, we saw there was extensive information, which took account of risks, aims and expectations, along with time scales.
- There was no formal strategy in place for trauma and orthopaedic services at the time of our inspection, and we were told, "a fundamental decision is needed from the trust board about what it wants in respect to elective surgical work." We were told there had been some development of options, supported by data and in respect to the acute component of surgical services. It was said, there was a clear end point, which encompassed the management of major trauma patients. An informed decision on the direction of travel was awaited, and a three point plan was being presented in April 2015 to the trust board.
- There was no awareness of the surgical strategy when we raised this question with nursing staff.

Governance, risk management and quality measurement

- The governance arrangements in the surgical division at PRUH were organised as follows: Monthly risk and governance meetings took place. These were chaired by the governance lead. Information from this meeting fed into the PRUH safer care forum, and upwards to the serious incident committee. The latter was chaired by the Medical Director. Risk and governance meetings also fed into the Denmark Hill governance meetings.
- We were told the surgical divisions had a strong clinical governance framework, which followed the London Strategic Clinical Networks Governance Framework Toolkit (August 2014).
- There was good governance awareness amongst senior doctors and senior theatre staff, but poor awareness among more junior medical staff. For example, they were unaware of what the risk register was and unsure of the audit process and why audits were carried out.
- Medical staff reported that they had protected time for clinical governance meetings, which were held monthly. These were half days, and included specialty specific information, presentation of audits and, mortality and morbidity information. Incidents and complaints were also reviewed.
- We reviewed the terms of reference for the PRUH Surgical Quality and Risk Committee. This reflected the domains of the NHS Outcomes Framework and covered patient safety, the patient experience and clinical effectiveness. Divisional quality and governance meetings reported into the Trust Quality Governance Framework. We saw minutes of the PRUH Surgical Clinical Risk and Governance Meeting, which covered patient experience and incidents. Attendees included the Friends and Family Test manager, along with other staff who could not be identified by role.
- Divisional risk and governance meetings took place monthly, and we reviewed minutes of such meetings, in which we saw discussion of incidents and presentations from departments.
- The risk register, which covered surgical areas and theatres, was viewed by us. We noted that most actual and potential risks had been identified, along with the control measures, likelihood of it arising, consequences, and a traffic light rating. The required action had also been outlined. The risk owner was identified and the risks were reviewed at governance meetings. For

example, we saw the risk register had been reviewed in minutes recorded from the Surgery, Urology, ENT and Orthopaedics Clinical Governance Meeting held on 27 January 2015.

- Staff on wards and in theatres confirmed that they received information following the review of incidents and complaints. Information was also communicated about risks at team meetings, in daily information sharing at handover times, and in 'huddle meetings'.
- There was a process in place, which enabled reviews of incidents, review of patient safety reports, and the risk register. However, we were not provided with any information about audits of compliance with the WHO surgical safety checklist.

Leadership of service

- Staff told us there was good teamwork, and that staff were motivated to deliver good patient care. One agency nurse said, “we do a good job and get lots of good feedback.” Nurses on the ambulatory emergency care ward said the team work was good and they had felt supported during their period of adaptation, as overseas nurses. One nurse said, “they don’t get tired of my questions and I have learnt a lot.” Another member of staff on this ward described the leadership as, “awesome, great leaders” and the way respect is shown is, “really great.” An example given by staff was with regard to the ‘Commit2care’, where the ward manager was said to show by example, the standard she wished things to be done.
- A ward manager on the ambulatory emergency care ward, where they had been awarded level three ‘Commit2care’, and a personal King's Service award, said they always tried to be visible and to act as a good role model. They said "I will do the same as what I expect of my staff."
- Consultants reported that there were good opportunities for development, and the clinical management were supportive.
- Theatre staff said there was a lack of visibility of the CEO and members of the trust board. Others said there was a lack of visibility above matron level. We were told the theatre manager was “trying their best” and, change had been for the better.

Culture within the service

- The culture was observed to be open, and staff received positive praise and feedback. For example, we saw appreciative thanks stated in the matron’s message heading the theatre newsletter for March 2015. The theatre department had been awarded the King’s Commendation award for outstanding services.
- There was a good atmosphere observed in theatres, and staff demonstrated loyalty to the department and to the hospital. However, some staff reported feeling not valued, and of being made to feel inferior to the Denmark Hill site. A member of theatre staff commented that it was, “King's way or no way.”
- Clinicians reported that they were very involved in the delivery of the services, and we heard examples of this in our discussions.
- A member of the regular nursing agency staff, who had been working in the day case unit regularly for a year said there been lots of changes in the culture, which had been beneficial to patient care. They said they were encouraged to share ideas and felt listened to, as well as feeling valued by the team.
- A nurse, who had worked at the hospital for seven years said there was great comradery in the team, and that the manager would help if short staffed. Staff said they worked well with consultants, and they were asked for their opinion, and were treated with respect.
- A nurse who had friends working at the Denmark Hill site described how they discussed the differences in cultures on the two sites and said, “we are still adjusting, but I don’t think there is a difference in patient care.” Things were said to have improved. For example, a senior nurse said there was greater recognition of needs, and there was improved access to consultants. They also said there was openness and honesty linked to the Duty of Candour.

Public and staff engagement

- A member of ward staff said they could raise a matter, and felt this would be supported if they did it in an appropriate manner. A theatre staff member said that they did not feel they could 'whistleblow', as they had seen another member of staff persecuted in the past for doing this.
- Staff on wards reported feeling “very much valued and respected”, and said their line managers asked how they were. There were opportunities for discussion and feedback, which helped them to feel part of the team. Staff ward meetings were held and minuted, so that staff who could not attend were aware of the discussions.

- We noted in theatre staff meetings reviewed for February and March 2015 there were opportunities for staff to discuss a range of subjects, such as recruitment, audit results, e-learning, staffing and surgical instrument issues.
- The performance metric for the surgical division at PRUH was provided to us for December 2014. We saw that with respect to patient engagement, the division scored 85% against a target of 87%, which was the same as the previous month, but better than last year's score.

Innovation, improvement and sustainability

- A long serving staff member said there had been improvements in specialist nurses and more courses available to them to help in their development. They felt encouraged to develop since the change in structure.
- Improvements had been seen by staff since the introduction of more specialist nurses. In particular, staff cited how having access to the tissue viability nurse had resulted in decreased pressure ulcers. The fractured neck of femur pathway and the lead nurse for this was said to have been beneficial in enhancing the patient pathway. However, it was noted there were no formal arrangements to cover this staff member during times of leave.
- We were told by a member of nursing staff that there had been long delays in organising patient discharges from the hospital because Social Services could not undertake some of the necessary adjustments which were needed in people's homes. In order to deal with this, a 'handyman' had been employed to install grab rails and key safes. This was said to have reduced the delays in getting people home.
- Innovations related to patient services were being developed. For example, with respect to day surgery options for patients requiring prostate surgery. We saw a draft protocol for short acting spinal anaesthesia for urology day surgery, which was aimed at managing high risk patients, and also those who were elderly or may have memory problems. This would avoid the need for complete general anaesthesia and extended inpatient stay.

Critical care

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

Information about the service

The critical care unit is a ten bed facility, funded for six level three beds and four level two beds. The unit has the ability to flex up to ten level three beds and opens two additional 'satellite' critical care beds in theatres recovery when capacity is an issue. Between April 2014 and March 2015, 575 patients were admitted to the critical care unit.

Patients are mainly admitted from the emergency department, but a proportion are also admitted via the hospital wards, either due to becoming more unwell, or after elective surgery. The iMobile critical care outreach team support ward staff to care for deteriorating patients prior to their transfer to critical care, as well as reviewing patients following discharge from the unit.

We visited the critical care unit, recovery and the coronary care unit (which also cared for level two patients at times) over the course of one announced inspection day and one unannounced inspection day. During our inspection, we spoke with 21 members of staff including doctors, nurses, allied health professionals and ancillary staff. We spoke with the divisional leadership team within critical care at the trust. We also spoke with four patients and four relatives. We checked eight patient records and many pieces of equipment.

Summary of findings

Overall, we rated critical care services as requires improvement. Access to and flow through critical care were poor due to high capacity and issues accessing ward beds. Using two 'satellite' critical care beds had done little to relieve capacity issues. Although senior staff were aware of the problem and plans to address this were being discussed, no actions were in place at the time of our inspection. Senior staff could identify potential expansion plans but ward staff were unaware of the developments that may occur in the service.

We found information in some records was incomplete and some notes lacked sufficient detail. Some aspects of medicines management on critical care were concerning, such as inappropriate storage and minimal stock control oversight. Neither of these issues had been identified by senior staff, suggesting limited overall insight into how the unit functions. Senior staff were aware of equipment issues relating to the ventilators and blood gas analyser and steps were in progress to address these concerns.

Overnight, we found critical care used a higher than recommended proportion of agency nurses and relied upon one critical care registrar, who was often away from the unit dealing with unwell patients in other areas of the hospital. A serious incident occurred as a result of the medical staffing overnight and no changes to night time medical staffing numbers had been implemented,

Critical care

although some additional support was provided for doctors out of hours. Learning from incidents was variable, despite staff having a proactive approach to reporting.

Patients received effective, evidence-based care and patient mortality outcomes were within the expected range. The management team had plans to further develop key areas of patient care. The Patient Safety Thermometer information showed a good track record and there were no concerns about infection control. Recent innovations in clinical practice had been introduced and regular audit occurred. The unit was generally clean and tidy, with sufficient hand-washing facilities and alcohol gel dispensers.

Staff were well supported by an experienced, immediate management team who maintained a regular presence on the unit. Staff had a positive approach to their work and worked together to complete care for patients, as well as to facilitate learning within the team. Patients and their relatives were positive about interactions with staff and told us they received compassionate care and were treated with dignity and respect. They said staff introduced themselves but that it could be difficult to tell who was who as therapists, nurses and doctors all wore theatre scrubs on the unit.

Are critical care services safe?

Requires improvement

Safety on the critical care unit requires improvement. We found aspects of medicines management concerning, such as inappropriate storage, minimal stock control measures and no availability of an authorised signatory list. We had concerns about record keeping as we observed gaps in care plans and entries which lacked sufficient detail. Senior staff acknowledged concerns regarding equipment reliability and availability, including the blood gas analyser and ventilators.

We had concerns about both nursing and medical staffing overnight. A high proportion of night nurses were agency staff. The overnight registrar was extremely busy in other departments as well as in critical care, which had led to a serious incident occurring, but no change to night time medical staffing as a result of this. Learning from and awareness of incidents was variable among ward staff and there was some cross-site shared learning from incidents.

We found the unit was clean and tidy, with oxygen as well as consumables appropriately stored. The Patient Safety Thermometer information showed a good track record and we noted mainly appropriate use of personal protective equipment as well as hand-washing during our inspection.

Incidents

- We reviewed evidence which confirmed incidents were reported on the unit and staff could provide examples of incidents they had raised. Feedback from specific incidents was available to staff if requested.
- We reviewed 95 registered incidents from September to December 2014, including two serious incidents (SI). Learning from SIs on the unit was variable. One SI stimulated a change in procedure and a subsequent audit, whereas an SI which was related to medical staffing out of hours had instigated an investigation, but not resulted in any changes to medical staffing numbers at the time of our inspection, although some additional support was provided for doctors working out of hours.
- There was a monthly risk and governance meeting where incidents were discussed by senior nursing staff and the medical team. Staff received feedback via

e-mail, critical care risk update posters and the staff newsletter. This feedback included information about the incident that had occurred, details of relevant audit data and clarification of correct procedures.
- Nursing staff identified a 'Big Three' on a monthly basis which were key messages that were reinforced to ward staff during every nursing handover as well as in the staff newsletter. These included learning and changes since incidents. Some staff could give us examples of 'Big Three' learning.
- Some cross-site learning with Denmark Hill critical care occurred through informal matron communication about incidents and this was sometimes passed onto ward staff in the monthly newsletter.
- Senior nursing staff were aware of their Duty of Candour (DoC) but were unable to identify an occasion where this process had been instigated. We saw evidence that the DoC had been adhered to in a response to a patient complaint.
- We reviewed documentation showing Root Cause Analysis (RCA) when unit acquired pressure ulcers had occurred. An appropriate RCA method was used and suitable action plans had been identified in the examples we saw. For one example, we saw evidence that the action plan had been implemented through the purchase of a different type of non-invasive ventilation face mask, which should not cause pressure areas on the bridge of the nose.

Safety Thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and venous thromboembolism (VTE). This information was clearly displayed in the entrance corridor to the unit, making it easily accessible for visitors and staff. Information was up to date and demonstrated the relevant information appropriately.
- The Safety Thermometer data for the unit demonstrated better results than the national average. From April 2014 to March 2015, there had been one incidence of unit-acquired MRSA and two occurrences of C. difficile. Three unit-acquired pressure ulcers had occurred from January 2015 to March 2015; this was an improvement on previous trends.
- The information board also showed the number of nursing staff expected, together with the actual staffing for that day. On our unannounced inspection, the board stated seven nurses and one healthcare assistant were needed and there were eight nurses on shift, with the shift coordinator being supernumerary.
- Hospital audit data in January and February 2015 showed 100% compliance with patient VTE risk assessment on the critical care unit. The data also showed that 100% of patients had received appropriate VTE prophylaxis.
- Audit data in January and February 2015 showed compliance with catheter care guidance; no patient had had a catheter in situ for more than 28 days.
- Staff used the Waterlow Pressure Ulcer Prevention Score to assess the patients' risk of developing a pressure sore. This assessment was available in the new nursing care plans and had been completed in records we checked.

Cleanliness, infection control and hygiene

- On our inspection, we noted a clean clinical environment and a housekeeper who was based solely on the critical care unit. The housekeeper completed basic cleaning of the unit on a daily basis and more thorough 'deep' cleans as required.
- Intensive Care National Audit and Research Centre (ICNARC) data for the unit showed no concerns in relation to hospital-acquired infections, such as MRSA or C. difficile and performance in these areas was better than in comparable units.
- All patients were screened for Vancomycin-resistant enterococci (VRE) on admission to the unit. Staff told us the number of patients admitted from other wards in the hospital with positive VRE swabs was high. No VRE screening occurred elsewhere in the hospital and the microbiology or infection control teams were unable to investigate this due to short staffing.
- The unit adhered to trust policy (reviewed in December 2014) identifying which patients were prioritised for a side room due to their infection risk. On our inspection, two side rooms were in use with barrier nursed patients. There was appropriate signage indicating required precautions and doors were kept closed. Personal protective equipment (PPE) was available at the

entrance to each room. We observed pink aprons were used for barrier nursing, which is against the National Patient Safety Agency (NPSA) guidance of yellow aprons for this purpose.

- We observed staff following hand hygiene protocols and using PPE for procedures and care interventions. Hand hygiene audits over previous months demonstrated 95-100% compliance. However, the most recent hand hygiene audit took place during a ward round and showed 70% compliance, with allied health professionals (AHPs) demonstrating poor adherence to protocols. Patients told us staff always wore gloves and washed their hands. There was an alcohol gel dispenser available in each bed space and hand-washing facilities were available within most bed spaces.
- Alcohol gel and hand washing facilities were available at the entrance to the clinical area of critical care.
- Needle sharp bins were available at each bed space and in the medication preparation area. These bins were changed regularly and we observed none were over-full. However staff told us they occasionally found used needles discarded on the worktops in the unit.
- The sluice was clean and tidy with plenty of enclosed storage space. Commodes were clean and green labels were used to identify when they were last cleaned and by whom. A cleaning schedule was displayed and filled in appropriately. Other areas within the critical care unit, such as the relatives waiting area, quiet room and nursing stations, were clean and tidy.
- We observed bed space curtains were labelled with the date they were last changed. Curtains were changed in-between patients or if they were soiled.

Environment and equipment

- The seven bed spaces within the main critical care area were suitably spread out and there were three cubicles adjacent to the main ward area. Adjacent bed spaces were separated by disposable curtains.
- The unit mostly had sufficient equipment for patients and it had been suitably maintained. Staff expressed concerns around the reliability of the blood gas analyser, which was described by one member of senior staff as “not fit for purpose”. We saw it had stopped working on the afternoon of our inspection, but a technician arrived within 20 minutes of the fault being reported. We were told about an incident where the machine had broken on a Friday afternoon and had not been looked at by a technician until Monday because staff did not know how to seek help over the weekend. Staff could access other blood gas analysers in the hospital when the departmental machine stopped working, but this required leaving the unit and therefore took longer to obtain results.
- There were ten ventilators available to critical care; two different makes of ventilator were used on the unit. Senior nursing staff told us substantive nurses were trained on both machines and agency staff would be trained at the start of their shift if needed.
- Some of the ventilators used on critical care were private finance initiative (PFI) funded and some were owned by the trust. Machines owned by the trust could only be serviced; no replacement parts were available due to the age of the machines.
- The unit could accommodate ten ventilated (breathing with the support of a machine) patients which meant there would be no spare equivalent ventilator available should one break down. High flow oxygen and portable ventilators were available on the ward and could be used if required. Senior staff were aware of the issues surrounding ventilator availability and told us they would borrow a ventilator from Denmark Hill critical care if needed but this had not happened as yet.
- The unit had purchased a new, third type of ventilator which they told us 20% of nursing staff were trained to use and so the new machine was not yet in use day-to-day. Senior staff told us they were hoping to purchase enough of this new type of ventilator for the whole unit.
- There were two high flow oxygen and three continuous positive airway pressure (CPAP) machines available on the unit, providing different treatment capabilities for patients.
- A resuscitation trolley was available in the main critical care ward area. The trolley was securely sealed and stocked with appropriate equipment. Stock checks should be completed twice each day but we saw some gaps on the recording document, suggesting these checks were not always taking place. Staff told us it was an oversight which might happen if the unit was particularly busy.
- Difficult airway and emergency tracheostomy equipment was available on a separate trolley, located next to the main resuscitation trolley.

- There was one defibrillator available on the unit. Current guidance suggests the availability of two defibrillators on a critical care unit. This had been identified as a risk and placed on the risk register while the unit was awaiting the delivery of a further machine.
- There was sufficient storage for general consumables (such as spare tracheostomy and cannulation equipment) on the ward and this was tidy on inspection. We observed a colour-coded system to assist staff in finding equipment quickly.
- Intravenous (IV) fluids, enteral feeds, giving sets and syringes were appropriately stored in a digi-locked store cupboard which meant access was limited to just staff.
- The blood gas analyser was located just outside the main unit, in a room primarily used for document storage and faxing. We observed the door to this room was a fire door but had been propped open with a waste bin, which was not compliant with fire safety regulations.

Medicines

- Staff on critical care were not allowed to administer any medicines until they had passed a formal drugs test. This was supported by the practice development and senior nurses. Regular agency nurses also completed the test. Agency nurses who did not work on the unit regularly did not complete the test and required the support of competent substantive staff with administering medicines.
- A pharmacist visited the unit daily during the week and for one hour each day at weekends. The pharmacist was dedicated to critical care during weekdays but had other responsibilities over the weekend.
- We observed four sets of medicine administration records and found that all were completed accurately and according to national guidance. The pharmacist was responsible for compiling patients' drug histories and recording allergies. This allowed the pharmacist to check for inappropriate drug interactions and risks.
- There was no medicines management technician, which meant pharmacists had to manage medicine stocks. Pharmacy staff told us that there was not enough time to keep the medicines storage tidy and ordered due a busy caseload across several wards.
- All drug storage cupboards were securely locked and regular audits were completed regarding the accuracy of controlled drug documentation and medicines management. Audit results from December 2014 showed critical care was satisfactorily adhering to eight controlled drug management standards. There were three areas of controlled drug management which were deemed unsatisfactory; accurate recording of waste, documentation of significant errors in the CD book and orders in the CD requisition book appropriately entered into the CD register.
- We observed three boxes of medicines stored inappropriately on top of the locked drugs cupboard. When we brought this to the attention of the pharmacist, the problem was immediately rectified.
- Patient's own medicines were stored in a separate cupboard. However we found medicines belonging to patients who were no longer on the unit stored with those belonging to current patients, which could lead to unnecessary confusion and errors. Staff were made aware of this finding and medicines which were no longer needed were disposed of.
- The medicines refrigerator was within the appropriate temperature range. There was a fridge temperature checking record which showed it had only been checked on four days out of 14, when it should have been checked on a daily basis. We were told that this was due to a member of staff leaving who had responsibility for this and that the task had not been reallocated.
- Controlled drugs were mainly stored safely. Concentrated potassium was stored as a controlled drug and had it's own register and order book. Midazolam was labelled and stored as a controlled drug but was not managed as such; there was no formal stock control system in place. Bupivicaine had been stored in the controlled drugs cupboard and we were told by pharmacy staff that this was incorrect storage and "against trust policy".
- We asked to view a list of authorised signatories for controlled drugs but were told this was not available. The nursing and pharmacy staff were both unsure where this list might be located. This meant that unauthorised people could request drugs from pharmacy and these could be dispensed without question.
- IV fluids were mainly found in a digi-locked store cupboard, but there were also some which were found unsecured at the nurses' station for quick access in an emergency. The risk of this type of storage had been assessed and was on the unit's risk register.

- Oxygen had been appropriately prescribed on each patient record we checked and reviewed by the critical care consultant during ward rounds.
- Oxygen cylinders were mainly stored appropriately in racks and in a designated area with a suitable signage on the door. All oxygen cylinders were seen to be in date.
- All drug errors were discussed at risk and clinical governance meetings. Senior nursing staff also attended a critical care medication safety group which encouraged cross-site learning with staff from the Denmark Hill site.

Records

- The critical care unit used paper-based records. We were told new care plans were due to be introduced soon. When we returned on our unannounced inspection, the new paperwork had been used on the unit for three days.
- Daily care plans and observation charts were found on the nurse's desk at each patient bed space. Medical notes were stored in a drawer on the same desk, making information readily available to staff looking after the patient.
- Eight patient records reviewed showed most areas had been completed. Significant omissions from notes included a discussion that staff had had regarding a decision as to whether a safeguarding referral was required for a particular patient. We also found a pressure area incorrectly marked on a wound chart and no documentation that any discussion with the tissue viability team had occurred when their advice had been obtained.
- It was unclear who had written some note entries, as the role and printed name of the person writing had been omitted.
- We raised our concerns regarding records with the Head of Nursing who told us that regular notes audits used to happen. These were replaced by spot checks which are usually completed by the Matron.
- Confidential patient information was disposed of in a secure bin, located just off the main area of the unit, when it was no longer needed.
- Each patient on the unit had a critical care patient safety analysis (CCPSA) booklet. This contained details such as falls risk assessment, psychosocial assessment checklist and information about mental capacity and Deprivation of Liberty Safeguards (DoLS).
- Ventilator-associated pneumonia (VAP) care bundles were documented on a daily basis and were seen to be complete in the records we checked. Completion of this documentation was audited on a monthly basis and adherence was found to range from 80% to 100% over the last three months.
- IV line documentation was reviewed on a monthly basis as part of the IV line audit and was found to be 100% in January, February and March 2015.

Safeguarding

- Staff were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the trust safeguarding policy. Most staff were aware of who the lead safeguarding nurse was.
- A checklist in the CCPSA booklet would indicate when a safeguarding referral was needed. This checklist had been appropriately completed in all but one patient record we reviewed.
- The unit had access to the hospital safeguarding team and made referrals via a telephone call. Staff told us they have a proactive approach to contacting the team and would often use them to obtain advice, even if a safeguarding referral was not required. Senior staff described an example where the safeguarding team had been involved on the unit following concerns about an adult with a learning disability.
- Adult safeguarding training (Levels 2-5) had been completed by 84% of critical care nursing staff.

Mandatory training

- Staff were given one long shift per year to complete their mandatory training; a combination of classroom-based teaching and e-learning modules.
- Most mandatory training had been completed (over 85%) however some important modules had a low uptake; aseptic non touch technique (ANTT) 75%, information governance 52%, mental capacity 73% and VTE 75%.
- Staff told us they felt supported to complete their mandatory training and were reminded to keep up to date in appraisals and the staff newsletter.

Assessing and responding to patient risk

- When a deteriorating patient was identified via an elevated NEWS (National Early Warning Score) calculation, a referral was made to iMobile (the critical care outreach team). Since November 2014, this service had been available 24 hours a day, seven days a week.

iMobile supported ward staff to provide specialist care to patients becoming more unwell who may require escalation to critical care. The service was provided by experienced band seven critical care nurses.

- Of the patients admitted to critical care from A&E between January and March 2015, 56% were transferred within the four hour decision to admit to actual admission national standard.
- Within A&E and across other wards, normal observations were increased to more frequent and thorough assessments if the patient's NEWS was increasing (indicating the patient was deteriorating).
- Once a patient was transferred to critical care, NEWS was no longer calculated, but other tools for assessment were used. For example, the team used the Glasgow Coma Scale (GCS) to assess the patients' conscious level and the Richmond Agitation-Sedation Scale (RASS) to measure agitation of an unconscious patient (RASS is used in ventilated patients in order to avoid over and under-sedation).
- Patients were evaluated using the Confusion Assessment Method for the ICU (CAM-ITU) flowchart to determine whether delirium was evident. The CAM-ITU was available as a separate document on our initial inspection but had been integrated as part of the daily care plan when we returned on our unannounced inspection.
- iMobile reviewed patients upon discharge from intensive care. If patients were discharged out of hours, they would be reviewed by iMobile within two hours, or within four hours if the patient was transferred during the daytime.

Nursing staffing

- The unit was overseen by a matron and day-to-day management was the responsibility of the shift coordinator. Full time staff worked three long shifts each week; day shifts were 7:30am to 8pm and night shifts were 7:30pm to 8am.
- Nursing staff received an overview of all critical care patients from the shift coordinator at the start of their shift and then a thorough bedside handover once they had been allocated a patient.
- An acuity tool was used to determine staffing levels. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units states that all level three (L3) patients (patients who need advanced respiratory support alone, or basic respiratory support along with support of at least two other organ systems) are required to have a registered nurse:patient ratio of a minimum of 1:1 to deliver direct care, and for level two (L2) patients (patients who need higher levels of care and more detailed observations or interventions, such as single organ support) a ratio of 1:2. The unit was usually able to comply with these standards; however, the allocation book showed several instances over the last two months where staff had looked after a L3 and L2 patient at the same time.
- The rota was planned in advance and agency requests were sent out up to eight weeks before a shift, but unexpected staff absence or a change in patient acuity meant that the desired level of nurse:patient ratio could not always be achieved. If staff had to look after more than one patient, this was risk assessed according to patient acuity and infection control prior to allocation.
- The Matron told us the shift coordinator should be supernumerary, but sometimes they had looked after a L2 or wardable patient when staffing was short.
- We were told if the additional two critical care beds were opened, additional staffing would be sought so optimum staffing could be achieved. It was not always possible to obtain enough agency or bank staff and this sometimes led to cohorting of patients.
- At the time of our inspection, there were 1.84 whole time equivalent (WTE) band seven nurse vacancies and 2.75 WTE band six vacancies. We were also told that the unit was underfunded by seven band five nurses and had a business case put forward to address the situation.
- We were told by several senior members of staff about the difficulties the hospital had in recruiting nursing staff. Critical care have attempted a European recruitment drive and managed to recruit two nurses. The Head of Nursing described the staff retention plan which was in place to reduce staff turnover. This plan involved an identifiable development pathway for staff to progress to more senior roles within the unit.
- New nurses were initially supernumerary while becoming orientated to the department. They were allocated a mentor and received support from the Practice Development Nurse (PDN). Staff who had started recently gave us positive feedback about the induction process.
- Agency nurses were given a temporary worker orientation pack, outlining key information about the

ward and they also completed a local induction checklist. For regular agency staff, there was a medicines administration competency document in place.
- Senior staff told us they were reliant on agency staff for night shifts, with the usual overnight staffing being 60% substantive staff, 40% agency staff. We were told that it can sometimes be 40% substantive staff, 60% agency staff. Best practice guidance suggests no more than 20% agency staff usage per shift.
- We were told agency usage equates to 11-12 WTE staff each month.
- The Matron told us there was not a trend of increased nursing incidents overnight. To ensure patients receive consistent quality of care, staff completed audits such as hand hygiene and IV line monitoring during night shifts. The audits overnight were in line with the results obtained during day shifts.
- The iMobile outreach team was staffed by one band seven nurse during the day and night shifts. They received support from critical care doctors.

Medical staffing

- There were five substantive critical care consultants who participated in the rota, three of whom worked cross-site at Denmark Hill. The consultant was responsible solely for the unit from Monday morning until Friday morning and would be replaced by another consultant who would cover Friday morning until Monday morning. As the ITU had ten beds, the consultant:patient ratio met intensive care standards.
- Consultants worked shifts from 8am to 8:30pm, supported by an ITU registrar and a minimum of three junior doctors. On the day of our inspection, there were five junior doctors on the unit.
- Consultants were on-call overnight, with a required response time of 30 minutes. There was one ITU registrar on the unit overnight.
- Staff told us of instances when the night ITU registrar had had to leave the ward to deal with emergencies in other departments, such as A&E, leaving ITU without a doctor on the unit. Senior nursing staff told us they would put a crash call out to get the doctor back if a patient's condition was significantly deteriorating. One consultant told us "there needs to be two ITU registrars overnight". A review of the rota and a consultation document was being prepared to increase junior doctor cover at night. In the meantime, support was available through the critical care consultant, anaesthetic consultant and Orpington anaesthetic consultant on call.
- Medical handover meetings took place at 8am and 8pm, where the doctors on duty would handover patient details and updates to medical staff coming on shift.
- Consultant led bedside ward rounds took place at 10am and 4pm.

Major incident awareness and training

- All staff received fire safety training as part of their mandatory training programme; however none of the staff we spoke with had practiced an evacuation procedure on the unit.
- Critical care, alongside other departments in the hospital, recently participated in an Emergo exercise, which simulated a major incident and the unit's response to this. The report showed positive feedback for the unit in all areas, including leadership, communication and cross-departmental working.
- Staff told us about recent major incident training they had received for managing patients with Ebola.
- Major incident plans were available on the intranet.

Are critical care services effective?

Good

Patients received effective care on the critical care unit. Critical care specific policies and procedures were based upon current guidance and were seen to be in date. Patient outcomes, such as mortality and unplanned re-admissions, were in line with other similar units. New care plans included evidence-based assessment tools. Pain was regularly assessed and patients told us they received pain relief quickly when needed.

Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Medical staff were mainly long-serving trust grade doctors and received regular training as well as support from consultants.

There was good access to seven-day services and multidisciplinary working on critical care, although there

was limited involvement from speech and language therapists and occupational therapists, due to staffing issues. Staff obtained consent and used mental capacity assessments appropriately.

Evidence-based care and treatment

- Intensive care specific policies and procedures were seen to be up to date and referenced to current best practice from a combination of national and international guidance. References included National Institute for Health and Care Excellence (NICE), Royal College guidelines and Intensive Care Society recommendations.
- Policies and protocols were mainly accessed by staff via the intranet but there were some available in folders at the nursing station. Most printed copies were found to be up to date, but several documents in the medicines folder had no date of publication or review, which meant staff may be using out of date information.
- We saw specific evidence-based antimicrobial treatment guidelines for adults had been made into a small reference booklet and was being used on the unit by staff.
- New care plans had been introduced prior to our unannounced inspection, which contained evidence-based risk assessment tools and checks for easy reference.
- The critical care unit contributed data to the ICNARC database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally.
- Hand hygiene, IV line and care bundle audits were completed on a monthly basis. Dates on IV line dressings were completed on 63% to 83% of lines from January to March 2015. Recommendations were made according to the results of these audits and staff were reminded about key aspects of care relating to the audit findings.
- Rehabilitation progress was measured using the evidence-based Chelsea Critical Care Physical Assessment Tool (CPAx), so patient progress could be monitored.

Pain relief

- Pain relief was managed primarily by consultants on critical care, using mainly IV or oral medicines.
- Staff used a standardised scoring tool to assess patients' pain. Patients told us they were regularly asked if they had pain and were given medicines quickly if requested.
- The Critical Care Pain Observation Tool (CPOT) was used to assess pain in non-communicating patients. The CPOT assessment was completed in all records we reviewed for appropriate patients.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed on a daily basis by the nursing staff using the Malnutrition Universal Screening Tool (MUST). In most patient records we observed the MUST assessment had been completed and documented.
- Patients receiving enteral feeding were reviewed by a dietician on a daily basis during weekdays. Other patients could be referred to the dietician when concerns about nutrition were identified; for example as a result of a raised MUST score. Staff were unclear about accessing dietetic support at weekends.
- We observed fluid monitoring in place for certain patients, which demonstrated hourly and daily fluid input and output totals. For fluid overloaded patients, restrictions were in place, documented and adhered to.
- Patients who were able to eat and drink were seen to be offered a choice of food and drinks. Drinks were observed to be within patients' reach when appropriate.

Patient outcomes

- The ICNARC Standardised Mortality Ratio shows a trend towards improved outcomes on critical care. Mortality rates lie within the expected range when adjusted for case-mix in comparison with other data submitted by similar units.
- The average length of stay on critical care was 5.8 days in March 2015, which was longer than in comparable units.
- Fewer patients were transferred out of the unit for non-clinical reasons in the last year than in comparable units, although in February and March 2015 one patient each month had to be moved.
- Unplanned re-admissions to critical care within 48 hours from unit discharge and after 48 hours were in line with other similar units, with approximately 2-3 patients per month returning to the unit.
- The majority of patients returned to their pre-admission residence and previous level of independence on discharge from hospital.

Competent staff

Nursing Staff:

Critical care

- There was one full time Practice Development Nurse (PDN) for the critical care unit, which is in line with core standards. Staff told us there had recently been a lot of newly recruited nurses and that one PDN was not enough.
- New starters attended an Introduction to Critical Care course within the first few months of working on the unit. Staff told us this had given them confidence as it supported bedside learning. Staff also had the opportunity to attend physiology, intensive care and mentorship courses as part of their development.
- Fifty per-cent of critical care nurses had completed an intensive care course. This was just in line with the Faculty of Intensive Care Medicine's standard that a minimum of 50% of registered nursing staff should be in possession of a post registration award in Critical Care Nursing.
- Senior staff told us the tool used for allocating nursing staff to shifts took into account who had additional intensive care qualifications, to ensure a suitable skill mix for each shift.
- Staff had to achieve specific competencies before completing certain aspects of patient nursing, such as tracheostomy care.
- Nurses completed a test overseen by the PDN to be able to administer oral medications and then a second assessment to administer IV medications. If medicine errors occurred, these were addressed with staff and, where necessary, the relevant assessment would be taken again.
- Agency staff had an induction to the unit on their first shift and would be allocated a patient next to a permanent member of staff if possible so that they were supported during their work.
- Computer records showed that 60% of critical care nursing staff had received an annual appraisal. We were told the new computerised system had been introduced during 2014 and so not all staff without an appraisal on the computerised system were overdue as they still had an in-date paper version. We saw records to support this and staff we spoke with told us they regularly received appraisals.
- Staff could have bedside training from the PDN or their mentor if arranged. They also had the opportunity for one-to-one performance review sessions.
- Senior staff described their staff retention plan which supported a two year development programme for band five nurses, before moving onto an 18 month programme at band six level.

Medical Staff:

- Of the five critical care consultants who worked on the unit, three worked cross-site at Denmark Hill. All critical care consultants had additional intensive care qualifications.
- Junior medical staff were mainly staff grade doctors who had worked on the unit for a long time. There were also doctors on rotation to the unit as part of their on-going training scheme.
- They received 1.5 hours formal teaching each week as well as bedside teaching from consultants during ward rounds. They had opportunities to lead various training sessions, such as journal clubs and audit feedback.
- One doctor told us they enjoyed working on the unit, despite it being very busy and they valued the support provided by the whole team.

Multidisciplinary working

- Senior staff were enthusiastic and committed to patients and the critical care unit. Staff were positive about the acquisition by King's College Hospital NHS Foundation Trust and felt it was an opportunity to develop skills, knowledge and patient care. There was a strong emphasis on working collaboratively with the critical care units at Denmark Hill and one member of staff told us there is "no more us and them".
- Management staff had a great deal of pride in the changes made in critical care since the acquisition and wanted to show us examples of where best practice had been adopted at Denmark Hill critical care based upon practice at Princess Royal University Hospital. An example of this was the new cross-site care plans which were based primarily on those previously used at the Princess Royal site.
- Care and treatment of patients in critical care was the responsibility of the consultant intensivists on the unit. When patients were discharged from the unit, they were placed under the care of a relevant surgical or medical consultant. One critical care consultant told us it was difficult to get medical physician input for critical care patients who had been admitted via A&E because they had not been seen by any of the ward consultants previously. Surgical patients were reviewed by their

surgical team daily but we were told there were concerns about their lack of documentation after reviews. Staff also told us it could be difficult to ensure the correct specialism consultant picked up patients on discharge from the unit.

- The acute physiotherapy team consisted of one band eight, one band seven, two band six and two band five therapists. The band eight and band seven therapists were dedicated to critical care patients. Staff told us there were no formal multidisciplinary meetings but the senior physiotherapist attended the daily board round to receive referrals and set patient goals.
- An emergency on call physiotherapist was available overnight and at weekends.
- Speech and language therapy input was provided by an external provider but nursing staff told us there was insufficient access to these therapists.
- Staff told us it was rare to see occupational therapists on the ward as they were short staffed and focused on patient discharges within the hospital rather than rehabilitation of critical care patients. However, ICNARC data showed that almost all patients were discharged back to their pre-admission residence and at the same level of independence as prior to their admission.
- A daily board round was held on the unit which was a short patient briefing and an opportunity to make or receive MDT referrals. This was attended by medical staff, pharmacy, physiotherapy and dietetics. No occupational therapy or speech and language staff attended due to short staffing.
- Staff told us physiotherapists and nursing staff worked closely together to complete rehabilitation with patients and therapists told us they felt this worked well. Patient rehabilitation goals were set by the physiotherapist who attended the board round, not necessarily by the therapist seeing the patient. Patients and their families had limited involvement in goal setting.
- Doctors worked collaboratively with nursing and physiotherapy staff to plan and implement ventilator weaning programmes (when patients' reliability on breathing machines is reducing and they are able to do more breathing on their own). Staff told us this ensured a joined up and coordinated approach.
- Staff told us MDT meetings were not routinely held although might be considered for long term or complex patients.

Seven-day services

- The unit had a consultant present from 8am to 8:30pm every day and on call overnight, with a response time of 30 minutes. There was a registrar available 24 hours each day and they were supported by junior doctors during long day shifts.
- Medical staff told us there was no problem accessing imaging services, such as x-rays or CT scans, out of hours or at weekends.
- Microbiology support was available via telephone within the trust at all times.
- The iMobile team was available 24 hours a day throughout the week, with one member of staff rostered to work. It was unclear what provision might be available if this person was off sick.
- Emergency respiratory physiotherapy cover was available overnight and at weekends, on a bleep referral basis.
- Chaplaincy services were available 24 hours a day, seven days a week.
- Staff told us support from the biomedical engineering (BME) department was available during "office hours" during the week and at weekends. An engineer from BME told us work on critical care was always prioritised and they received a fast response.

Access to information

- When patients were admitted to the unit, medical details were passed on via their medical notes from their previous ward or A&E. A verbal handover took place between the medical teams and also nursing staff.
- On discharge from critical care, a brief discharge summary was printed for each patient which described their past medical history and key points of care. Again, a verbal handover was completed between medical staff and also nursing staff.
- On admission to the unit, patients and their relatives were given a Critical Care Unit Information leaflet, outlining key information and what to expect. Other information leaflets were available for visitors in the entrance corridor to the ward.
- Safety Thermometer information was clearly displayed at the unit entrance, while a noticeboard in the visitors' waiting room provided other information, such as how to make a complaint and how to access pastoral support.
- Staff obtained most of their in-house information via the hospital intranet site. This included links to policies,

procedures, mandatory training and emails. There were three computer terminals available at the nurses' station and staff told us they could usually access the computers when needed.

Consent and Mental Capacity Act

- All levels of staff could describe how they would seek consent, where possible, from patients prior to procedures being undertaken. Where consent could not be obtained, such as if the patient was unconscious, staff told us care was provided in the patients' best interests; for example, repositioning patients to avoid pressure ulcers.
- Patient's relatives told us they were asked to help guide patient care when the patient was unable to make decisions for themselves.
- Mental capacity assessments were completed for people who were suspected as not having capacity to consent. Key information about mental capacity protocols and Deprivation of Liberty Safeguards (DoLS) could be found in the critical care patient safety analysis booklet and staff knew where to find this.
- Best interest conversations were held with family or independent advocates where appropriate. Staff described a situation when an Independent Mental Capacity Advocate (IMCA) had been appropriately used to support a patient with a learning disability and no next of kin.
- Staff told us the unit had close links with Green Parks House, which was a mental health unit located opposite the hospital. Psychiatric review to support Mental Capacity Act 2005 (MCA 2005) or DoLS assessments could be initiated by nursing or medical staff.
- We were shown documentation relating to DoLS assessment for patients using 'mittens' to stop them accidentally removing IV lines and ventilator tubes, following Royal College of Nursing guidance to use the least restrictive method of restraint available. At the time of our inspection, no patients were subject to DoLS and so no documentation was available to review.

Are critical care services caring?

Good

We found the critical care service was caring. We observed staff speaking kindly to patients and visitors while meeting individual care needs. Nursing staff were described as being attentive and friendly by relatives. Family and friends were encouraged to write in patient diaries alongside staff and told us they felt involved in the decisions about care of their loved one, although information was sometimes communicated in a way that was not easily understandable.

Emotional support was provided routinely by nursing staff or chaplaincy services could be accessed if patients or their families preferred. Staff were observed to introduce themselves but patients told us they struggled to tell who was who because nurses, doctors and physiotherapists all wore theatre scrubs on the unit.

Confidentiality had potential to be breached as visitors could overhear discussions about other patients during ward rounds. We also observed staff on the ward round sometimes speaking over the patient, rather than including them in care discussions.

Compassionate care

- We reviewed 29 recent patient and relative feedback questionnaires; all had positive comments. One person described the nursing staff as "friendly, kind, thoughtful and so attentive". All respondents felt that their friend/family member had been treated with dignity and respect and we observed staff pulling curtains fully around bed spaces for interventions.
- Individual care needs were usually met by staff, such as mouth care at regular intervals for a patient who was unable to eat or drink, as well as when the patient requested additional input. We saw staff ensuring a patient's hearing aid was suitably placed and working appropriately. One patient described staff as providing "everything you need".
- Staff worked quietly on the unit, with little unnecessary discussion amongst themselves. They spoke gently to unconscious patients as they approached and prior to touching them. Staff explained what they were doing when completing procedures or providing personal care, even to unconscious patients.
- We observed most staff interacting with patients and their visitors in a respectful and considerate manner, such as asking how they were feeling. However, we saw one member of staff asking a patient personal questions loudly from the edge of the bed space, rather moving closer to the patient for a more private discussion.

Critical care

- Patients told us staff regularly asked if they were in pain and were given pain-relieving medication efficiently when needed.
- One relative told us staff had gone out of their way to make sure they were "as comfortable as possible" when visiting their loved one and described staff as "absolutely fantastic".
- Confidentiality could be compromised during afternoon ward rounds, as visitors were not routinely asked to leave the ward. This meant they could potentially overhear confidential conversations happening with patients other than their relative. We discussed this with senior nursing staff and we were told relatives were asked to leave during ward rounds "on a case by case basis only".
- Staff introduced themselves to patients, but nurses, doctors and physiotherapists all wore similar coloured theatre scrub uniforms on the unit and patients told us they sometimes struggled to tell who was who.

Understanding and involvement of patients and those close to them

- Patient diaries were started for all ventilated patients on the day of their admission, to assist patients to reflect on their admission retrospectively. Family and friends were encouraged to make entries in the diary alongside staff.
- Patients and their families told us they felt involved in decisions about their care and they had been able to ask questions. Some patients told us they were unclear about certain aspects of their care as explanations had been confusing. One relative said she felt "involved and informed, every step of the way" when discussing her relative's care plan.
- Patients were encouraged to make decisions where they were able, such as what to eat or drink and when to wash. Nurses supported and guided patients to make these decisions. For long-term patients, staff requested family members bring the patient's own clothes into the hospital.
- We observed a ward round in the unit and saw the team sometimes talked over the patient, rather than including them in care discussions.
- Hospital data from April 2014 to March 2015 showed that out of 15 patients, who had been identified as no longer having activity in their brain stem (known as brain stem death), eight patients had donated organs or tissues.
- The specialist nurses for organ donation worked closely with the chaplaincy team to support families when their relative had been identified as dying and suitable for organ donation.

Emotional support

- We were told nurses provided emotional support to patients and their families routinely. Feedback from patients and relatives was positive and they told us staff had been reassuring and comforting.
- Patients and their families had 24 hour access to a chaplaincy service and we were given examples of when the chaplain had provided emotional support to families on the unit.
- Bereavement counselling could be accessed via a referral from the critical care unit.
- Staff could provide information about additional, external support networks if required by the patient or their relatives

Are critical care services responsive?

Requires improvement

The responsiveness of critical care requires improvement. The unit was very busy and occupancy on the critical care unit consistently ran above 100%, with two 'satellite' critical care beds opened in theatres recovery to mitigate the bed shortage. Discharges out of critical care were regularly delayed due to lack of bed availability in the rest of the hospital and this had a knock-on effect of creating further access difficulties for other patients. An increasing number of patients were transferred from critical care out of hours. The high capacity levels also caused mixed sex breaches on the unit.

Staff used a variety of communication tools, such as picture boards and translators, when needed, giving patients the opportunity to make decisions about both their care and day-to-day tasks. Patient passports and 'This Is Me' booklets were used for patients with a learning disability or dementia respectively. Social work or safeguarding referrals were triggered by checklists in the critical care patient safety analysis booklets.

Visiting hours were in the afternoon only but could be flexible if discussed with the nurse in charge. Facilities for

visitors were limited to a small waiting room with no drink making facilities or a specified toilet. Visitors could stay overnight in the ward quiet room, but this was not a purpose built facility.

Service planning and delivery to meet the needs of local people

- Most patients accessed critical care via the A&E department. Senior staff told us how receiving most of their patients from A&E made service planning difficult, as patient flow was unpredictable.
- Between January and March 2015, 88% of patients admitted to critical care via A&E were general medical patients. Patients were also admitted from wards or following elective surgery. Other patients from within the hospital also accessed the critical care unit if their health deteriorated.
- Between April 2014 and March 2015, 60% of patients admitted to critical care required level three support.
- When patients were well enough to be weaned from ventilation, an MDT approach to weaning was used. This included a weaning plan and goal setting to ensure suitable progress. Patients with a tracheostomy (a tube placed in the windpipe via an incision in the neck for the patient to breathe through) could access portable ventilators to allow progression of their rehabilitation while still receiving support with their breathing.
- Visiting hours were 2pm-7pm daily and visits were limited to two people per bed space. Visiting was allowed outside of these times if agreed with the nurse in charge, or in exceptional circumstances. On the day of our unannounced inspection, we spoke with relatives who told us they had been allowed to visit their relative at 9am as he had become unwell overnight and they were worried. They felt welcome on the ward despite it not being within normal visiting hours.
- There was a small waiting area for visitors within the critical care unit, which was, at times, not large enough for the number of people waiting to see patients. We observed some visitors waiting in the corridor before being able to see their loved one.
- There was a noticeboard with information about the Patient Advice and Liaison Service (PALS), visiting times and chaplaincy services displayed. Patient and relative feedback questionnaires were available to complete, with a box situated within the room for ease of return, and previous results were displayed on the noticeboard. There was also an acknowledgement of the inadequacies of the waiting area and details of how the unit was aiming to address these.
- No drink making facilities were available for visitors.
- Visitors could stay overnight in the ward quiet room if they wished; the room had a sofa-bed and an adjacent shower but it was not a purpose-built facility.
- Patients had access to a critical care follow up clinic, which was run by the critical care nursing team. During this clinic, patients had a one hour appointment during which they could reflect upon their critical care experience and discuss anything they were unclear about. Patients also had the option of visiting the unit if they wished.

Meeting people's individual needs

- Patients with a learning disability had information passports which were used throughout the hospital to identify important information about the patient and how best to interact with them. Staff told us they also relied upon the patients' family to support their admission. A patient passport and referral to the safeguarding team would be triggered upon completion of the basic psychological assessment checklist in the CCPSA booklet.
- The CCPSA could trigger a social work or safeguarding referral for those considered as vulnerable adults according to the basic psychological assessment checklist.
- Patients living with dementia were identified to staff by having a flowered sticker placed on the outside of their medical notes. The purpose of this was to make the patient's needs easily identifiable from the outset. These patients had a 'This is Me' information booklet started, if there was not already one available from the community or in their medical notes.
- Staff told us the unit had close links with Green Parks House which was a mental health unit located opposite the hospital. Patients could be referred for a psychiatric review, which could be initiated by nursing or medical staff if required.
- Patients were not routinely asked if they objected to having a staff member of the opposite sex caring for them. If a preference was expressed, staff would attempt to fulfil this as much as possible, but senior staff acknowledged this could be impossible at times. They

told us that in these circumstances, they would ensure intimate care was only performed by someone of the same sex but that other interventions, such as blood taking, could not be guaranteed.
- Staff were able to describe various formats of communicating with patients who could not speak, such as pen and paper, picture charts and using closed questions.
- A translation service was available for patients and families. The main service was available via a telephone system but face-to-face translation could be booked if needed. Staff told us they might also use patients' family members or other members of staff if difficulties with obtaining translation services occurred.
- Various information leaflets were available on the unit and these could be provided in large print or in other languages if required.
- Mixed sex breaches had occurred frequently over the last six months. A mixed sex breach occurs when level one or zero patients are placed on an open ward area with a member of the opposite sex. Staff told us clinical need was always put first when organising the unit, which made avoiding breaches difficult. Mixed sex breaches should occur infrequently on critical care units, as patients are stepped down to a ward once they reach level one dependency. Due to the lack of beds within the hospital, patients from critical care were not always discharged in a timely manner, leading to these breaches occurring.
- Visitors with physical difficulties were required to seek help from the hospital reception desk if they were unable reach the intercom buzzer or open the ward door once they had been allowed access.

Access and flow

- Critical care had ten beds available on the unit and was funded to provide six L3 beds and four L2 beds, but has the flexibility to accommodate ten L3 patients. The critical care unit was extremely busy and had been at over 100% occupancy in the previous four months prior to the inspection.
- To mitigate the busy winter period, up to two additional 'satellite' ITU beds had been opened in theatres recovery, staffed by critical care nurses. This extra capacity was on the risk register for the department. In January and February 2015, 11 patients each month were cared for in satellite beds and this increased to 14 patients in March 2015. We were told that L2 patients would be transferred to this area, prioritising L3 patients in the main unit.
- There was a protocol in place that meant these extra beds would not be opened if there was a patient on intensive care who could be transferred to a ward if a bed was available.
- It was acknowledged amongst staff of all levels that critical care capacity was insufficient and senior staff mentioned a potential expansion plan. This plan was only in its infancy and so there was no supporting documentation for this.
- The largest proportion of critical care patients access the unit via the A&E department. Hospital data from January to March 2015 showed that although 56% of patients were transferred within the four hour decision to admit to actual admission national standard, patients waited an average of five hours nine minutes until they were transferred to the unit. In this timeframe, five patients were cared for in A&E for over 11 hours while waiting for a critical care bed.
- Patients within the hospital were assessed by the iMobile team prior to admission to critical care. iMobile nurses would support ward-based staff to care for patients requiring escalation prior to being transferred.
- Very few patients were admitted to critical care following elective procedures. This meant that it was rare for elective operations to be cancelled on the basis that there were no critical care beds available. Records showed that this had occurred twice in the twelve months up to March 2015.
- Staff told us there were difficulties discharging patients from the critical care unit due to a lack of bed availability in the rest of the hospital. The critical care scorecard from January to March 2015 showed over 40% of patients' ITU discharges were delayed by more than four hours. In March 2015, ten patients were delayed more than 12 hours to be discharged to the ward from ITU. This could lead to access difficulties for patients requiring a critical care bed.
- An increasing number of patients were discharged from the unit between 10pm and 7am in recent months, most notably in March 2015 when eight patients were transferred overnight. Discharges from critical care out of hours is against national patient safety guidance and the core standards.

Critical care

Learning from complaints and concerns

- Information provided by the unit showed there had been no formal complaints about the unit in the last year. Most concerns raised by relatives were dealt with informally on the unit by nursing staff.
- Some relatives told us they were aware of how to make a complaint and could reference posters advertising PALS in the waiting area. They felt they could also discuss any problems with staff on the unit.
- Staff identified a common theme of negative comments from friends and family feedback related to the visitors waiting area being too small. We were told that there is a plan for the unmanned reception area and the quiet room at the entrance of the unit to be converted into a larger waiting area. No specifics for this plan were available at the time of our inspection.

Are critical care services well-led?

Requires improvement

Leadership of the critical care unit requires improvement. Managers were able to identify some goals for the service, such as increasing cross-site learning but did not provide evidence of steps being taken to achieve this. Junior staff were unaware of senior staff intentions to develop the service. Senior staff were enthusiastic about potentially expanding the unit but, again, ward staff were unaware of any expansion plans beyond opening the two satellite beds that had occurred already. We noted some oversights in day-to-day management of the unit, such as tasks not being reallocated once someone had left their post, and lack of awareness of some important issues, such as poor record keeping.

A change in consultant staffing after the acquisition had strengthened clinical leadership on the unit. Staff told us the immediate management team were visible and provided supportive leadership. Staff we spoke with and observed on the unit demonstrated a positive and cohesive approach to their work. Teamwork and learning on the job were actively encouraged by management. The introduction of a 24 hour iMobile team, provision of the high flow oxygen service and introduction of new CPAP masks demonstrated innovative practice on the unit.

Quality was measured through a series of audits, such as hand hygiene and ventilator optimisation. Adequate assessment of risk occurred and the unit risk register largely reflected our inspection findings. Senior staff had encouraged incident reporting and cascaded information to staff via emails and newsletters. Management were keen not to instil a 'blame' culture relating to incidents.

Vision and strategy for this service

- Senior management, nurses and consultants told us they envisaged the service developing to provide a larger number of critical care beds. Plans to permanently expand the service were in their infancy and so there was little documentary evidence of this.
- Ward staff knew the limitations that current bed numbers provided, but those we spoke to were not aware of a plan to address this issue beyond the opening of two satellite beds in recovery.
- The vision for the trust was widely viewed as embedding partnership working across all sites. Staff we spoke with were enthusiastic about this and felt it would offer opportunities for personal as well as service development.
- Ward staff were generally aware of values held by the trust and some could explain how this would translate into their day-to-day work. One nurse mentioned "aiming higher" and told us this meant they were always trying to improve the care they provided to patients.
- All staff were committed to improving patient care and we were told of aims to develop the research involvement of the critical care unit, both at local and wider levels.
- Senior staff explained their commitment to improving critical care outcomes and described a number of quality measures they were hoping to implement, such as a pain clinical audit programme and a pharmacy audit.
- Examples were also provided of action plans relating to recent publications, such as the anaesthesia sprint audit of practice as well as audit of blood sampling and labelling. Staff expected the implementation of these plans would develop the critical care service and improve outcomes for patients.

Governance, risk management and quality measurement

- The unit was engaged with governance activity within the hospital and had representation at a range of relevant meetings across the trust, such as morbidity and mortality meetings (providing staff with the

opportunity to discuss errors and adverse events in an open and learning-based forum), as well as quality governance committee meetings (which assessed the quality of governance mechanisms).

- There was a monthly risk and governance meeting where incidents were discussed by senior nursing staff and the medical team. Information from governance meetings was disseminated to ward staff via emails or in the staff newsletter. Staff told us they only received feedback about specific incidents if they requested it. Information from governance meetings would also be considered as part of the 'Big Three' themes for the month which were reiterated during each handover session.
- Governance of critical care was also reviewed within divisional clinical effectiveness meetings. Within these meetings, discussions were held to ensure the unit met national standards. We were shown a presentation from the most recent meeting which included details about on-going and up-coming clinical audits and their implementation deadlines.
- The senior team told us staff had been encouraged to use incident reporting as a way of highlighting issues in the workplace so that changes can be made. We were told nurses were fully on board with this as they had received funding for additional staff as a result of incidents being submitted. Staff said the medical team had been slower to fully engage with incident reporting but that this was improving.
- The unit maintained a risk register, including concerns and assessments of potential risks on the unit. This was reviewed regularly within risk meetings and classifications discussed and modified as required. The contents of the risk register largely supported our inspection findings which showed they were aware of and monitoring the issues.
- The most recent control of substances hazardous to health (COSHH) risk assessment provided to us by senior nursing staff was dated 2011 and related to the hospital prior to the acquisition by King's College Hospital NHS Foundation Trust. The senior member of staff this was discussed with was unaware this assessment needed to be completed.
- Action plans addressing the quality of data collected for the ICNARC database, were in place as part of the unit's on-going service improvement plan.
- The unit completed routine audits such as weekly hand hygiene, IV line and care bundle audits. We were told notes audits used to happen regularly but these had been replaced by 'spot checks' only. Senior staff were surprised when we described the gaps we had observed in patient notes on the unit.
- Staff described a recently completed doctor-led audit which revealed 60% of patients were being over-ventilated when breath volumes were considered against their body weight. This was now being addressed to modify practice on the unit.

Leadership of service

- Divisional management expressed pride about the work done by the critical care unit. They acknowledged a significant change in culture and atmosphere on the unit and told us how it positively affected patient care. They also expressed pride in the managerial development of specific staff on the unit, including their leadership and the knock-on effect this had had.
- Clinical leadership was the responsibility of the Clinical Director, who worked closely with the Lead Consultant and nursing management.
- Staff told us a big change in consultant staffing following the acquisition had reinvigorated the critical care team and provided a new, much improved style of day-to-day leadership on the unit.
- Doctors felt supported by the wider team, as well as their medical colleagues, and told us they received good support from the consultants.
- There was a matron responsible for overseeing the critical care unit, with managerial support from the on-site Deputy Head of Nursing, and cross-site Head of Nursing respectively. They reported to the Divisional Director.
- Staff told us they received good support from the nursing managers, especially from Matron. They spoke positively of all levels of critical care management and felt they were approachable if concerns needed to be raised.

Culture within the service

- Staff had a positive and cohesive approach to their work. Staff worked together to complete patient care tasks, check medicines and share knowledge. We observed staff asking senior colleagues for guidance and advice being passed on in a patient and supportive manner. Staff treated each other respectfully and appropriately on the unit.

Critical care

- We observed good working relationships between substantive and agency staff. Substantive staff valued their agency colleagues and acknowledged that they would have many staffing gaps without them.
- Staff told us the culture on the critical care unit had previously been very hierarchical and that challenge had been unwelcome. A staff member told us working on the unit was "very different now compared to before [the hospital was acquired by King's College Hospital NHS Foundation Trust]. We can give our opinions and they listen".
- Managers and ward staff expressed pride in their roles, in the progress that had occurred in the unit over recent months and in the development of skilled ward staff.
- Staff sickness data (June 2014 to February 2015) showed a higher than average sickness percentage.

Public and staff engagement

- Staff told us they were aware of who the executive board members were and had seen them previously, but that they rarely visited the unit. Staff were positive about interactions with senior management that had occurred.
- Senior critical care management staff who were based within the hospital were seen regularly on the unit.
- Staff were encouraged to come forward with ideas to develop the service and to provide feedback about recent changes. We were told the critical care ward staff were heavily involved in the development of the new cross-site patient care plans.
- Relatives and patients could complete feedback forms and were encouraged to provide additional feedback on their follow up clinic visit. The response rate to feedback forms was consistently poor. For example, 12 forms were received from a potential 61 patient discharges in March 2015. Staff received feedback from these surveys via posters displaying results on noticeboards and via the staff newsletter.
- When staff passed specific courses or attained any relevant work-based achievements, their accomplishment was acknowledged in the staff newsletter.

Innovation, improvement and sustainability

- There were hopes of creating additional critical care beds within the hospital; however this was only in the early stages of planning. The senior management team were very aware of the capacity issues faced by the critical care unit and felt that space limitations, as well as busy caseloads, were limiting what innovation could occur.
- We were told that the PDN had little opportunity to introduce innovative practice, as significant time was taken up inducting and supporting new starters.
- Staff described the trust-wide research programme, which was focused primarily at Denmark Hill. Staff expressed their wish for further involvement in this research.
- Senior management told us they were keen to promote even more collaboration within critical care across the trust and were investigating options of staff rotating between sites to maximise learning and development.
- The introduction of the 24 hour iMobile team was viewed as a very positive development across the critical care team. One nurse told us patients were being admitted sooner than before and so they were not as unwell by the time they received critical care.
- It was hoped that the iMobile team would increase staffing to two nurses overnight to provide support for the ITU registrar.
- The iMobile team rolled out a new high flow oxygen service on one of the medical wards at the start of 2015. iMobile assessed and initially applied the high flow oxygen. They then supported the ward staff in caring for the patient. In January, they had ten referrals for this service and eight patients remained on the ward rather than being admitted to critical care as a result of this additional breathing support.
- Staff described recent innovation in applying non-invasive ventilation via total face masks, rather than the standard nose and mouth mask. They told us they hoped this would address pressure issues related to the standard masks and improve patient care.
- Senior staff told us of positive patient feedback relating to the critical care follow up clinic and the staff hoped to expand this availability.
- Several staff described financial pressures relating to the trust and the knock-on effect this had on critical care. We were told no critical care bed closures were being considered and that expansion was likely.

Maternity and gynaecology

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

Information about the service

The Princess Royal University Hospital provides all services relating to pregnancy including antenatal clinics. The hospital has a Maternity Day Assessment Unit (MDAU). A maternity ward with 30 beds (post-natal ward), 2 bed triage ,and two 4-bedded bays are in the Labour Ward along with 10 delivery rooms (consultant- led delivery suite), The Oasis birth centre, which is midwife-led, has six rooms, two with birthing pools. The consultant-led delivery suite has 10 delivery rooms and the postnatal ward has 30 beds.

Each year about 5000 women deliver their babies in the maternity unit.

Antenatal clinics are run in the hospital and in the community. About 820 women a month attend antenatal clinics at the hospital. Other women are cared for by community midwives, employed by the hospital, at various locations in the local area.

There are two dedicated theatres within the maternity unit, one for planned caesarean sections and the other for emergency obstetric surgery.

The gynaecology service provides in-patient and outpatient gynaecology services including an Early Pregnancy Diagnostic Unit (EPDU) and 900 outpatient sessions a month, about half of which are new appointments. Gynaecological surgery is carried out both in the Alan Cumming Day Surgery Unit and the main theatres. The hospital also provides inpatient care after planned surgery for women seen by consultants at the Denmark Hill site. Bromley patients needing specific gynaecology day procedures attend both Orpington Hospital and PRUH.. The gynaecology ward has 16 beds,

We visited all inpatient areas of the gynaecology department and maternity service as well as outpatient areas. We talked to over 50 staff, spoke with 14 women and reviewed patient records as well as other documentation. We received comments from our listening events and from people who contacted us to tell us about their experiences.

Maternity and gynaecology

Summary of findings

Overall we judged the maternity and gynaecology services to be good.

Maternity care was based on national guidelines and evidence based, and processes and procedures supported safe and effective care. The shortage of midwives had been addressed and there were enough staff to meet the needs of women, with recruitment in hand to fill remaining vacancies.

Staff had relevant training and a good awareness of safeguarding issues. Outcomes for women were positive. Women had choices during birth and were involved in decisions about their care. Twenty per cent gave birth in the birth centres and the caesarean section rate had been reduced to below the national average. The antenatal department offered a comprehensive screening programme.

Staff on the maternity unit were friendly and supportive. The atmosphere was calm.

The acquisition of the hospital by Kings College Hospital NHS Trust had caused significant change, but most staff in maternity and gynaecology considered that it was bringing about improvements. The increase in staff numbers had been particularly welcomed and we found a positive culture with optimism about the future. Leadership was evident in the changes to the service, such as the review of midwifery staffing and the reorganisation of gynaecology services across all hospital sites within the trust.

Are maternity and gynaecology services safe?

Good

We assessed both the maternity and gynaecology services to be good. There were effective procedures to ensure that women received safe care. There was an open culture in which incidents were reported and lessons learned by key themes being shared with staff.

All areas we visited were visibly clean and we had no concerns about infection prevention and control. Medicines were managed safely and stored securely and equipment was regularly checked. Patients' notes were clearly documented. There had been an on-going problem with the availability of some patient notes since the hospital had been acquired by the King's College NHS Foundation Trust but this was a corporate issue rather than one for women's services. Steps had been taken to mitigate the impact of this and there was evidence of improvements.

There were arrangements for assessing and responding to patient risk. The modified obstetric early warning system (MEOWS) was used to detect women becoming more unwell, and staff knew what action to take.

Midwifery staffing levels were adequate although there remained some vacancies. We saw good examples of team working. The gynaecology ward was staffed to the agreed establishment.

Incidents

- It is mandatory for NHS trusts to monitor and report all patient safety incidents. We looked at the root cause analysis reports of three serious maternity incidents including an investigation into a maternal death. Each report provided a detailed account of the event, the outcome and the root cause of the incident. Serious incidents were reviewed at maternity governance meetings and the trust's Serious Incident Committee. Action plans included details of the objective, actions required, start date and the person responsible for monitoring progress. Staff were aware of the serious incidents that had taken place at the hospital and

thechanges to practice introduced as a result. An example of such a change was to stagger induction of women so that women were less likely to go into labour at the same time.

- After a serious incident midwives involved were debriefed by the risk manager and their 'buddy' midwife. A group debriefing was also offered to a wider range of staff in the unit. and many attended. The supervisors of midwives (SoMs) debriefed the midwives they supervised. A SoM attended the weekly Incident Review Meetings that discussed significant cases and tracked and closed less serious incidents.
- Quarterly perinatal mortality meetings reviewed mortality and morbidity at a high level. Serious incidents were discussed and analysed as part of decision making to reduce risk in the department. Changes that had been made were to implement a new rota for increased consultant presence on the labour ward and the development of a neonatal morbidity action plan.
- Midwives told us that they reported incidents, including staff shortages. Thirteen incidents relating to insufficient staffing had been reported in the previous quarter (October - December 2014) as well as 10 relating to late attendance by consultants. Such incidents were classified as near misses. At ward meetings staff received feedback on incidents and a safety briefing on trends in incident reports. The feedback was used to reinforce good practice such as recording MEOWS scores, for women having induction of labour. One of the 370 maternity incidents had been reported in the last quarter of 2015, had been graded red, a serious incident and seven had been graded amber one of which had resulted in minor injury and one moderate injury.
- The risk manager covered both maternity and gynaecology. Incidents were reviewed weekly and those rated amber and above were investigated. There was a plan to involve more community midwives in the incident review process, on a rota basis. Staff always received feedback if an incident had caused harm. Feedback was also given through ward meetings and specific themes were included in the monthly 'Maternity Risk' newsheet. For example, the March issue reminded staff to ensure all babies had the correct notes, and of the use of thrombo-prophylaxis and antibiotics for women who had a third degree tear. Midwives reported an improvement in risk management over the past year.
- There was no formal mortality and morbidity meeting in gynaecology. Any issues were reviewed as part of risk management meetings.

Cleanliness, infection control and hygiene

- Every ward and department that we visited was visibly clean. Cleaning schedules were on display, and cleaners understood cleaning frequency and standards and said they felt part of the ward team. Women confirmed that there were good standards of cleanliness. However, visitors told us that cleaning of public areas was less good at weekends.
- There had been five instances of bacteremias (serious blood stream infections reportable to the Department of Health) in maternity between April 2014 and March 2015. One Clostridium difficile and four of E-coli two in women and two in babies.
- We observed staff washing their hands or using hand gel between women. Staff told us there were daily hand hygiene audits because audit scores had been low past year, and any staff not complying with standards were named and shamed. Staff adhered to the trust's 'bare below the elbow' policy. There was ready access to personal protective equipment and clear guidelines on infection control,(for example for different types of isolation for specific infections). We observed an example of adherence to isolation policy on the gynaecology ward.
- Midwifery staff were aware of cleaning procedures for birthing pools.

Environment and equipment

- Staff we spoke with told us they generally had sufficient equipment on the wards for the safe monitoring of women and babies. In the recovery area staff were temporarily using cardiotocography (CTG) machines to monitor women's blood pressure, pulse and oxygen saturation levels until the dedicated wall-mounted vital signs monitors, that were on order, arrived. This was on the risk register but was being appropriately mitigated..
- An equipment library had been set up at the hospital. Staff were using this and expected it to prevent staff borrowing equipment from wards and not returning it.
- Resuscitation equipment was in line with national guidance and checked regularly. When drugs or equipment needed to be replaced this was signed as

completed when done. Checking had been a concern at our previous inspection in December 2013. On this inspection we found that checking of resuscitation trolleys complied with expected standards.

- There was currently no formal High Dependency Unit on the labour ward. One delivery room was available for use when women needed higher levels of observation and some midwives had been trained in managing women who required a higher level of care. The case for a full high dependency facility for maternity had been agreed after a serious incident. The new facility would be available in November 2015.
- Some part time community midwives had to share equipment. The neonatal 'on call' resuscitation bag was fully equipped but there were only three bags. Midwives told us they did not all need a full resuscitation bag but that it would improve safety if they carried a neonatal Ambu bag (hand held resuscitator) as part of their standard equipment.
- The new gynaecology ward, S8, was being ring fenced for women having gynaecology treatment. This enabled Denmark Hill hospital patients needing planned gynaecology surgery to have their surgery at the PRUH where a post-operative bed could be guaranteed.

Medicines

- Staff were aware of medicine management policies. We found that medicines were stored appropriately and that controlled drugs, were recorded showing time and date of administration to a named patient. Drug charts in patients' notes were fully completed.
- In a controlled drugs audit in September 2014, the gynaecology ward had scored well. The maternity unit had scored less well on 3 of 10 standards. The policy had been changed, all ward managers had received a memorandum about the changes required to bring wards into line with trust policy and staff had changed their practices accordingly.

Records

- All women attending maternity clinics carried their own hand held notes. However, the hospital maintained fuller notes for some women who attended other hospital clinics for medical problems or for whom there was safeguarding information. These were known as 'ghost' notes. The tracking system was reported to have become less robust since the introduction of the Patient Information Management System (PIMS) in November 2014 which meant that doctors sometimes saw women without full notes. Staff had sought ways of minimising the potential risk to women through tighter tracking of 'ghost' notes, and labelling the front of folders showing where the notes were kept. They considered this had helped mitigate the problem. The availability of patient records was a high risk on the corporate risk register. This was to a large degree out of the control of women's services.
- We reviewed a sample of patient records in obstetrics and gynaecology. They had been completed with relevant clinical information and signed and dated in accordance with guidelines. Women we spoke to understood their care plans. Quality of records had been noted as an issue in our inspection in December 2013. On this inspection we saw evidence of appropriate record keeping.
- In the past year gynaecology patients' notes had not always been available for clinics and procedures. Courier arrangements had been set up to bring notes from the Denmark Hill site to the PRUH which had significantly reduced the risk of surgery being cancelled for lack of notes.
- There had been ongoing problems in locating records of PRUH patients in a timely way. These were stored off site. This issue was high on the corporate risk register with a score of 20. A service level agreement with the records department was planned to improve the turnaround of medical records. Progress was being reviewed monthly, and the availability of notes was improving.
- A further records problem was that multiple sets of records had been generated for some patients. The 'choose and book' system was not fully compatible with the hospital's patient information system and legacy hospital numbers from the previous trust meant that there were several different patient number series. Staff were working on these issues, which were hospital wide, but meanwhile some patients had five or six hospital numbers.
- There had been IT problems in the past year that had led to difficulty in generating NHS numbers for babies. These were resolved in December 2014.

Safeguarding

- Managers and staff showed an understanding of what was important to promote women's safety and to protect unborn and new born babies. Midwives knew the name of the midwife for safeguarding at the PRUH.

The safeguarding team stressed that safeguarding was everybody's business and staff were aware of guidance on the process to follow when a woman or baby was at risk. The named midwife and named doctor for safeguarding were based at the Denmark Hill site.

- Mothers who missed antenatal appointments were followed up and an alert placed on the maternity IT system. An audit of reasons for non-attendance was planned to look for opportunities to encourage attendance.
- Midwives and medical staff were required to attend level 3 safeguarding training updates. Nursing and support staff were also expected to complete safeguarding training, although the level varied depending on their role. Ninety per cent of clinical staff had completed level 3 training, in line with the trust target.
- Midwives assessed social vulnerability at a woman's booking appointment. Extra information was requested from a woman's GP if necessary. Midwives gave women information about relevant support services, (for example about substance abuse, sexual abuse of under 16s or a violent partner). Safeguarding alerts were made on the maternity system and held in the hospital's own maternity notes, known as 'ghost' notes.
- Group supervision on safeguarding had formerly taken place annually at the PRUH. We saw that new arrangements had been introduced in April 2015 to ensure that team supervision on safeguarding would be held quarterly.
- Staff had identified the lack of perinatal mental health services for women as a concern. A case had been put forward to the commissioners for a full time mental health worker, and pharmacy and psychiatric support.

Mandatory training

- The practice development midwife oversaw mandatory training. Staff reported that training had improved in the past year. A week's block of mandatory training was now built into workforce planning to ensure that all staff completed the full range of training updates on midwifery issues and breastfeeding.
- Completion of mandatory and statutory training was 91%. Staff who had not yet attended were booked to attend. A further day was devoted to skills/drills and resuscitation to rehearse emergencies. Completion of this was 83%. Staff told us study days were not cancelled to undertake clinical care. Mandatory training had been below trust targets in the previous inspection. In this inspection we observed that the proportion of staff who had attended mandatory training was sufficient.
- Over 80% of midwifery and medical staff had completed maternal and neonatal resuscitation training.

Assessing and responding to patient risk

- Staff said they had been trained in how to use MEOWS to recognise women who were becoming more unwell. We looked at women's records and saw charts had been completed appropriately and escalated when needed to manage women at risk. There were arrangements to monitor new-born babies.
- The labour ward was supported by other services such as an onsite blood transfusion service, with a dedicated emergency bleep (code blue) to quickly and safely manage postpartum haemorrhage of over 2 litres.
- Patients from the Denmark Hill site who had planned surgery at the PRUH were seen by their consultants on the ward round the day after their surgery. Overnight they were the responsibility of the PRUH on-call consultant.
- We saw from the risk register that a large number of women returned with their babies after discharge because their baby had either suspected jaundice or low blood sugar. To mitigate this risk community midwives had now received extra training in recognising how well babies were feeding.

Midwifery staffing

- Antenatal care was mainly provided by the nine teams of community midwives, including one for teenagers. The care was based at three locations. The teams were fully staffed, and each team booked their own women and sought to provide continuity of care.
- There were three midwives on call each day in addition to the daytime shift to cover home birth and the birth centre. After 4.30pm if not called out, these midwives worked in the birth centre, alongside the two core staff members. Rotation of community midwives through the birth centre was a safe model for maintaining competencies. Staff reported that visits were rarely missed or cancelled. Community midwife teams each had links to a named consultant who would respond quickly to any questions or concerns with information which the midwives could then pass on to the women involved.

Maternity and gynaecology

- The midwifery leadership structure had been changed to provide band 8a and 8b midwives on each site, to support the staff, lead and manage. The new matron for the labour ward was due to start in June.
- Staff were pleased that their acquisition by King's College Hospital NHS Foundation Trust had improved their staffing. In the previous year about 30% of midwives had been bank and agency staff, but this had now reduced. A rolling recruitment programme of midwives was in place to ensure that normal staff turnover did not result in staff shortages. Although there were 9.34 vacancies at band 6 on the labour ward, the vacancy rate was low for other bands. Midwives were confident that staffing levels supported effective patient care.
- Birthrate Plus is a tool used to assess the needs of women and the number of midwives required in order to ensure that women are cared for safely. An assessment had been carried out which had recommended that 1 midwife was needed for every 28 women needing maternity care. The hospital had a budgeted ratio of 1:30 births, with vacancies filled with bank and agency staff. The actual midwife to birth ratio was 1:34.
- The Labour Ward Coordinator used the intrapartum acuity tool every 4 hours to monitor if there were insufficient bed capacity, high clinical demands or short term staffing level problems.
- The maternity (post natal) ward was staffed by four midwives during the day, with one midwife for eight women. In addition, there were three health care assistants, a nursery nurse, a midwifery support worker and two part-time infant feeding advisers. At night there were three midwives (one midwife for ten women) and two support staff. Midwives and support staff said providing responsive care was difficult when all the beds were occupied and there were women or babies needing extra care. Midwives were occasionally moved from the maternity ward to support the labour ward at night. The workforce review by the director of midwifery had identified the need to reorganise staffing on both the labour and maternity wards.
- Sickness rates were low. Staff were positive about working in the maternity unit. Managers told us that if a member of staff was off, even at short notice, they would be able to get bank or agency staff who had worked on the unit before. All staff were expected to have a break during their shift. Their allocated time was written on a white board and the ward manager and matron provided cover to make sure that the breaks were taken.
- A theatre list for women with planned caesareans was run four days a week. A labour ward midwife acted as a theatre scrub nurse for other caesarean sections. This was contrary to trust policy and national guidance, and took midwives away from women in labour. The risk was mitigated by bank staff providing theatre cover so that the labour ward was not short of midwives. Out of hours and at weekends theatres provided scrub nurses to assist with peri-operative procedures. However, after October 2015, once sufficient staff had been recruited, theatres would provide scrub nurses at all times.
- Some specialist midwives worked across sites (for example the midwife for public health).
- The previous inspection in December 2013 had required action to improve the staffing for maternity services. On this inspection we saw evidence that the hospital had improved staffing levels and had plans for further improvements.

Gynaecology staffing

- Bank and agency nurses had made up 30% of the staff in the previous year, but the ward was now staffed to establishment with permanent staff.
- The EPDU was run by two locum consultants, one of whom had been designated 'consultant of the week'.
- In addition to obstetrics and gynaecology staff based at the PRUH, gynaecologists from the Denmark Hill site carried out planned surgery lists on a 4 week cycle of 20 lists. The job plans of these consultants had been changed to reflect the reconfiguration of services.

Medical staffing in maternity

- The Royal College of Obstetricians recommends 98 hours a week of consultant cover for maternity units with between 4000 and 5000 births.There were 96 hours of consultant cover, 7am to 9pm every weekday and 9am to 9pm at weekends There had been an increase in the number of consultants to 13. Five locum consultant posts had been advertised and would become substantive consultant posts in May 2015. Twelve consultants were on the on-call rota, covering both maternity and gynaecology.
- Consultant cover at weekends had been identified as a concern at the inspection in 2013 but on this inspection we saw that there was now adequate consultant cover

throughout the week. We noted that in the consultant rota for March in 10 out of 20 week days there was no separate consultant rostered and available to do planned caesarean sections; this was unexpected given the number of consultants. However, the staff we spoke with told us that they were always able to get hold of a consultant if they needed to.

- Junior doctors reported good induction to the trust, the hospital and the obstetrics and gynaecology service. Rotas were set with 4 days on call to provide continuity of care to women and patients. The junior doctors were positive about the quality of training they received and they found the consultants and registrars approachable and supportive, without much emphasis on hierarchy. One doctor reported considerable improvement in medical staffing organisation over the past year with a greater focus on education. There was now a junior doctor's forum and a journal club.
- We were also told that there was always access to an obstetric anaesthetist.
- The move of planned gynaecology procedures to the PRUH had meant that consultants from the Denmark Hill site were working with new theatre teams. We were told there had been complaints when this change had first been introduced. However, a joint training plan with gynaecology and surgery divisions had led to more effective working.
- Consultants carried out a daily ward round on the gynaecology ward.

Major incident awareness and training

- The trust had an escalation policy in place for maternity. The 'Management of extreme workload in the maternity services' policy outlined minimum staffing levels below which the unit would not be able to provide safe care. We were told that the maternity unit had not closed since December 2013.
- Staff said they would follow trust policy in the event of a major incident. The policy was available on the intranet.

Security

- There was no ward clerk on the delivery suite at night. This meant that triage midwives had to swipe their cards to open the door to women and partners coming in. The midwives also had to take extra telephone calls after the MDAU closed at 7pm. Both these activities detracted from caring for women. Managers told us that agreement had been reached on funding reception cover and there would be 24 hour cover in future.
- Community midwives did not have a lone worker monitoring device. Currently the birth centre kept a log of midwives attending home births and they reported in when they had attended and finished. A business case had been made for a lone worker device to improve safety and this was to be provided.
- We saw a revised draft abduction policy. We were told that managers were considering electronic baby tagging across the trust.

Are maternity and gynaecology services effective?

Good

Women's care and treatment in the maternity and gynaecology services were planned and delivered in line with current evidence-based guidance, standards and legislation.

There were arrangements in place to audit the care and services provided and outcomes for women were good. Twenty per cent of all births took place in the birth centre. The hospital had successfully reduced the rates of caesarean section to below the national average.

We saw that women received pain relief as required and there were adequate arrangements to ensure women and their babies received adequate nutrition and hydration.

There was effective multidisciplinary team working between the hospital, community midwives and GPs, with a referral system to specialists for women who were at high risk. Staff training was well supported with opportunities for professional development.

Consent was obtained appropriately in maternity and gynaecology.

Evidence-based care and treatment

- Policies in maternity were based on guidelines from the Royal College of Obstetricians and Gynaecologists (RCOG), the National Institute for Health and Care Excellence (NICE) and the Royal College of Midwives (RCM).

Maternity and gynaecology

- The hospital provided data on maternal, infant and perinatal deaths to MBRRACE-UK (Mothers and babies: Reducing Risk through Audits and Confidential Enquiries across the UK). The stillbirth and neonatal death rates were well below the national average.
- We saw examples of maternity audits that had been carried out across the trust, (for example neonatal and foetal outcomes of hypertensive pregnancies to provide an evidence base for the management of such women).
- There were also hospital-specific regular audits on infection prevention and control, medicines and records. Results of audits were reported at maternity ward meetings, and actions identified. For example the controlled drugs audit had been discussed at a ward meeting. Staff then adopted new processes such as ensuring that amendments to the controlled drugs book must be witnessed by a second person and not obscure the original entry.
- Clinical guidelines were being developed to cover both maternity units (at the PRUH and the Denmark Hill site) and there was a guidelines review committee which met monthly to review and ratify guideline. Staff said they were consulted about the development of care guidelines. The PRUH was slightly behind the Denmark Hill site in terms of reviewing guidelines and acting on NICE quality standards; this reflected its short time as part of this trust. The progress of the maternity guidelines group was regularly reviewed by both the Divisional Quality Group and the Patient Outcome Committee Improvement Sub Group. .
- Screening in the first trimester included an offer of combined screening for chromosomal abnormalities and pregnancy associated plasma protein A (PAPP A), an indicator of risk of some abnormalities and risks to the mother and baby. Only women meeting specific risk criteria had 12- week ultrasound scans with Doppler to measure blood flow between the placenta and the foetus. Women with risks identified at scanning were referred to the Harris Birthright Centre for Foetal Medicine at King's College Hospital.
- The hospital met the 18-20 week National Screening Committee standards. A 36 week scan to assess foetal growth was due to be started at the PRUH in line with practice at the Denmark Hill site. A suitable ultrasound scanner was available and a research fellow had been appointed.
- Gynaecology audits were carried out trust wide.A consultant was the audit lead.An example was the recent inclusion of the PRUH in a long running trust re-audit of the outcomes of the management of ectopic pregnancy to improve outcomes for women.As a result improvements made had reduced the number of out of-hours operations, the potential problems of unnecessary surgical intervention, and ensured that second opinions were sought when women attended the hospital and their pregnancy could not be seen within the womb on an ultrasound scan.
- Monitoring of services had been identified as limited in our previous inspection in 2013. On this inspection we saw sufficient evidence to show that the monitoring of quality was no longer a concern.

Pain relief

- Staff told us there were no problems in obtaining pain relief or other medication for women. All the women we spoke with told us they had received pain relief as required.

Nutrition and hydration

- Women on the postnatal and gynaecology wards said they were satisfied with their meals. There were snacks such as bread and yoghurt, and drinks available 24 hours a day.
- Mothers on the postnatal ward were pleased with the support they received for breastfeeding their babies.
- On the gynaecology ward we saw that relevant patients had nutritional assessments and dietary supplements. One patient we spoke with understood the importance of compliance with dietary advice.

Patient outcomes

- A centrally produced obstetrics dashboard reported on activity and clinical outcomes for the maternity department. In addition, staff used a locally produced monthly maternity data sheet.
- The obstetrics dashboard for February 2014 to February 2015 showed that the target of booking 90% of women by 12 weeks and 6 days was not yet being met. The number of late bookings over 20 weeks was also over target. We were told the Clinical Commissioning Group had been working with pharmacies and GPs to advertise the importance of early booking.
- All women who were assessed as low risk were referred to the birth centre. Twenty per cent of women gave birth there. The normal delivery rate had increased. Factors

affecting this had been the review of all abnormal cardiotochographs (CTGs) weekly to improve staff skills in interpretation, a change in the induction of labour method and increased consultant cover. The percentage of women transferring to the delivery unit from the centre was within expected limits, indicating that the assessment criteria were sound.

- The caesarian section rate was below the national average of 23%. Staff had succeeded in reducing the caesarean section rate (both emergency and planned) by three percentage points in February and March and the unit was hoping to maintain this lower level of 23%.. This had been achieved by a multidisciplinary review of the reasons for each caesarean section after the procedure. An audit had shown a caesarean section rate of 41% at night. This had now been reduced to 20%. The number of women with third and fourth degree tears had been low throughout the year. The number of women who suffered a severe postpartum haemorrhage (blood loss during or immediately after birth) was well below the level that would give the hospital concern. Fewer than 4 women a month had suffered serious blood loss in the 12 months to February 2014. There is no figure for national incidence but the hospital aimed to have fewer than 10 in a month.
- The hospital was within expected limits for maternal and neonatal readmissions, and for puerperal sepsis ans other puer
- Staffing levels allowed for one-to-one care of women in labour and we saw this was achieved during our inspection. Women reported that they had one-to-one care. The policy on management of extreme workload said the maternity service strives to provide: '1:1 care and support to all women in established labour in all birthing environments in hospital and community settings'.
- We observed prompt response to a maternity emergency during our inspection.
- Breastfeeding rates were recorded on the obstetric dashboard. The results for breastfeeding at first feed were good, only just below the trust goal of 85%. Breastfeeding rates had dropped to 75% on discharge, but this was nonetheless above the national average.
- The management performance scorecard for gynaecology covered key clinical effectiveness measures. Work was being undertaken to align data from the PRUH with the format of data collected at the Denmark Hill site so that trust-wide information was available.

Competent staff

- There was an induction programme for new midwives. They were supernumerary for their first month and supported by a clinical practice facilitator. A maternity ward handbook was useful in explaining how the ward worked – discharge processes, neonatal assessments, bleeps, staff roles,etc. Staff said they were supported by their mentor or buddy.
- Staff said they were encouraged to take up development opportunities. For example, a healthcare assistant was taking a college course, and a midwife was attending a leadership course.
- The head of midwifery provided assurance that before the planned high dependency unit (HDU) opened there would be a full HDU training programme for relevant midwives including adult life support training.
- A nurse from the Denmark Hill site was providing urogynaecology training for nurses at the PRUH as part of work to ensure urogynaecology patients at this hospital had an equivalent level of care to patients across the trust.

Multidisciplinary working

- Staff reported that medical and midwifery staff worked well together and there was clear communication at the multidisciplinary team (MDT) handovers that took place twice daily. There was evidence of joint leadership by consultants and midwives. Ward rounds and handovers included midwives.
- A multidisciplinary meeting was held every other week for staff from the PRUH to review maternity cases at the hospital.
- We were told that there were regular communications with local GPs as well as social services.
- There was a daily consultant-led gynaecology ward round on weekdays. The labour ward consultant was responsible for the gynaecology ward in the afternoon.

Seven-day services

- All women could report to the hospital in an emergency through the accident and emergency (A&E) department.

Maternity and gynaecology

The maternity unit had ultrasound scanners available that could be used out of hours if necessary, and we observed an instance of this taking place with a chaperone.

- There were two dedicated and fully staffed obstetric theatres from Monday to Thursday, the days when planned caesarean sections took place. On Fridays and at weekends, there was one obstetric theatre.
- One emergency theatre in the main theatres was staffed 24/7 and this could be used in the event of a gynaecology emergency. Planned gynaecological surgery took place on weekdays.
- Consultant cover was provided for maternity at weekends and there was a consultant ward round on Saturdays and Sundays. Gynaecology patients were not necessarily seen by a consultant at weekends.
- Antenatal clinics were normally Monday to Friday but Saturday clinics were run at Orpington Hospital. We noted that there were fewer consultant-led clinics than in some hospitals but staff did not consider this to be an issue.
- Restaurants for staff and visitors did not serve hot meals at weekends.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Arrangements were in place to seek consent to surgery for all aspects of obstetrics and gynaecology. We reviewed a sample of patients' notes and found that consent forms had been signed when it was appropriate to do so. All women we spoke with had signed consent forms.
- The trust had procedures for assessing patients' capacity whether they were admitted through the emergency or planned routes. We were told that medical staff had responsibility for assessing a patient's capacity and the staff we spoke with talked confidently about mental capacity assessments within the remit of their role.

Are maternity and gynaecology services caring?

Good

Women who attended the Princess Royal University Hospital (PRUH) received good care. Staff in all roles put effort into treating women with dignity and kindness and most women said they felt well looked after.

Staff gave emotional support to women who had complications in labour or birth.

Women told us that they had their care explained well and were encouraged to discuss their plans for birth. Feedback from women and their families in the trust's own surveys showed that women and their families were happy with the care provided.

Compassionate care

- The women and relatives we spoke with all reported that they received good-quality care and and all staff were kind to them. . They felt staff listened to them. We observed woman-centred care and saw staff responding compassionately when a woman needed help.
- Feedback from the NHS Friends and Family Test (FFT) for maternity services was positive, particularly for the antenatal service where women were pleased with the continuity of care and said staff were approachable and helpful. Staff reported that the increase in staff numbers had enabled them to give better-quality care. On the postnatal ward results over the year to 27 March 2015 showed that 88% of women had confidence in the staff caring for them and 89% had been spoken to by doctors in a way they could understand; the figure for midwives was 92%.

Understanding and involvement of patients and those close to them

- The women we spoke with about the maternity service all reported that communication had been good throughout their pregnancy and that their partners had been involved. They felt they had been consulted on all aspects of their care.
- Women on the gynaecology ward also reported having received clear information from doctors and nurses at the clinics and in the hospital.

- Women we spoke who had been referred from the PRUH for procedures at Orpington Hospital considered the gynaecology service efficient and effective, and said they had been given clear information. Patients in the gynaecology ward at the PRUH also spoke highly of the explanations of their care.

Emotional support

- A debrief service was offered to women who had had a difficult birth experience and wanted to review their experiences.
- A bereavement midwife was responsible for speaking with women and their families who had been bereaved during or after childbirth or had a termination for medical reasons. She was notified of all losses over 14 weeks. She also provided support and advice to women who became pregnant again after a loss. She was able to provide information about agencies offereing counselling and support for women and their families.
- The chaplaincy team supported people of Muslim and Christian faiths and would contact other community faith leaders and the humanist association as appropriate. The chaplains were assisted by a group of volunteer ward visitors.
- Nurses helped people cope emotionally with their care on the gynaecology ward. Feedback from patients was positive.

Are maternity and gynaecology services responsive?

Good

Maternity and gynaecology services were responsive to women's needs. Antenatal risk assessments were carried out and there were clinics for women with higher risk factors such as diabetes. Women were encouraged to have a normal birth, including those who had had a previous caesarean section. They were given choice about where to have their babies.

There was an early pregnancy diagnostic unit (EPDU) for women who had concerns in early pregnancy and a maternity day assessment unit (MDAU) for mothers' with concerns at a later stage.

We saw evidence that complaints were monitored and learned from, although responses were not always timely.

Service planning and delivery to meet the needs of local people

- The maternity unit was able to meet demand because the number of births had fallen slightly. The unit had not had to cap bookings and had not closed since December 2013.
- The birth unit had capacity to care for women who were expected to have low-risk births and there were opportunities for women to find out about birth options early in pregnancy.
- An active maternity services liaison committee (MLSC), made up of recent parents, midwives, hospital staff and voluntary groups, met every 2 months. It had links with other local MSLCs and local groups. Committee members visited the maternity wards, gathered the views of women and fed back to the hospital to support service planning. An issue they had recently looked at was that of partners being allowed to stay overnight. The presence of women who had given birth at the hospital on the labour ward forum also contributed to service development.
- The signage to the Oasis birth centre and the delivery suite were clear. At night the main reception was open until 10pm. After that, women needing access to the labour ward were admitted to the hospital building through an intercom system.
- The EPDU was open on weekdays, which meant that women could attend after referral from their GP. Chaperones were always present when women were scanned.
- The MDAU was available for women later in pregnancy who had concerns about their pregnancy or foetal movement.
- The gynaecology service catered to patients from a wider area, including patients from the Denmark Hill site.

Access and flow

- All referrals for ante natal care were received in the ante natal clinic. Most referrals were from GPs but women could refer themselves. The clinic allocated women a named midwife in a team. Women confirmed they had good continuity of care.
- Women who suspected they were in labour were assessed by a triage midwife. Women who attended out of hours with other concerns such as reduced foetal movement also attended triage. The triage area was small and women had to wait in a corridor. Midwives

considered that triage needed more space and it was difficult for a single midwife to manage triage after the MDAU had closed and the ward clerk had left which increased women's waiting times. Two other midwives monitored the eight induction beds and could support triage if necessary.

- Discharge planning started early, the day before if possible. However, the discharge documentation was not streamlined. Insufficient computers on the ward meant that discharge could be delayed as medical staff (obstetric and neonatal) waited for access to complete the records.
- Recent training for midwives in examining newborn babies had improved flow through the postnatal ward. One midwife on each day shift was able to take on this role. However, delays were reported when a paediatrician's view was required and none was available to visit the ward. Mothers were moved to the day room to await checks, so as to reduce bed pressure on the postnatal ward.
- Staff said that flow through the gynaecology ward worked well. However, there was sometimes pressure from the accident and emergency (A&E)department to use beds on the gynaecology ward.
- Staff told us that 2-week referrals for suspected cancer were being met. The gynaecology service was not meeting the referral to treatment time (RTT) of 18 weeks in 12% of cases. This was because of the closure of one theatre and a shortage of theatre staff. The gynaecology operating list had been reduced by six sessions at the PRUH and three at the Denmark Hill site. Cancellations had been inevitable, although the number had reduced from about 59 a month towards the end of 2014 to 34 a month in March 2015. About one-third of cancellations were on the day. To improve the flow, procedures were carried out by other surgeons and any theatre slots becoming available were filled by patients who had agreed to come for surgery at short notice. There were further plans to tackle the backlog by outsourcing some procedures. However, in the longer term, the trust needed to build a sustainable infrastructure that would include using all trust sites optimally. As part of this, the gynaecology service was working with the estates team to develop a 23-hour facility for day surgery. Better management of theatre time could also enable more operating time.
- The gynaecology ward at the PRUH accommodated almost all women whose planned gynaecology procedures required an inpatent stay, whether they had initially been seen at the Denmark Hill site or the PRUH. For women in the Bromley area, some day surgery took place at the PRUH and some specific procedures at Orpington Hospital. Orpington offered nine colposcopy sessions a week (for diagnosis and treatment after an abnormal cervical smear); seven of these were consultant led and two were nurse led. Hysteroscopy and urodynamic procedures (for diagnosis and treatment of urinary incontinence) also took place at Orpington. All women were seen in fewer than 8 weeks for dynamic spectral imaging for colposcopy (Dysis).

Meeting people's individual needs

- Early in pregnancy, women and their partners were able to attend a meeting with midwives to talk about maternity services and birth options including advantages and disadvantages of home birth, the midwifery-led suite and the main delivery suite. Women who fell outside the inclusion criteria for the birth centre but who wanted to use the midwifery-led unit were given an individualised care plan, put in place after consultation with their obstetric consultant.
- There was a dedicated team for teenagers who were pregnant which had links with other support services for this group.
- Bookable ante natal classes were run for women over 24 weeks into their pregnancies. Books and toys were provided in the antenatal waiting area to occupy young children while their mothers awaited appointments.
- There was information on display for women and new mothers on a wide range of topics including caesarean section and breastfeeding. There was also information about the complaints process.
- We were told that if women needed an interpreter this could be booked. A telephone translation service was also available. Staff reported that this worked well. They said that interpreters had been used for British Sign Language and for languages such as Albanian and Russian.
- Staff told us that if a woman using the service had any specific needs, whether these were mental health, social needs or safeguarding, they would contact the midwife or trust safeguarding lead or refer to guidance on the intranet for advice. Midwives could refer women to specialist NHS services and support services for domestic violence, forced marriage, female genital

mutilation(FGM) and other harmful practices. There was a day room for where staff gave sessions to groups of women and their partners on breastfeeding and bathing a baby.
- The atmosphere in the maternity unit was calm and peaceful.
- Women's partners had been allowed to stay overnight since December 2014. Feedback from women was very positive and this arrangement was to become formalised, with a document for partners explaining expectations.
- A dedicated and well designed bereavement room was located in a quiet area of the ward where crying babies could not be heard. This had a 'cold' cot so parents could spend time with their baby. This was an exceptionally good example of sensitive provision for families.
- Breastfeeding teams were available one evening a month to support women with breastfeeding.
- Gynaecology clinics were run Mondays to Thursdays. A one-stop clinic where women could be diagnosed and treated for common gynaecological conditions had recently been introduced. Women who had come to the hospital for gynaecology diagnosis and treatment said they had been given clear information by staff.
- The Early Pregnancy Diagnostic Unit (EPDU) had a small waiting area and no quiet room for women to go to adjust to bad news.
- The antenatal clinic and the early pregnancy diagnostic unit both had limited space for buggies.

Learning from complaints and concerns

- Women and families we spoke with knew how to raise concerns or make a complaint. There were leaflets about the Patient Advice and Liaison Service (PALS) in English, Spanish, Portuguese, Polish, Vietnamese and Chinese, which explained the support available from PALS. Patient feedback cards also signposted PALS.
- Staff said complaints were handled at the time as far as possible by the shift coordinator or matron. Learning from formal complaints was integrated with clinical governance. Staff were aware of the complaints process. They were involved if a complaint related to their own actions so that they could learn from it. We saw examples of action taken following complaints (for example, one woman's report of poor experiences had been used as a case study for ward staff about dignity in care). In gynaecology, we also saw examples of learning from complaints, such as the introduction of a postoperative record form to aid communication of postoperative management plans, including discharge medicines.
- Between January 2014 and January 2015, a total of 37 maternity complaints had been received. There had been 22 complaints about gynaecology, some about cancellations and missing notes. Systems were in place to respond to and monitor complaints and they were discussed at risk meetings. Not all complaints had been responded to within the trust's target of 25 working days, and the response times to complaints in gynaecology were slower than in maternity.

Are maternity and gynaecology services well-led?

Good

The acquisition of the hospital by King's College Hospital NHS FoundationTrust had resulted in significant change, but in general staff in maternity and gynaecology considered that it was bringing about improvements. The increase in staff numbers had been particularly welcomed.

There was a clear governance structure in the Women's and Children's Division. Clinically, staff felt confident in the service but some issues such as IT problems were still perceived as a frustration. The latter was an issue for all PRUH services.

Maternity staff were complimentary about the changes made by ward managers and matrons at the PRUH. There was improved communication and a sense of shared values.

The gynaecology service was being reconfigured to provide greater equity between the services across the trust. Gynaecology staff had experienced more change than maternity staff, but the changes were being been phased in gradually. The final phase had been delayed to allow for consolidation. Staff were aware of this strategy. Staff felt well supported by their immediate line manager and most staff we spoke with said they enjoyed working in the hospital.

Vision and strategy for this service

- Maternity staff understood the hospital's role in the wider South-East London strategy to place women at

the centre of maternity care, to improve equity of access, continuity of care and meet maternity quality standards. After a year of change, they hoped for more stability now that the services at the PRUH were more in line with those at the Denmark Hill site. Managers recognised there was still work to do as new staff appointments were made.

- The gynaecology services were undergoing a significant reconfiguration to provide greater equity between the two hospitals including the transfer of almost all planned surgery from the Denmark Hill site to the PRUH. These plans were being phased gradually and, in the long term, they would enable the trust to cope better with demand and offer a better service to patients.
- Staff were aware of plans to improve theatre productivity.

Governance, risk management and quality measurement

- The trust had extended its principles, systems and standards of corporate governance to the PRUH. There were clinical leads in maternity and gynaecology at the hospital. The acquisition had involved a significant amount of work at the PRUH to try to equalise services. Staff accepted that it would take time for the changes to be fully embedded but they could see progress being made.
- Management meetings took place across the site by teleconference to reduce travel. Doctors and midwives said these worked well.
- Separate risk registers were maintained for maternity and gynaecology. These reflected the key risks identified by staff and managers and we saw examples of good risk assessment and mitigation. Staff at the PRUH reported that risk management and feedback had improved in the past year.
- In maternity, there was an integrated risk management structure between the Denmark Hill site and the PRUH. A joint maternity clinical governance meeting was held monthly and received reports from the maternity risk committee, monthly meetings of the supervisors of midwives (SoMs) and the labour ward forum (a group that reviewed clinical and organisational issues relating to the labour ward). Risks graded over 12 were reported to the trust's quality and governance committee. The director of nursing and midwifery was the lead executive at board level. There was a PRUH multidisciplinary meeting on alternate weeks for maternity and neonatal staff to review cases.
- The obstetric clinical lead for risk at the PRUH worked closely with the patient safety and risk manager for maternity whose responsibilities had recently been increased to cover gynaecology. The clinical director for gynaecology at the PRUH provided clinical leadership for the hospital and was involved in joint meetings with the Denmark Hill site. The trust-wide clinical governance and risk meeting for gynaecology took place monthly.

Leadership of service

- The women's and children's division had a clearly defined accountability structure. The clinical director had spent much of the week at this hospital during the past year to lead and manage change.
- Leadership was evident in the changes to the service, such as the review of midwifery staffing and the reorganisation of gynaecology services across all hospital sites within the trust. Department and service managers were visible and matrons were open with staff. In maternity, work had been done to build relations between consultants and midwives, including joint training to help develop shared leadership with women at the centre.
- The management team had prepared an organisational development paper and an associated action plan for midwifery. There had been a cultural review to understand the stress on staff and unease caused by the acquisition and the improvements that were being sought. A report collating the information gathered was being finalised. As a result of the inclusive approach and focus on improvements, the expectation was that staff would have ownership of the strategy and feel valued. At ward level, band 8 staff had been introduced as managers. Ward staff we spoke to felt their views were being listened to and they were generally supportive of the changes.
- Community midwives considered they were well managed and supported. We saw evidence of good risk reporting and responsiveness to complaints to avoid repeats of unsatisfactory occurrences. Teams met monthly to a schedule planned a year ahead, to share information. The meetings were minuted.

- Gynaecology staff had been through two phases of reorganisation, the first in January 2014 and the second in July 2014. They appreciated the management decision to place the third phase on hold to give time for consolidation.

Culture within the service

- We found a positive culture with optimism about the future. Staff reported that they felt supported by their immediate line management and that they had good working relationships with other groups in the hospital. Nurses and midwives felt the service had become less hierarchical since the hospital had become part of King's College Hospital NHS Foundation Trust and as a result of some staff changes. Consultants were more engaged with the service and there was more multidisciplinary working. Managers encouraged staff to raise concerns. A midwife told us, "People feel like voicing the issues because they will be listened to." Ward staff were not sure about how their views reached the trust's senior management. One of them said, "I would like to know what's happening up top."
- Although morale was positive on the clinical front, it was affected by non-clinical issues such as the frustrations of the limited compatibility between different computer systems and the difficulties obtaining patient notes, which affected most areas of the hospital. These was recognised and high on the corporate risk register. Administrative staff felt their jobs had become increasingly difficult and they had to front complaints from the public about surgery and appointments that had been cancelled for reasons outside their control. We were told that a representative from the clerical staff had been appointed to the board; it was hoped that this would improve the level of consultation and information sharing.
- New members of staff on the maternity ward said that they were made welcome and everyone was willing to help out. One of them said, "I feel very supported. If I'm not sure, I can ask anyone, any time." Staff also said their skills and knowledge were recognised and they were encouraged to make suggestions to improve services.
- The maternity ward meetings, which were minuted, were arranged over 2 days to encourage attendance . Staff said their views were listened to and changes made, an example being a request from the postnatal ward to transfer women one at a time, and after the baby had had its first feed.
- Typical comments from staff were "Things have improved since the acquisition" and "There are more staff, better management and new posts."

Public and staff engagement

- Staff had the opportunity to provide feedback daily at handover meetings as well as at ward meetings.
- The trust used its own system for gathering comments and suggestions: 'How are we doing?' Patients, visitors and staff could complete this online or fill in cards in the hospital. On a heatmap covering patient experience at a high level, women's services scored 87% against a benchmark of 86%.
- Volunteers came in every day to complete the NHS Friends and Family Test (FFT) with inpatients. However, the tablets that were used on the maternity ward to record answers were broken on the day of our inspection. The results of the FFT were reported back to staff each month. All inpatients were asked how likely they were to recommend the ward to friends and family. The feedback from the FFT question for maternity services was positive. For March 2015 there had been a 23% response rate for antenatal services, of which 86% were positive. Response rates were lower for labour, birth and postnatal but over 90% of respondents said they would recommend the hospital for labour and birth.

Innovation, improvement and sustainability

- The ward accreditation scheme rated wards on achieving quality standards. The gynaecology ward had achieved a gold award. It was evident that the scheme had motivated staff to work together to achieve success and drive improvement.

Services for children and young people

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

Information about the service

The neonatal, children and young people's service at Princess Royal University Hospital (PRUH) consists of a special care baby unit (SCBU), a children's outpatients' department which provides a weekly paediatric referral and follow-up clinic, and an 18-bedded children's ward. Currently the number of inpatients in the children's ward fluctuates between 12 and 15 daily. The children's ward cares for both medical and surgical patients, including some children undergoing day surgery. The service is part of the women and children's division and treats approximately 1,120 patients every year. A small number of children also undergo day surgery which is provided by the Alan Cummings Day Surgical Unit.

The SCBU has 12 cots and is commissioned to provide lLevel 1 care to babies aged from 30 weeks gestation. This means it can provide care for babies thatwho need additional oxygen and continuous monitoring of their breathing or heart rate. It also has facilities to care for babies that require short term intensive care until they are transferred to a unit assessed to provide that level of care.

We spoke with three patients, five relatives and 22 staff including consultants, junior doctors, nurses, play specialists; and support staff. We observed care and followed the post-operative case notes of three patients, and looked at the care records and patient notes of two babies receiving care on the SCBU. We reviewed other documentation, including performance information provided by the trust.

Summary of findings

There had been significant progress in how the trust delivered services to neonates, children and young people since our last inspection. Some improvements were still required to ensure that nursing levels were aligned to national standards and to ensure that staff complied with trust-wide policies regarding infection control practices including the screening of patients for MRSA.

In the main, patients could expect to receive care which was aligned to evidence based practice however some improvements were required in areas such as the management of children presenting with asthma. Clinical outcomes for children with diabetes was better than the national average in a number of areas.

We rated the caring domain of this service as outstanding. Staff had fully embraced the concept of family centred care. All members of the family played pivotal roles in the care and treatment of neonates and children. Staff strongly advocated the concept of kangaroo care which has been proven to deliver better clinical outcomes for the ill baby.

Access into children's services was generally good. There had been a reduction in the number of surgical cases being cancelled and pathways were being delivered to ensure that children and young people who presented to the hospital requiring surgical intervention were appropriately managed in a safe and effective way.

Services for children and young people

Local leadership at ward level was considered to be good. Staff were complimentary about their direct ward leaders who were seen to be working at ward level, supporting staff.

The service had a specific child health strategy that was aligned with the trust-wide strategy. The strategy was driven by quality and safety, and took into account the requirement for the service to be fiscally responsible.

There were governance arrangements in place for which a range of healthcare professionals assumed ownership. There was evidence that risks were managed and escalated accordingly. However, there were a small number of examples where risks that might have an impact on the clinical effectiveness of the service were not recorded on the divisional risk register.

Since our previous inspection in December 2013, the service had introduced a quality measurement scorecard; however, there was a lack of information for some metrics, which meant that the scorecard was not being used to its optimum.

Are services for children and young people safe?

Requires improvement

While staff were aware of the process for reporting incidents, the threshold for reporting incidents among clinical staff was high, meaning that incidents were not always reported. When incidents had been reported, there were processes in place for investigating incidents and lessons from incidents were disseminated to staff. Themes were identified and remedial action taken to reduce the risk of harm to patients.

Although there were processes for assessing staffing levels, there were not always sufficient nursing staff present on the special care baby unit (SCBU) to ensure that suitably qualified nurses were always available to attend to emergency situations on the labour ward.

The clinical areas were seen to be visibly clean and there were arrangements in place for monitoring cleaning standards. However, there was insufficient monitoring of hand hygiene practice and MRSA screening standards to ensure compliance with local trust policies.

In the main, management of medicines was found to be acceptable although there were some areas for improvement to ensure that medicines were suitably stored.

Risks to people who use services are assessed, monitored and managed on a day-to-day basis. These include signs of deteriorating health and managing medical emergencies. People were involved in managing risks, and risk assessments were family-centred, proportionate and reviewed regularly.

Incidents

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

of incident reported across both sites within the child health division. There was considerable focus on the reduction of incidents that had resulted in patients receiving medication dosages that were 10 times the recommended amount. Nursing staff were aware of the newsletter and the recommendations that had been made as a result of the incidents that had occurred during the previous year.

- Nursing and support staff on the children's ward and the SCBU said they had been encouraged to report incidents by members of the senior nursing team. However, senior members of the divisional team reported that there had historically been a negative culture towards incident reporting within the children's service at the PRUH; this had been attributed to a culture of 'blame' instead of the positive learning culture that the senior team was currently trying to instil within the service. As a result of the historical negative culture, the senior team perceived there to be a significant lack of reporting of incidents within the service. However, it was reported that there had been a marginal increase in the number of incidents being reported month on month since the hospital had become part of King's College Hospital NHS Foundation Trust.
- The matron confirmed that incidents were reported via the electronic Datix system and she felt that all clinical incidents had been appropriately reported in recent months. Nursing staff we spoke with were aware of how to use the Datix system; some reported that it was easy to use while two members of staff considered it to be 'Cumbersome' and 'Awkward'; however, staff reported that they had received extra training and that the senior management team had invested time in ensuring that staff were using the system appropriately and consistently.
- Regular incident trend reports used red, amber, yellow and green indicators. Incidents marked yellow or green were investigated by ward managers; those marked red or amber were passed to the clinical governance and risk management team and would be investigated by a consultant and a senior nursing staff member.
- Between September 2014 and December 2014, 133 incidents had been reported that were attributed to incidents occurring within the children's division at the PRUH. Seventy-seven of these incidents were graded as having caused no harm, one was graded as having caused moderate harm or illness and fifty-five were ungraded. One of the incidents that was ungraded was reported as requiring a divisional investigation while the remainder were allocated for investigation by ward managers or the clinical team associated with the department in which the incident occurred.
- Incidents that had been rated as amber or red were discussed at the local child health and risk management group (CHARM) and then referred to the trust-wide divisional quality and governance committee, which was attended by the senior divisional team. Root causes were considered, actions generated and named health professionals assigned to incidents to ensure that actions were consistently resolved against timelines.
- There were arrangements in place to ensure that mortality and morbidity meetings were held and fed into CHARM. Because of the low frequency with which child mortality cases occurred at the PRUH, mortality review meetings took place by exception.
- Consultants and nursing staff were well-versed on their responsibility regarding duty of candour. There were local arrangements in place to ensure that patients and their carers were told of incidents, given necessary support and informed of any investigations and their outcomes.

Cleanliness, infection control and hygiene

- All the wards were visibly clean. Appropriate colour-coded equipment was used for respective areas.
- Hand-wash basins were available at the entrance to both the children's ward and the SCBU. We observed visitors using these facilities and staff challenging visitors when they did not wash their hands on arrival at the clinical area. A dispenser for disinfectant soap and paper hand towels were available by each hand-wash basin. A dispenser for disinfectant gel was also available. There were instructions on the corridor noticeboard for visitors to follow with regard to washing their hands and promoting good infection control practices in general.
- We observed staff complying with the trust's policies for infection prevention and control (IPC); these included wearing personal protective equipment such as aprons and gloves, following the 'bare below the elbow' policy and decontaminating hands both before and after patient contacts.
- The trust provided us with a child health scorecard that was dated December 2014 and specific to services provided at the PRUH. The scorecard recorded '0%' against the 'hand hygiene audit' and 'no data' for MRSA screening and 'total hospital-acquired alert organisms;

it was therefore not possible for us to determine whether staff were consistently following local trust policies with regard to hand hygiene and MRSA screening.
- Thirty-one per cent of nursing and midwifery staff and 15% of medical and dental staff working within the women's and children's directorate had completed training in infection control; this was below the trust standard of 80%.
- All nursing staff working on the SCBU and the children's ward had completed hand hygiene training.

Environment and equipment

- The children's ward and the SCBU were locked, preventing unauthorised access. Parent, carers and visitors were able to gain access to the clinical areas by using a buzzer system that was monitored by nursing staff. We saw that members of the nursing or administrative team greeted each visitor as they entered the unit.
- The department had a range of equipment that was cleaned and checked regularly, and sent for routine maintenance. Staff were aware of whom to contact or alert if they identified faulty equipment or environmental issues that needed attention.
- Members of the clinical team raised some concerns regarding the temperature of the children's ward and the SCBU during warm and cold periods, respectively. The issue was listed as a risk on the divisional risk register because the cold conditions on the SCBU had had an impact on the welfare of some babies; there were arrangements in place to ensure that, when the environment became too cold, babies were placed in incubators and moved to alternative clinical areas within the SCBU. While there was processes in place to mitigate the impact of the cold environment on the newborn, and while there was evidence that the issue had been discussed at CHARM meetings and escalated internally, there was little evidence to show that robust action was being taken to resolve the issue in the long term.
- We checked resuscitation trolleys on the children's ward, SCBU and children's outpatients and found that they had been regularly checked by staff. We were told that the sealed section was checked once a week in accordance with local policy; we were shown records up to 16 April 2015 that showed that the trolleys had been appropriately checked.
- Staff said that when admissions increased in winter there was a shortage of monitoring equipment and infusion pumps. They felt this placed children at risk because staff were unable to monitor a patient's oxygen saturation level, heart rate and blood pressure to generate an early warning score. The number of inpatients on the children's ward fluctuated between 12 and 15. It was noted on one Datix report that at one stage there were only three monitors available on the ward; when surgical patients came back to the ward postoperatively, they needed enhanced levels of monitoring and some staff said that this was sometimes difficult to provide because of the limited equipment. We discussed this issue with the ward matron who confirmed that a business case had been submitted and responded to positively by the executive team.
- A statement in the executive summary of requirements for paediatric monitoring equipment stated, 'Ideally there would be one monitor per bed space, although one for every two beds would be a minimum requirement.' This issue had been highlighted both on the divisional risk register and as an area that needed addressing within the action plan submitted to the Care Quality Commission (CQC) after the previous inspection of the service. We were told that three monitors had been transferred from the SCBU to be used on the children's ward. We saw that extra syringe drivers, infusion pumps and monitors were available on the ward at the time of our inspection. There was a significant amount of medical equipment stored in clinical areas in the SCBU but not being used; this was because the number of cots commissioned was lower than had been intended when the SCBU had first been designed.

Medicines

- We found that some medicines were not locked away on the children's ward, therefore increasing the risk of theft, unauthorised access and tampering. These concerns were escalated to the matron and pharmacist at the time of our inspection.
- Nine incidents involving medicines were reported between September and December 2014. One incident was reported as having caused minor injury or illness; there was evidence that staff had escalated the incident and had sought the necessary advice and support.
- Staff were observed to be preparing intravenous medications in line with the local trust policy. They

reported receiving daily advice and support from a pharmacist whom we observed to be screening drug charts for inaccuracies and prescribing errors, so as to reduce the risk of harm to patients through drug errors.

Records

- We randomly checked five observation records and case-tracked three patients' records. The ward used a paediatric nursing risk assessment and evaluation booklet that had been appropriately completed in each case. The booklet included person-centred information and care planning, safeguarding information and communication methods. The risk assessment section included a paediatric-specific falls risk assessment tool, nutritional risk assessment tool, and a skin integrity and wound chart. The section on evaluation and progress of care had been completed by the doctors and nurses. Audit data provided by the trust showed that there had been improvements in the completeness of the paediatric nursing risk assessment and evaluation booklet during the previous 3 months.
- We saw that the observation records included a detailed bedside paediatric early warning system (BPEWS) chart, which was kept up to date.
- Staff told us there had been serious issues with the patient information management system (PIMS) that was used to access patients' medical notes. There were many cases of patients having multiple records on the system. Some staff had reported this as an issue on the Datix incident reporting system. Some patients had multiple reference numbers on the system and therefore multiple sets of records. Staff were expected to work round the problem by explicitly searching for multiple records, but this procedure was prone to error and time consuming. A member of staff told us it helped if a patient's date of birth was entered on admission but this was not always done. Staff said that action had been taken to try to ensure that the problem would not occur for new patients, but it still remained for existing patients and so posed a potential risk due to their medical records not being held in one place.

Safeguarding

- Staff said that they had received training in safeguarding. However, data provided by the trust indicated that 33% of staff working on the children's ward and 70% of nursing staff working on the SCBU had completed safeguarding children level 3 training. These figures were below the trust standard of 80%.
- Staff could describe the referral process for alleged or suspected child abuse and they knew the names of the lead safeguarding staff. We were told there was no formal clinical safeguarding supervision available for staff. However, staff said they were well supported by the safeguarding team.
- A policy relating to safeguarding children and young people was readily available and accessible. It had last been reviewed in August 2014 and made reference to national guidance and best practice.

Mandatory training

- The managers for the children's ward, the day surgical ward and the children's outpatients' unit confirmed that their staff had completed mandatory training. Mandatory training was monitored through staff appraisals. Seventy-four per cent of administrative staff, 23% of medical and dental staff, and 73% of nursing staff had completed mandatory training in health record keeping; this was below the trust standard of 80%.
- Ninety-three per cent of nursing staff on the children's ward and all the nursing staff in the SCBU had completed their mandatory training in clinical moving and handling. This was above the trust standard of 80%.

Assessing and responding to patient risk

- The service used the bedside paediatric early warning system (BPEWS) to help them recognise a deteriorating patient. BPEWS charts were in use, which gave staff directions for escalation. There were BPEWS monitoring charts for different age groups: namely, 0–3 months, 3–12 months, 1–5 years, 5–12 years and 12 years upwards. We saw that the BPEWS charts were completed on admission and then at planned frequencies during a patient's stay.
- We looked at completed charts and saw that repeat observations had been taken within the necessary time frame. Audit data provided by the trust showed that there had been consistent improvements in the completeness of the BPEWS charts between January and March 2015.
- Staff explained how they used the BPEWS chart and matched the score to care recommendations. They were aware of the appropriate action to be taken if a patient's BPEWS score was elevated.
- The ward manager showed us a paediatric escalation flowchart for escalating all risk and emergency issues on the children's ward, such as violence, absconder safeguarding, Child and Adolescent Mental Health

Services (CAMHS) issues, non-accidental injury and bed management issues. The flowchart had emergency numbers for staff to bleep or phone appropriate colleagues, such as consultants, the resuscitation team, security and safeguarding leads.

- We were shown the PRUH paediatric emergency department (ED) escalation process chart, which gave staff guidance as to when and how to contact the medical team to assess patients waiting for paediatric review during both routine hours and out of hours. Nursing staff told us that all the children currently on the children's ward had been seen by the medical team within an hour.

Nursing staffing

- Nursing staff turnover within the women's and children's directorate was reported as 7.9% between April 2013 and March 2014 and data showed a turnover of 3.8% between July 2014 and September 2014.
- The overall nursing vacancy rate for women's and children's services was reported as 14.1%.
- Sickness rates within the women's and children's services were seen to be increasing between July and September 2014: 2.88% in July, 3.61 in August and 4.21% in September.

Children's Ward

- The ward manager said the staffing complement each day was usually four nurses (one band 6 and three band 5), one healthcare assistant, an activity play specialist and a ward clerk. Staff ratios could be flexed to meet the needs of the patient. The night shift comprised one band 6 (or an experienced band 5) and two band 5 nurses. Healthcare assistants were not routinely used to support night shifts.
- Staff said they considered the number and skill mix of staff to be adequate. The matron and the ward manager worked Monday to Friday. We were told both the ward manager and the matron gave support if needed.
- The ward manager confirmed that the children's ward had vacancies for two band 6 nurses and three band 5 nurses. However, because one band 6 nurse was on maternity leave, the service had recruited four band 5 nurses; three of these were newly qualified and waiting for their professional registration to be confirmed with their professional body. Shifts that could not be covered by substantive staff were referred to the trust bank to ensure that there were sufficient numbers of staff available at all times.
- Ward handovers were undertaken twice during the day at shift changes: once in the morning and once in the evening, when the night shift started. One nurse told us that each member of staff was given a handover list by the nurse in charge of the previous shift, and then a formal group handover was undertaken whereby the clinical condition and nursing needs of each child were discussed. This was followed by a bedside one-to-one handover by the night nurse to the day nurse allocated to care for each patient, and vice versa.
- The matron confirmed that they supervised the ward managers on the children's ward, the SCBU and the children's outpatient department. There was a weekly meeting every Monday and extra weekly one-to-one meetings when issues and concerns were discussed and an action plan drawn up for each manager.
- The Alan Cumming day surgery unit, whose governance and management was coordinated by the critical care, theatres and diagnostics directorate also treated children. The service was managed by a matron and a team of nurses, including four paediatric nurses. These nurses comprised one part-time band 6 nurse, two part-time band 5 nurses and one full-time band 5 nurse. The paediatric practice development nurse had conducted competency assessments on each paediatric nurse employed in the unit to ensure that they had the necessary skills to care for children.

Special Care Baby Unit

- The SCBU was commissioned to care for a maximum of 12 babies. Nursing support was given by 19.5 wte equivalent nurses; 9 of these were band 6 nurses who had completed postgraduate training in providing course in either special care, high dependency care or neonatal intensive care to the new-born and 5.5 wte band 5 nurses. The unit employed 1.2 wte nursery nurses and was managed by one band 7 ward manager.
- Nursing levels were such that they met with the standards set by the British Association of Perinatal Medicine (BAPM) when babies required special care (i.e. nursing ratios were set at one nurse caring for four special care babies). We noted, however, that the nursing ratios did not allow for there to be a supernumerary nurse-in-charge on each shift as recommended by BAPM, nor was there sufficient flexibility within the daily workforce for a member of the nursing staff to routinely attend to emergency calls from

the labour ward. Junior medical staff were therefore required to attend to emergency calls involving the newborn independently and without the support of experienced nurses.

- Because of the low acuity of babies admitted to the SCBU, some medical staff raised concerns about the skill set of nursing staff when acutely unwell babies were admitted to the unit or when babies rapidly deteriorated while receiving special care. A skilled neonatal consultant was providing advanced scenario-based training to both nursing and medical staff so that advanced life support skills could be rehearsed. It was acknowledged by the nursing lead and consultant neonatologist that recruitment to a 0.6 wte practice development nurse role within the SCBU would have a positive impact on the ability of the team to drive forward nursing standards and skill sets. However, the post was still vacant at the time of our inspection.

Medical staffing

- The trust employed 7.5 wte consultant paediatricians. The SCBU was supported by one wte consultant neonatologist who worked each weekday but also provided some out-of-hours cover for the unit. The remaining paediatric consultants covered the unit out of hours. While junior doctors and nursing staff were supportive of most of the paediatricians who covered the unit out of hours, three experienced members of staff raised concerns over the skill set of one consultant. We reviewed Datix incidents and spoke with staff at length regarding the concerns, but we were unable to identify any clinical incidents attributed to the consultant. Staff acknowledged that, in the small number of clinically complex cases that the consultant had been required to manage, they had acknowledged their limitations and sought advice and support from fellow consultant paediatricians. We fed our concerns back to the senior divisional team at the time of the inspection.
- We were told that the PRUH had 10 senior house officers (SHOs), 5 paediatrician trainees and 2 GP trainees (ST1) and one vacancy. There were 2 junior doctors (F2) and one F1 doctor who was not included in the on-call duty rota.
- Doctors were available 24 hours a day. There was consultant cover 7 days a week, including a consultant on call at night. There was cover from junior and middle-grade doctors on the children's ward day and night. Locum doctors had also been deployed because there was a shortage of substantive junior doctors; the lack of substantive junior doctors had been listed as a key restraint that had an impact on 'Patient access, safety and experience' within the child health strategy document.
- An internal audit had identified that, over a 6-month period between March and August 2014, 49 paediatric surgical cases had taken place between 5pm and midnight. In order that the hospital could continue to provide a safe surgical service to children, a paediatric surgical committee had been established and changes made to the consultant anaesthetist rota to ensure that suitably qualified staff were available at all times to safely meet the needs of young children. Clinical pathways had been developed to ensure that only appropriate surgical cases were managed at the PRUH and alternative arrangements made for those children who fell outside the scope of the relevant pathways.
- Doctors' handovers between the night team and the day team took place in the morning and a consultant was present. Incidents had been highlighted during daily handovers. Doctors' ward rounds took place twice daily and were facilitated by a consultant paediatrician. Surgical patients were reviewed by their named consultant but also by consultant paediatricians to ensure that their medical needs were being met.

Major incident awareness and training

- Senior nursing and clinical staff reported that they had received major incident awareness training. However, it was not clear from our discussions with junior staff that any training had taken place to allow them to rehearse the appropriate local protocols.

Are services for children and young people effective?

Good

The children and young people's service used evidence-based national guidance to assist in the delivery of care, and it participated in a range of national and local audits to measure its clinical effectiveness and to drive improvements and unit performance.

Overall, performance against a range of national audits provided mixed outcomes; performance against the

national paediatric diabetes audit was better than the national average. However performance against the British Thoracic Society's asthma audit was worse than the national average on a range of outcomes. Performance against the national neonatal audit programme also produced some mixed results. The local clinical teams were aware of the areas that required improvement and had a local action plans to address them.

Children had been given pain relief appropriately. Children and adolescents needing a psychiatric assessment were referred to the Child and Adolescent Mental Health Services (CAMHS).

Parental consent was sought appropriately before treatment was provided. There was consultant cover seven days a week, supported by a team of registrars, and there was effective multidisciplinary team working within the service and with other services in the trust, as well as with external organisations. There were some areas for improvement in the multidisciplinary working arrangements within the special care baby unit (SCBU).

Evidence-based care and treatment

- The trust's hospital protocols were based on the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH) guidelines. Local policies were written in line with this. Staff knew where to find policies and local guidelines, which were available on the intranet. We noted that two policies stored in the SCBU were excessively out of date and made reference to 'Bromley Hospitals NHS Trust' ,which had merged with two other organisations in April 2009.
- The SCBU was seen to use NICE clinical guideline 149: Antibiotics for early onset neonatal infection.
- There was a range of clinical pathways and protocols for the management and care of various medical and surgical conditions. These had been developed in conjunction with healthcare professionals from a range of specialties.
- Nursing staff confirmed that clinical governance information, and changes to policies, procedures and guidance, had been cascaded down by the matron and ward manager via emails, special meetings and discussion at team meetings, which were held every 6 weeks.

Pain relief

- We observed that a variety of tools was used to assess pain, depending on the age of a child and their ability to understand information. The pain assessment chart was embedded in the BPEWS chart. For a younger child, we noted the pain assessment tool with 'smiley faces' had been used. The child had been asked to choose a face that best described their pain. In the case of a child with a learning disability, a face, legs, activity, cry, consolability (FLACC) behavioural tool was used.
- Condition-specific guidance was available to staff to help them manage cases (for example, those presenting to the hospital in sickle-cell crisis).
- We saw that the SCBU used kangaroo care (a technique where the baby is held skin-to-skin with the parent) as a means of helping to stabilise neonates. We observed that parents were encouraged to engage in skin-to-skin care as frequently as the condition of the baby permitted.
- We observed some children being cared for by nurses postoperatively in one bay on the children's ward. Two children told us they were not in any pain because they had been given medicines for pain. Parents confirmed that their child had been given pain relief appropriately.

Nutrition and hydration

- Patient records included an assessment of each patient's nutritional requirements. The service used the adapted Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) to assess nutritional risk for all patients.
- Patients with poor food and hydration intake were observed closely. The care pathway observation chart included a section for nurses to monitor the food and fluid intake of these patients. This ensured that patients' nutritional and hydration needs were monitored and maintained.
- Parents and children commented that there were choices on the menu offered each day and that the food provided was "good". The menu card was given to patients to make their choices in the morning and hot meals were served twice a day. Sandwiches and snack boxes were available throughout the day. We saw that children had drinks by their bedside.

- Both the ward and the SCBU had facilities for parents to prepare their own meals and drinks.
- The SCBU operated one of only 15 donor breast milk banks in the country. The milk bank was a member of the United Kingdom Association for Milk Banking. There was a process for receiving and screening donor breast milk that was coordinated by a substantive band 6 donor milk nurse.

Patient outcomes

- The service participated in a range of national audit programmes so that benchmarking and measuring of clinical effectiveness could take place. Audits participated in included childhood epilepsy, British Thoracic Society Paediatric Asthma, National Paediatric Diabetes, maternal, infant and perinatal (MBRRACE-UK) and the National Neonatal Audit Programme (NNAP).

National Paediatric Diabetes Audit

- HbA1c measurement is recognised as the best indicator for long-term diabetes control; data from the 2013 National Paediatric Diabetes Audit showed that the PRUH paediatric diabetes service performed better than the national average with regard to Hba1c ratios below 58mmol/mol in that 19.1% of the hospital case mix had a Hba1c below this level; this compared with a national case mix mean of 17.1%.

British Thoracic Society Paediatric Asthma Audit

- Performance against the national clinical audit for paediatric asthma was varied. A higher proportion of patients could expect to receive both a chest x-ray and also prescribed antibiotics if they were admitted to the PRUH when compared nationally (72% of children had a chest x-ray versus 26% nationally, and 61% of children received antibiotics versus 26% nationally). Fifty per cent of children who were administered steroids to help manage their condition had received a dose before admission versus 18.6% nationally.
- It was reported that no children received information leaflets, peak flow meters or a store of steroids before discharge; this compared negatively against national performance where 47% of children were given information, 4% were given a peak flow meter and 11% were given a store of steroids. Furthermore, the number of children who had their technique for using an inhaler device assessed before discharge was reported as 6% locally versus a national average of 44%.

National Neonatal Audit Programme

- Performance against the NNAP 2013 was varied. The SCBU performed better in three out of five key indicators: administration of antenatal steroids (83% locally versus 79% nationally); the number of eligible babies screened for retinopathy of prematurity (RoP) (100% locally versus 87% nationally and 98% regionally); and the number of babies discharged home receiving some or all of their mother's breast milk (45% locally versus 35% nationally).
- The SCBU performed worse than the national average in two areas against the NNAP 2013: recording of a baby's temperature within 1 hour of birth (64% locally versus 89% nationally); and the number of cases where there was a documented consultation between parents and a senior member of the clinical team within 24 hours (74% versus 79% nationally). That said, the number of parents who received a consultation before the birth of their baby was better than the national average, with 13% of parents being offered a pre-birth consultation. We observed expectant mothers receiving a tour of the SCBU on the day of our inspection.
- There were care pathways for patients with certain conditions such as diabetes, head injury, management of acute abdominal surgery in children aged above and below 5 years or asthma. Work was in progress to revise the paediatric/ED care pathway at the PRUH after a meeting on 20 February 2015. The surgical, ED and mental health pathway groups were developing pathways for the management of appendicitis and children requiring referral to CAMHS.
- The PRUH paediatric surgical meeting minutes dated 24 February 2015 reported that two care pathways had recently been signed off by the anaesthetic team: the 'Paediatric ENT pathway PRUH – Child requiring ENT intervention including stridor' and the 'Paediatric orthopaedic pathway – Child requiring orthopaedic Intervention'.
- The service had two clinical nurse specialists for diabetes. Their role included reviewing new admissions and they also visited different schools in the local community to educate teachers on the care of the diabetic child and how to look after the individual patient in their school.

- Nursing staff on the children's ward confirmed that local audits had been carried out on hand washing, pain assessment documentation, medicine charts, BPEWS, care plans and other records. Staff received feedback on the outcomes and action plans were developed when necessary.
- We case-tracked three patients' care plans on the children's ward. We found appropriate care and treatment had been provided for the patients postoperatively. We observed constant care and supervision by the nurse allocated to each patient. The observation records had been well maintained. For example, in the case of a patient admitted during the night via the accident and emergency (A&E) department for surgery, BPEWS scores had been recorded since admission and postoperatively. We saw that the paediatric neurovascular circulation chart for fracture operations was used. Before surgery, a patient was seen by the consultant surgeon and anaesthetist, and parental consent was obtained. The preoperative patient documentation and checklist were used. We saw a copy of the theatre checklist that was signed by the surgeon and two other theatre staff. The trust protocols had been followed.

Competent staff

- The ward manager carried out appraisals for nursing staff, identified training and development needs, and maintained records of staff.
- Staff reported that they had attended both induction on starting employment and mandatory training including basic life support. All nursing staff working in the SCBU had completed newborn life support training.
- Staff working in other areas of the hospital where children were treated, such as the outpatients' surgical unit, had all completed life support training, and there were paediatric-trained staff on each shift.
- Staff commented there had been more training opportunities for nurses since King's College Hospital NHS Foundation Trust had acquired the PRUH. Training included paediatric intensive life support (PILS), tracheostomy care, paediatric intensive care, mentorship and antibiotics given intravenously. One healthcare assistant had been supported financially to undertake general nurse training. They had now completed this training and would shortly be joining the team on the children's ward as a newly qualified nurse.
- There were arrangements in place for ensuring that newly qualified nurses were orientated across both the hospitals (King's College Hospital at Denmark Hill and the PRUH). Newly qualified nurses were also supported by undertaking a preceptorship programme and receiving support from a practice educator.
- There were systems in place for monitoring training for new staff through the training department. A practice educator oversaw newly qualified nurses and those going through their induction period to ensure that appropriate training had been arranged for them. This included mandatory training, mentorship training and competency assessments, such as for the administration of oral and intravenous medication.

Multidisciplinary working

- Overall, staff reported good multidisciplinary working within the children's department, with other services within the trust and with external organisations such as the local authority and GPs who had made referrals. After an incident in which the service had difficulty sourcing a specialist tertiary bed for a patient who needed treatment for a mental health condition, significant work had been undertaken by the hospital and national commissioners to address contractual and commissioning issues so that care pathways could be improved.
- There were good shared care arrangements with surgeons and other services such as theatre, orthopaedic, dental, urology and psychiatry.
- Several multidisciplinary team (MDT) meetings were held monthly, including serious case reviews, a safeguarding steering group meeting and a weekly psychosocial meeting. The care and treatment of each patient was discussed and different views were listened to before making decisions in the best interests of the child.
- We found that, while there was a level of multidisciplinary working within the SCBU, dieticians raised concerns with us that they felt "surplus to requirements" in the unit and so no longer visited to offer advice and support.

Services for children and young people

- Activity facilities, such as toys, colouring books and games, were provided to entertain children on the ward. Play activity specialists covered the ward to assist inpatients.
- Certain individuals, especially those in the children's play specialist and education team, were key players in ensuring that children and their families were supported emotionally during their inpatient stay at The Princess Royal University Hospital. Play was recognised as having a special function within the hospital environment and was used as a therapeutic tool to support children.

Seven-day services

- There was a 24-hour consultant-led service, with medical and nursing cover for the children's ward and SCBU 7 days a week.
- CAMHS, allied professionals and other services provided 7-day cover between 9am and 5pm.

Access to information

- Staff could access guidelines via the intranet, and e-learning to complete their mandatory training.

Consent

- Parents on the children's ward and the day surgical unit confirmed that their consent had been sought before their child was treated. They felt they had been given clear information and were well informed before they signed the consent form for surgery and treatment.
- The ward manager confirmed that there had been no cases subjected to Deprivation of Liberty Safeguarding (DoLS). Members of staff were aware of the Mental Capacity Act 2005 and, if the situation arose, they would adhere to the Act and take appropriate action in the best interests of the child.

Are services for children and young people caring?

Good

Services for children and young people had a strong focus on providing family-centred care and staff strove to provide care that was compassionate, dignified and respectful. Parents were complimentary about the medical and nursing staff and they felt their child was in safe hands. They felt involved in the care of their child and participated in decisions regarding their child's treatment. Feedback from patient questionnaires was continually positive and parents considered that staff went "the extra mile", especially within the SCBU.

The concept of developmental care within the SCBU was strongly embedded and standard practice. Staff recognised the significant importance of the bonding process between the parent and newborn child. They strove to minimise the emotional impact that the SCBU environment had on new parents and also the newborn baby.

Parents were actively encouraged to engage in positive handling and touching of their baby as well as promoting the concept of 'kangaroo care'.

People who used services were active partners in their care. Staff were fully committed to working in partnership with families and children. They empowered parents and children who used the service to have their voices heard.

Compassionate care

- Throughout our inspection, we witnessed exceptional staff interaction with patients and parents. We observed good, friendly and appropriate communication by nursing and medical staff with parents and their child.
- Parents were all complimentary about the care their child had received and the staff who had provided it. Both children and parents were treated with compassion, dignity and respect.
- One parent commented, "Fantastic service throughout. The staff are polite and very helpful. My child is well looked after; the staff clearly go the extra mile."
- Another parent said, "It was an emergency last night; my child was seen very quickly. We received good service from admission to the ward. My child is in safe hands. The staff are respectful and helpful. We are going home shortly." Other comments included, "The staff are all great, both doctors and nurses."
- We noted that curtains were pulled around bed spaces for personal interventions and on ward rounds to ensure that the privacy and dignity of patients were protected.
- The service had introduced age-specific patient feedback questionnaires, although at the time of our inspection they had not yet started to compile data.

Services for children and young people

Understanding and involvement of patients and those close to them

- Parents felt well informed before they signed the consent form for surgery or other treatment. They felt involved in the care and the decisions regarding their child's treatment. One parent said, "I was given time to make my decision; there was no pressure put on me."
- Another parent commented, "The surgeon asked for my consent and explained the procedure and everything else. I was allowed to ask questions and I didn't feel rushed." There was a named nurse for the child.
- There was a good range of information leaflets available, including leaflets on various medical conditions and how to make a complaint. These leaflets were available on the children's ward and in the children's outpatients department.
- Patients' and parents' satisfaction survey questionnaires were available and the results were published on the dashboard, together with the actions taken to improve the service.
- On the day surgical unit, one parent commented, "It would have been good if we had met the consultant surgeon earlier on rather than on the day of the operation. We were told the person was on holiday. We did, however, see another consultant at the time." Both parents said they were very pleased with the theatre team and the unit staff.
- Parents reported that they were given appropriate information and the proposed treatment was explained to them by both doctors and nurses.

Emotional support

- All parents were complimentary about the staff of every discipline. One parent felt reassured and commented, "The doctors and nurses are very reassuring, especially for me as a parent. I am pleased with the care provided."
- We were told that, in the case of long-term patients who required emotional support, the medical team had made referrals to a specialist child psychologist.
- Parents whose babies were admitted to the SCBU were actively encouraged to participate in the concept of developmental care to ensure that their baby was appropriately supported and stimulated; this enabled parents to bond with their baby during stressful situations.
- Outcomes from the patient and parent experience measure (paediatric diabetes) suggested that, while parents and patients did not always strongly agree that services were caring and met their individual needs, performance against the 'Agree' component was better than the national average in 8 out of 9 measures.

Are services for children and young people responsive?

Outstanding ☆

The service maintained good communication and relationships with local GPs and other healthcare providers. The children's service worked closely with the integrated community children nursing team that provided nursing care for children at home. This ensured that patients received continuity of care when discharged from the hospital. Children with diabetes were well supported by the clinical nurse specialist.

Service planning and delivery to meet the needs of local people

- Both doctors and nursing staff said they worked well with local GPs, local authorities and other healthcare professionals. Generally communication within the multidisciplinary team (MDT) was effective.
- The nursing and support staff felt they had received appropriate training to meet the needs of children and young people in the community, including supporting children with diabetes, asthma, sickle cell anaemia or learning disability.
- The children's service worked closely with the integrated community children nursing team that provided nursing care for children at home. The team also visited children with complex needs and chronic illnesses. They carried out a range of services from dressing wounds to taking blood and giving injections.
- The matron said there was a good rapport with the integrated community children nursing team that attended ward rounds once or twice a week. This had improved the relationship with the team, encouraged shared learning and enabled early discharge. It had made it possible to respond better to each child's needs.

Services for children and young people

- The children's outpatients' department organised eight outpatients' clinics for diabetes, allergies, epilepsy, neurology, gastroenterology , cardiology, surgery and phlebotomy.
- The Alan Cumming day surgical unit treated 248 children between 1 January 2015 and 26 April 2015. The unit specialties included ear, nose and throat (ENT) surgery, eye surgery and dental extraction under general anaesthetic for children with special needs.

Access and flow

- There was a good flow of patients in the children's ward, including day cases for elective surgery and medical inpatients. Staff confirmed that there had been no incidents of surgery being cancelled on the day in recent months, and this was reflected on the child health scorecard.
- Once admitted onto the children's ward, patients were usually seen within an hour. Parents confirmed this was the case. Many patients were referred by their GP and the first point of admission was the accident and emergency (A&E) department. Patients who needed admission would be transferred to the children's ward.
- Parents reported that their child had received good continuity of care on the children's ward.
- Parents were aware of the plans for their child's discharge and follow-up appointments, and they felt well informed.
- Parents were given information about the integrated community nursing service and a referral if required.
- The SCBU was commissioned to support 12 cots. However, the department had significant environmental capacity to provide extra cot spaces. Performance against both the 31- and 62-day cancer waiting list was 100% as at September 2014.
- The scorecard for the service that was given to us lacked any data with regard to emergency readmission rates, diagnostic waits of more than 4 weeks and incomplete referral to treatment time pathways.
- The outpatient 'Did not attend' rate was seen to be improving although performance remained red rated against the trust target.
- We found the Alan Cumming day surgery unit, which was part of the adult critical care and theatre and diagnostic service, had provided day surgery for children. From 1 January 2015 to 16 April 2015, the unit had carried out 248 surgical procedures on children.

Meeting people's individual needs

- Support was available for patients with different medical needs, such as diabetes, sickle cell anaemia or an allergy.
- The menus included cultural dishes reflecting the local community.
- There were information leaflets available for many medical conditions, including child-friendly leaflets on diabetes, asthma and sickle cell anaemia.
- The children's outpatients' department and the day surgical unit had good play areas, with toys and games for younger children.
- Children were given educational support 5 mornings a week. The teacher gave a range of subjects for the children to choose, depending on their age group. When a patient was admitted, one of the teaching staff spoke to the child and their parents. All activities were documented in accordance with education guidelines. The education team was able to provide specialist support to children with learning and complex physical disabilities; this included the use of pictorial communication tools as well as one member of staff being trained to use Makaton.
- On the children's ward, parents could stay overnight, next to their child's bed.
- The diabetes clinical nurse specialist (CNS) confirmed that parents and their child would be seen on the ward and supported and guided in managing the diabetic equipment to be used. The CNS instructed the parents and the child, depending on the child's age group and ability. A competency form for parents or carers would be completed before discharge. Parents and children were given the contact number of the named CNS who would follow up with telephone calls and home visits; if necessary, the child could be seen on the children's ward.
- Translation services were available for patients and families for whom English was not their first language.

- Information leaflets for parents were on display on the noticeboard on the children's ward and in the SCBU.
- People's individual preferences and needs were always reflected in how care was delivered.

Learning from complaints and concerns

- Staff confirmed that the ward manager discussed at staff meetings any concerns or complaints raised, and the lessons learned. The minutes of the children's ward sisters meeting dated 30 March 2015 indicated that one complaint was being investigated.
- There were information leaflets displayed on how to provide feedback on the service patients had received, and how patients and relatives could make a complaint.
- After repeated complaints about the choice and quality of food, the service had worked with the third-party catering provider to improve the meals.

Are services for children and young people well-led?

Good

Staff were aware of the trust's vision and values, and were given information by their line managers about developments within the trust. The service had a specific child health strategy that was aligned with the trust-wide strategy. The strategy was driven by quality and safety, and took into account the requirement for the service to be fiscally responsible.

There were governance arrangements in place for which a range of healthcare professionals assumed ownership. There was evidence that risks were managed and escalated accordingly. However, there were a small number of examples where risks that might have an impact on the clinical effectiveness of the service were not recorded on the divisional risk register.

Since our previous inspection in December 2013, the service had introduced a quality measurement scorecard; however, there was a lack of information for some metrics, which meant that the scorecard was not being used to its optimum.

Nursing staff reported good management support from their line managers. They felt they received appropriate training to meet the needs of children, babies and young people in the community. They generally spoke positively about the recent acquisition by King's College Hospital NHS Foundation Trust. However, there was frustration with the use of some phrases such as 'It's the King's way or no way'.

Vision and strategy for this service

- There was a service-level clinical strategy for child health that was aligned to the trust strategy. The strategic vision included both short- and long-term priorities for the next 1–2 years and 3–5 years, respectively, and included developments regarding the environment, finance, service provision and governance arrangements.

Governance, risk management and quality measurement

- Governance arrangements at the Princess Royal University Hospital (PRUH) were underpinned by a documented risk management process. which senior staff were well-versed with this and reported that it's overall effectiveness was good. There was engagement from a range of health care professionals with regards to the clinical governance and risk management process.
- Regular directorate meetings, chaired by a named clinician responsible for clinical governance, were held and attended by a range of health professionals including nursing staff and the divisional quality and risk lead. Outcomes of the child health and risk management group (CHARM) meetings were discussed at the child health divisional quality and governance committee meetings that were hosted on the Denmark Hill site; representation from the PRUH clinical and nursing team was evident.
- Standing agenda items at the CHARM meetings included reviews of actions from previous meetings, reviews of the divisional risk register, reviews of recent incidents, consideration given to recent safety alerts and infection control issues.
- It was evident that some issues that had had an impact on the clinical effectiveness of the service, including the commissioning arrangements for Child and Adolescent Mental Health Services (CAMHS), had been escalated to the divisional risk register, and that action was being taken to address these issues.
- Furthermore, there was evidence that serious incidents were being appropriately investigated and lessons

learned disseminated to staff. Examples included learning after an incident involving the transfer of a neonate in 2014. There had been engagement with external health professionals who had also been involved in the care of the baby to ensure that lessons were disseminated.

- However, we noted that some risks that staff spoke about had not been recorded on the divisional risk register. An example was the lack of medical equipment including patient monitors and drug infusion devices. Senior members of staff were aware that this had caused problems with the delivery of care on a number of occasions, and business cases had been developed and submitted to the executive team for consideration. While staff had clearly escalated the risk and taken action to resolve the issue, the fact that the issue was not recorded on the register meant there was a risk that escalation of the problem may not always have sufficient oversight and mitigation in place to effectively educe the risk of harm
- While the service had introduced a child health scorecard so that the quality of service provided could be monitored, we found that some metrics contained no information. It was therefore not possible to be reassured from the scorecard that all components of quality measurement all quality measurements were being effectively undertaken.
- Staff reported that, after our previous inspection in 2013, efforts had been made to review the provision of paediatric surgery services at the PRUH, including anaesthetic cover to ensure that services were safe. We noted that a number of paediatric surgery committee meetings had taken place. Staff reported that it was sometimes difficult to ensure that all relevant healthcare professionals attended the meetings so that risks and service provision could be widely discussed.. It was noted that there had been no representation from the anaesthetic team at either the January or February 2015 meetings despite there being a standard agenda item for updates to be provided by the anaesthetic team.

Leadership of service

- Staff were complimentary about the front-line management team. Junior doctors felt the consultants were approachable and supportive.
- The ward manager for the SCBU had chosen to remain as part of the workforce numbers. While staff reported that it was positive to see the ward manager working clinically, it was acknowledged by the ward manager that development of band 6 nurses with regard to clinical leadership could be impeded by this arrangement.
- The appointment of a named neonatologist had meant that the SCBU had evolved from a nurse-led service to one that was medically led. The relationship between the consultant and nursing team was considered to be fractious at times because of differences of opinion, although it was important to note that both groups of healthcare professionals had the interests of the neonate at the centre of all decisions being made.

Culture within the service

- Staff generally spoke positively about the recent acquisition of the hospital by King's College Hospital NHS Foundation Trust although a number of staff voiced their frustration at the frequently used term 'It's the King's way or no way', which we heard being used by staff across the service. Staff of all disciplines reported that they worked well together and spoke positively about the service they provided.
- Staff felt there was a positive, open and supportive culture, particularly from managers, who were accessible and supportive of staff.

Public and staff engagement

- There was no formal patient engagement group. In part, this was due to the rapid turnover of patients across the service, with some patients only needing treatment for periods of less than 24 hours. However, the children's ward used the trusts "How are we doing" survey which incorporated NHS Friends and Family Test (FFT). They also took part in the 'You said, we did!' initiative whereby children and parents raised issues and the changes and responses were publicised on information boards on the children's ward and in the SCBU.

Innovation, improvement and sustainability

- Nursing staff felt there had been more training opportunities since the acquisition of the hospitals.
- Staff felt there had been some challenges in 2014 regarding missing notes, duplication of patients' notes and errors with reference numbers. However, staff commented that the situation had since improved.

End of life care

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

Information about the service

Kings College Hospital NHS Foundation Trust provides integrated end of life care across two hospitals; Denmark Hill and Princess Royal University Hospital (PRUH). End of life care was not seen as the sole responsibility of the Specialist Palliative Care (SPC) Team.

The PRUH site team consists of a SPC team that works in partnership with the local voluntary sector hospice provider, St Christophers, to provide support to patients with complex symptoms at the end of life. Palliative care consultants (0.9wte) and a part time (2.6wte) clinical nurse specialists(CNS) support the generalist staff in the delivery of end of life care, training and education of nursing and medical staff.

The SPC team is led by a Palliative Care Consultant and a Nursing Matron. The team consisted of CNSs, a service manager and team administrator. In addition, the bereavement office staff provides bereavement support after the death of a relative and the chaplaincy team provided multi-faith support. The core SPC team is available 5 days a week, Monday to Friday 9am - 5pm. At weekends and bank holidays, telephone advice is available from the consultant on call.

During our inspection we visited a variety of wards across the trust including Chartwell, the intensive therapy unit, stroke unit, Emergency Department and medical 1,2,3 and 8 wards ,the mortuary, bereavement centre and the chaplaincy to assess how end of life care was delivered.

We spoke with a palliative care medical consultant, junior ward doctors, CNSs, nurses,ward managers and matrons, mortuary staff and the hospital chaplain.

We reviewed documents relating to the end of life care provided by the trust and the medical records of six patients receiving end of life care. We observed the care provided by medical and nursing staff on the wards, and spoke with two patients receiving end of life care.

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

End of life care

Summary of findings

The Specialist Palliative Care (SPC) team provided face-to-face support 5 days a week, with a palliative care consultant on call providing telephone out-of-hours and weekend cover. There was strong clinical leadership of the SPC team. However the team was an unfunded resource which meant it was overstretched and reliant on the good will of the staff to maintain an effective service delivering compassionate good quality care.

No nursing cover was available when the clinical nurse specialists were on leave. All staff worked long hours to deliver the necessary end of life care to patients.

A bereavement service was not available at the PRUH as there was no resident social worker employed within the SPC team. The SPC CNS met with bereaved relatives and offered support by referring relatives to community services.

The PRUH had a strong well led chaplaincy team that supported the SPC team and wards with religious and spiritual support for patients and families. There was excellent spiritual and religious awareness across the hospital and facilities were in place to support the different cultures and religions of the local population. Relatives of patients receiving end of life care were provided with open visiting hours and patients were generally nursed in single rooms.

There was a multidisciplinary team (MDT) approach to facilitate the rapid discharge of patients to their Preferred Place of Care(PPC) or Preferred Place of Death (PPD). Patients were cared for with dignity and respect and received compassionate care.

Medicines were provided in line with guidelines for end of life care. Although there was a unified Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) policy, orders were not consistently completed in accordance with trust policy.

Are end of life care services safe?

Requires improvement

All the staff we spoke with told us they were encouraged to report incidents using the electronic reporting system. At the PRUH two serious incidents relating to medicine errors had been reported in the last year by the SPC team. We saw that clear descriptions were recorded of the incidents and the actions that followed. Learning from incidents was achieved by entering them on the risk register, including them in a daily bulletin to staff, emailing consultants and setting up a web page.

The trust had a project to develop 'treatment escalation plans.'(TEPS) We saw evidence of TEPs on both the Medical 3 wards and the Chartwell ward. However we found that forms were not signed or dated and no discussions recorded only the level of intervention was ticked.

The SPC clinical nurse specialist team consisted of four CNSs (2.6wte). During times of absence the service was not covered which meant that patients with complex symptom's may have had to wait longer for specialist input to manage their symptoms. The PRUH had one consultant in palliative medicine (0.7wte), with support from a second consultant (0.2 wte) one day a week from the Denmark Hill site. We were told that when the consultant was on leave there was no medical cover at the PRUH.

Out of hours and weekend medical cover was telephone advice via the consultant on-call rota. The service did not have any specialist registrars.

Incidents

- All the staff we spoke with told us they were encouraged to report incidents using the electronic reporting system.
- Incidents that related to end of life care were discussed at the Palliative Care Governance meeting. To monitor adverse incidents, the SPC team had set up a 'governance action tracker'. We reviewed the action tracker for January/February 2015 and saw that seven incidents were logged for both the Denmark Hill site and PRUH.
- At the PRUH, one serious incident related to a medication error had been reported in the last year. We saw that clear descriptions of the incidents were

recorded as were the actions taken after the incidents. Learning from incidents was achieved by entering them on the risk register and including them in a daily bulletin to staff, emailing consultants and setting up a web page.

- The mortuary provided data across both hospitals from incidents reported from 1 of January 2014 with summaries of the action taken to mitigate the risk of reoccurrence. Reviewing the list a total of 10 incidents have been reported at the PRUH. Of these, five were classed as yellow (i.e. low risk) and five green incidents (i.e. no risk). We reviewed how the risks were managed and saw that appropriate procedures were followed.
- On Medical ward 1 the ward manager told us that feedback from incidents would be at handover or via email because staff shortages meant that the ward was unable to have staff meetings.

Cleanliness, infection control and hygiene

- The wards, mortuary and viewing areas we visited were clean, bright and well maintained. In all clinical areas, the surfaces and floors were covered in easy-to-clean materials allowing hygiene to be maintained throughout the working day.
- Ward and departmental staff wore clean uniforms and observed the trust's 'bare below the elbow' policy. Personal protective equipment (PPE) was available for use by staff in all clinical areas. In the mortuary, we observed adequate supplies of PPE for use by visiting undertakers and porters.
- Draft guidance was available for staff to follow to reduce the risk of infection when caring for people after death. This was in the trust's 'last offices policy', which was in draft form and due to be introduced across all areas of the hospital. This policy was to be ratified by the end of life strategy group on 17 April 2015. It included the wearing of gloves and aprons, and the use of body bags.

Environment and equipment

- People reaching the end of their life were nursed on the main wards in the hospital. The bereavement policy suggested that, whenever possible, patients are cared for in side rooms on wards to offer quiet and private surroundings for them and their families; we saw this in practice when we visited the wards.
- The same syringe driver was in use across all wards and delivered consistent infusions of medication to support end of life patients with complex symptoms. The palliative care CNS told us that they had introduced an updated syringe driver checklist for monitoring syringe driver use. We saw evidence of the checklist on Chartwell Ward. The syringe was checked 4-hourly in line with trust policy.
- Syringe drivers were available across the hospital from the medical equipment library. The nurse responsible for a patient's care had to supply the patient's hospital number, name and ward before the pump could be used.
- We were told that the syringe drivers were serviced by the electronic and biomedical engineering team yearly. It was the responsibility of the ward to clean the driver before returning it to the equipment library. We saw that the SPC team had developed a user's guide for the syringe pump.
- Pressure-relieving equipment was available for patients needing it. Staff confirmed that alternating pressure mattresses were available. We saw these mattresses in use on both Medical 3 and Chartwell wards where two end of life patients were being nursed on an air mattress.
- The mortuary was secured by a swipe card system to prevent inadvertent or inappropriate admission to the area. Fridges were lockable to reduce the risk of unauthorised access and cross infection; however, staff told us they did not routinely lock fridges because the mortuary was secured.
- Mortuary staff told us that all the equipment was maintained by the estates department. Staff told us that, when equipment was broken, it was repaired in a timely manner.

Medicines

- The SPC team had introduced the 'Management of the dying patient', which included clinical guidelines for the control of symptoms and the management of patients who had been recognised as dying. The guidelines gave good, easy-to-follow instructions and information, including signs commonly seen in the last few days of life, common symptoms and essential components of care.
- Clear guidelines set out the drug management of symptoms in the dying patient and included reducing medication to a minimum, route of administration, 'as required' medication and the medication necessary to support the management of the five symptoms

experienced by patients at end of life. Symptom control algorithms had been agreed and implemented to support the management of dying patients. These were available on all wards.

- Medical teams were asked to contact the SPC team if symptoms persisted or the patient had a complex medical condition such as Parkinson's disease or diabetes. We saw that a second set of guidelines had been developed to support patients with end stage renal failure.
- The trust had undertaken an audit following the National Institute of Health and Care Excellence (NICE) guidance 'Opioids in Palliative Care'. Specific challenges identified included leadership, generalists versus specialists and monitoring outcomes. The King's opioid safety group (KOSG) meeting was developed to provide leadership. The terms of reference clearly set out the purpose of the committee, which includes focusing on adverse incidents, monitoring any developed action plans, reviewing the pain and palliative care register, reviewing safety alerts and cascading results via the risk management department. reviewing serious complaints, and reviewing and approving local guidelines.
- Minutes of a KOSG meeting showed that adverse incidents were discussed and a new KOSG action tracker was set up. Discussions around safety alerts included high-strength opioids that must not remain on the wards and need to be returned to the pharmacy within 7 days. Patient information was discussed, including whether there was a need to improve. The trust had responded proactively by establishing this group to provide leadership in the management of opioids which would improve patient safety. This was shown by the new 'opioid patch monitoring chart', approved by the group in February 2015, and which we saw in use on the wards we visited. This was secured in an inpatient's paper prescription chart. Two of the SPC CNSs were non-medical prescribers. One told us that syringe drivers delivered a dose over 24 hours and SPC CNSs reviewed the medication daily. We observed this when we visited Chartwell ward with the SPC CNS and saw the reviewing of prescribed medication.
- We were told by staff on the wards we visited that medication for end of life care was available on the ward and easily accessible. This was confirmed by the sister on the stroke unit. We saw that locks were installed on all store rooms, cupboards and fridges containing medicines and intravenous fluids on the wards we visited. Keys were held by nursing staff.
- On Medical 1 ward we saw that controlled drugs (CDs) were handled appropriately and stored securely, showing compliance with relevant legislation. CDs were regularly checked by staff working on the wards we visited. We audited the contents of the CD cupboard against the CD register on two wards and found they were correct. A registered nurse (RN) told us that, when delivering CDs, 2 RNs were present; they would observe the patient taking the drug and record that it had been administered. The two nurses would sign the safe delivery of the medication.

Records

- The PRUH was in the process of changing from paper to electronic patient records (EPRs). On Farnborough ward, we reviewed an end of life patient's notes and found many of the sheets were loose within the medical notes. This introduces a level of risk because information or instructions may be missed or lost.
- The SPC team completed a set of palliative care notes that stayed with the team. On the patient's first review with the team, a holistic assessment was undertaken and from this a management plan was developed. A copy of the first assessment was photocopied and placed in the patient's medical notes. This was confirmed on Medical 8 ward where we saw a printed-off version of the holistic assessment carried out by the SPC team
- We reviewed a set of medical notes for a patient on Medical 3 ward who was receiving end of life care, and saw evidence of good record keeping. Full discussions with the patient of their medical condition and mental capacity, and discussions with the family, were recorded; end of life care was recognised and recorded. Comfort care was documented as the goal of care. A referral had been sent to the SPC team. We observed that, when the SPC team reviewed a patient, a 'palliative care sticker' was placed in the patient's notes where the team member wrote their review. This highlighted to medical and nursing staff that a review had taken place and was readily accessible.
- The SPC team told us that a morning handover meeting took place to share key patient information, review referrals that needed an urgent management decision

and prioritise the day's work. Information discussed during these meetings was documented on the ward list on the palliative care server that recorded a patient's diagnosis, date seen and comments. This allowed all team members to access the information to ensure that there was good communication between and that accurate patient records were kept.

- On the stroke unit, in the nursing notes we reviewed, we found that documentation on clinical care was good but we saw no note of discussions with family or any end of life care plan. A trust web page was set up to guide staff, covering the key areas of an individualised end of life care plan, on-going care and care after death.
- An SPC CNS told us that they visited the wards daily to support the nurses and doctors with documentation. We were told there were no standard care plans for end of life care but the palliative care consultant said the trust might have to develop something to ensure that good end of life care was delivered to all .We saw that care was delivered and recorded. Patients receiving end of life care were placed on the 'generic medical pathway'.
- The chaplaincy service used a database to enter minimal data about their consultations. This included the patient's name, date of birth, episode of care and any particular requirements.

Mandatory training

- We reviewed the end of life training programme that was last updated on 6 April 2015. An end of life e-training module was developed in 2012 with mandatory training for nurses introduced in 2013. The trust had set an 80% compliance target. However, across the trust staff were achieving 60%. The wards that were achieving above the 80% target included Surgical 1 ward (100%), Surgical 2 ward (81.82%), Surgical 4 Ward (81.82%) and Surgical 8 ward (91.30%). Wards that were not reaching the 80% target included Farnborough ward (42.31%), Surgical 6 ward (39.13%) and Medical 2 ward (61.11%).
- Information showed that other staff across the trust, where end of life training was not mandatory, had completed the module. A variety of healthcare professionals including managers, consultants, occupational therapists and physiotherapists. The SPC CNS showed us evidence of an action plan that the team had put together to maximise measurable outcomes of training, including mandatory end of life training. One member of staff was allocated 6 extra days to help implement the action plan. We reviewed the plan and saw that 11 of the 12 actions had been achieved, with only one not being completed within the time frame set.
- The mandatory training records of the SPC team were up to date. Most of the team had completed their training in line with trust policy.

Assessing and responding to patient risk

- The trust had a project to develop 'treatment escalation plans' (TEPS). These plans would ensure consistent consideration of treatment and care needs, and support the timely decisions on the ceiling of care and resuscitation status for patients who were moving towards the end of their life. The plans were developed with involvement of the patient and family. We saw evidence of TEPs on both Medical 3 and Chartwell wards; however, we found that both forms were neither signed nor dated and no discussions were recorded; only the level of intervention was ticked. On Farnborough ward we saw the TEP was dated and signed however we saw no documentation of any discussions with the family.
- We spoke to a junior doctor on Chartwell ward who showed us that doctors working over the weekend had access to management plans for all the patients on the wards who had TEPS in place. This gave doctors, who did not know the patients, clear guidance on their management over the weekend. The system ensures that there was good communication around care and patients' needs were clearly documented and passed on to the doctors covering weekend and night shifts to ensure that safe consistent care was delivered.
- The sister on Medical 3 ward told us that risk assessments were carried out on admission. Assessments included moving and handling, pressure areas and nutritional risk assessments. We reviewed a set of nursing notes on the ward and found little evidence of individualised care plans or regular monitoring for comfort. It had been 3 days since the patient's bowel chart had been completed. Nursing observations had not been regularly recorded. No obvious pain scale was recorded. However, we saw that the monitoring of regular vital signs was discontinued when end of life care was recognised.
- For other patients with advanced illness, intervention was reduced to a minimum. Care was based on ensuring that the person remained as comfortable as

possible at all times. When patients were identified as at the end of their lives, monitoring was modified to ensure an emphasis on comfort. The charge nurse on Chartwell ward told us that intentional rounding took place hourly for dying patients, during which staff looked at hydration, nutrition and comfort with on-going symptom assessments to ensure that the patient was comfortable. We reviewed the medical records of a patient receiving end of life care and saw that palliative care medication had prescribed to include an opioid patch, syringe driver and anticipatory medication. Spiritual and emotional support were delivered by the SPC team. All steps were being taken to ensure that comfort care was delivered.

Nursing staffing

- The SPC CNS team consisted of four CNSs (2.6 wte). The team had one CNS who supported the palliative care service full time. The other CNSs had split roles that included one CNS covering palliative care and advanced breast cancer and the other CNS covering palliative care and lung cancer. The nursing team was managed by a 0.2 wte matron who had a large portfolio of roles and therefore could only support the team for 1 day per week.
- The number of staff did not allow flexibility in the service. During times of absence, the service was not covered. This meant that patients with complex symptoms might have to wait longer to have the specialist input to manage their symptoms

Medical staffing

- The PRUH site had one consultant in palliative medicine (0.7 wte) with support from another consultant (0.2 wte) 1 day a week from the Denmark Hill site. However, we were told that some of the time at the PRUH was spent covering the role of the assistant medical director. We were told that there was no medical cover at the PRUH when the main consultant was on leave. A palliative care consultant from St Christopher's hospice visited the PRUH on a Friday.
- Out-of-hours medical cover was provided by telephone via the consultant on-call rota.
- The PRUH had no specialist registrars.

Major incident awareness and training

- We were told by mortuary staff that a storage contingency plan was in place. The mortuary had capacity to store 67 deceased patients. If extra storage spaces were needed, a contract was made with a local undertaker. Staff told us that a business case had been developed for a room to store bariatric patients. However, we were told this business case had been put on hold because it was too costly. The mortuary could store patients weighing up to 28 stone .

Are end of life care services effective?

Requires improvement

The trust had responded to the national recommendations of the Liverpool Care Pathway (LCP) review. From 12 November 2013, it had stopped using the LCP to support the care of the dying. Trust policy was that, after communicating to the patient and their family that the person was dying, an individualised end of life care plan would be developed that included regular assessments and the management of symptoms. We saw no evidence of individualised care plans other than standardised medical and nursing notes.

The PRUH took part in the National Care of the Dying Audit of Hospitals (NCDAH) in April 2014. This audit highlighted five of the seven organisational key performance indicators (KPIs) and 2 of the clinical KPIs, were not achieved. However, the specialist palliative care (SPC) team performed above the national average on 5 out of 10 clinical KPIs. We saw evidence during our inspection that the action plan was developed and in the process of being implemented. At the PRUH,

The palliative care consultant told us that the SPC team were 'under-resourced and busy'; it had received 1,100 requests in 2014/15. The SPC core team provided a Monday–Friday 9am–5pm service.

We saw no evidence of advanced care planning apart from the proactive elderly advanced care planning (PEACE) documentation and no electronic system in place to flag up any palliative or end of life care patients admitted to the hospital. Effective pain control was an integral part of the delivery of effective end of life care. On the wards we visited, we reviewed nine 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders and found several of them had not been completed in line with trust policy.

End of life care

Evidence-based care and treatment

- The trust had responded to the national recommendations of the Liverpool Care Pathway (LCP) review, 'More care, less pathway' (2013) by removing the LCP from the trust. From 12 November 2013 it had stopped using the LCP to support the care of the dying. On the stroke unit, the ward sister we spoke to confirmed that the trust was not using the LCP.
- To maintain standards and ensure consistent care for patients approaching the end of their life, staff were asked to continue to regularly assess the needs of all patients and clearly identify those who appeared to be dying. This should have been a multi-professional decision led by the consultant in charge. On Chartwell ward, the charge nurse confirmed that placing a patient on the end of life care pathway was a multidisciplinary decision made by the senior clinician.
- An SPC CNS told us that they reviewed patients flagged as requiring end of life care. Data submitted showed that a snapshot audit was taken between 16 and 22 March 2015. A total of 23 deaths occurred across the hospital. Fourteen of these had been referred to the SPC team. Of the nine, four were sudden deaths, two were patients whose condition had deteriorated and in the other three cases the patients' notes were not available. This suggests that in most cases ward staff were alerting the SPC team when the decision was made that a patient was dying. Depending on whether the patient was regarded as routine, urgent or an emergency, an SPC CNS then visited the ward and reviewed the patient with ward staff around the five priorities of care.
- Trust policy was that, after communicating to the patient and family that the person was dying an individualised end of life care plan would developed that included regular assessments and the management of symptoms. In one set of medical notes on Farnborough ward, we found a copy of the five priorities of care. However, we saw no evidence of individualised care plans to address the problems in the dying phase, a standard nursing care plan was in place. This was confirmed in a second set of notes where we saw no evidence of an individualised care plan other than standardised medical and nursing notes. However, risk assessments were undertaken, pain assessments were performed and opioids were given. Anticipatory medication was prescribed and given.
- Medical records of six patients receiving end of life care showed that the SPC team had supported and provided evidence-based advice (for example, on complex symptom control and support for the patients and families as they traversed the care pathway). This specialist input by the SPC team ensured that a high level of expertise was used to deliver the best possible care to end of life care patients and that people had a positive experience of (health)care. While on Chartwell ward, we observed the SPC CNS gave the doctor a verbal update on a patient reviewed.
- A document, 'Care of the dying: questions and prompts for all professionals' was introduced to the workforce in August 2013 at the Denmark Hill site in preparation for the removal of the LCP. The document listed a number of core principles that were felt to be crucial to good care in the last few days of life. These incorporated a number of the NICE Quality Standard 13 statements. The flowchart was a checklist, which aimed to support healthcare workers as an aide memoire. This had been introduced into the PRUH to support the delivery of good end of life care.
- The end of life care policy was published on 1 January 2015 after being approved by the end of life strategy group and ratified by the trust's executive board of directors. The policy set out the trust's response to the withdrawal of the LCP and the systems in place to support identification and care for people who were dying and their families. The policy complimented other trust documentation: 'The management of the dying patient: clinical guidelines for control of symptoms' (September 2014), the bereavement policy (2007) and the 'Do not attempt cardio-pulmonary resuscitation' policy (2014).
- The PRUH took part in the NCDAH round 4:2014. This audit highlighted five of the seven organisational key performance indicators (KPIs) and two of the clinical KPIs, were not achieved. However, the specialist palliative care (SPC) team performed above the national average on 5 out of 10 clinical KPIs.
- In order to address the issue of the organisational KPIs not being achieved, a detailed NCDAH action plan had been developed (dated 23 September 2014). We saw evidence during our inspection that this plan was being actioned. We observed that a trust board executive for end of life care had been appointed; this was the chief nurse. Access to information had been addressed with the introduction of the 'coping with dying' leaflet;

however, the facilities leaflet was still in development. A formal feedback process regarding bereaved relatives resulted in the introduction of the bereaved carer's survey.

- Over the year, a palliative care consultant told us that 30% of their patients had a non-cancer diagnosis and 70% had a cancer diagnosis.
- Although there was no electronic system to flag up if a palliative care or end of life patient had been admitted, the acute oncology nurse informed the SPC team if a patient with a cancer diagnosis had been admitted. Other patients were dependent on the ward-based staff to refer them.
- A palliative care consultant told us that the only advanced care planning undertaken was the proactive elderly advanced care planning (PEACE) document. This was for patients who do not have mental capacity and were being discharged to a nursing home. It was developed in conjunction with the family to establish care in the patient's best interest

Pain relief

- The SPC team was involved in advising and reviewing the medicines of patients approaching the end of life. On the stroke unit, the sister told us that the SPC team was very helpful and responded quickly to support complex symptom management, including advice on medicines to manage pain effectively. This was confirmed on Medical 3 ward where we observed that patients' medicines were rationalised and anticipatory medication prescribed. We were told by staff on the wards we visited that all patients who needed a continuous subcutaneous infusion of opioid analgesia or sedation received one promptly. We found no information for patients and relatives on end of life medicines.
- On Farnborough ward, we observed in a patient's medical notes that a pain assessment had been completed; anticipatory medication had been prescribed and given twice. An opioid patch monitoring chart was in the medical notes and last signed the day before. In a second set of medical notes, we reviewed we saw another opioid monitoring chart. However, this had not been checked for two days.
- A nurse on the stroke unit told us that they scored pain using the 0–10 scale but there was no formal documentation. This was confirmed by the sister who thought that pain relief was good on the ward, but there was little evidence of pain scoring. The nurse felt that pain relief was given in a timely manner but they were unable to provide evidence to support this.

Nutrition and hydration

- In the 'Management of the Dying Patient' guidance and the end of life care policy, multi-professional teams were encouraged to pay specific attention to a patient's nutritional and fluid requirements. The guidance stated that 'oral fluid and nutrition must always be offered provided this is not causing any harm or distress to the patient'. In the daily care plan review, staff were encouraged to help patients with nutrition and hydration, and to ensure that the views and preferences of a patient and their family around nutrition and hydration at the end of life were explored and addressed.
- On the stroke unit, the ward manager told us that discussions about end of life nutrition and hydration discussions took place at the multidisciplinary team (MDT) meeting with relatives when appropriate. Food and intravenous fluids were withdrawn if they was thought to represent a clinical risk. Each decision was made on an individual case-by-case basis.
- Thirty cases were reviewed in the quality sampling conducted between January and December 2014, and it was found that a review of the patient's hydration requirements had not been undertaken by a senior clinician in 27 cases. Discussion of nutrition and hydration with the patient did not take place in 28 cases and no discussion with the family in 27 cases. This suggested that further work was required.
- The trust had a mouth care policy. The sister on medical ward 3 told us mouth care was regularly performed on patients who were entering the final stages of their life. We observed an end of life patient receiving regular mouth care.

Patient outcomes

- We found no evidence that the EOLC Quality Assessment tool (ELCQuA) was used to support the hospital to self-access and track progress against the NICE quality standards. The SPC team monitors compliance with the NICE guidance (Quality Standard 13) through the clinical effectiveness group. Gaps and actions are included in a plan and monitored by the group. We reviewed the gap analysis dated 23 November 2014 and submitted by the trust. This

identified that the PRUH had no on psychological support available on site but could use support from the Denmark Hill site. No bereavement support was provided at the PRUH and patients were referred to the local community services if issues were identified.

- The SPC team had introduced 'quality sampling' to monitor the quality of care delivered to end of life patients against the five priorities of care. The first five deaths each month were audited.
- The quality sampling included assessing whether a senior doctor responsible for a patient's care had identified that they were dying, whether the diagnosis had been communicated and whether end of life care medicines had been prescribed. With regard to the 30 deaths audited between September 2014 and February 2015. several areas for improvement had been identified. These included documenting that the patient was dying, and prescribing end of life medicines. Recommendations from the audit were on-going education via road shows and end of life 'champions' on wards.
- The SPC team submitted data to the National Minimum Data Set that allowed the team to benchmark its service nationally and thereby encourage the service to improve.

Competent staff

- The palliative care CNS accesses trust-wide programmes such as preceptorship study days, all nursing and midwifery induction, and clinical support workers training. The palliative and end of life care educational plan showed that training days at the Denmark Hill and PRUH sites had been scheduled in for 2015/16. Training records showed that the SPC team at the PRUH were actively involved in mandatory training sessions throughout the year.
- Between April 2014 and March 2015, 64 training courses were delivered at the PRUH by members of the SPC team attended by 667 staff; 459 staff were trained in end of life care. Records of training sessions confirmed that the team's involvement in training staff around end of life care included a study day that took place in November 2014, with attendees including 37 nurses, 4 doctors, 4 occupational therapists and a physiotherapist, and another study day in February 2015 with FY2 junior doctors.
- Two-day courses in end of life care are planned for staff across both sites to attend. We observed that the next study days were at the Denmark Hill site on 11 and 12 May 2015.
- No study days were being held at the PRUH but staff could attend training at the Denmark Hill and at other London trusts.
- The SPC team at both the Denmark Hill and PRUH sites were actively involved in the training and teaching of medical and nursing staff. In February 2015, we observed that 13 hours were allocated to the training of doctors, 35 hours to teaching doctors and 13 hours to teaching nurses. A total of 61 hours of the team's time in February 2015 was allocated to training and teaching. Reviewing the training records, we saw that at the PRUH in February the SPC team were involved in both nurses' mandatory training and FY2 training.
- Medical training records showed that junior doctors, medical students and core medical trainees had received end of life training throughout the year. The SPC team's operational policy 2014/15 demonstrated that all team members had undertaken national advanced communication skills training.
- The syringe drivers were introduced at the PRUH in June and July 2014.Initial training was by a company representative. Site practitioners, matrons and senior nurses were trained along with nursing staff band 5 and above. About 150 nurses completed the initial training and then a cascading programme took place across all the wards with the palliative care team providing face-to-face training as required. On the wards we visited, staff confirmed that they had attended training and felt competent to use the syringe drivers.
- Records confirmed that 24 palliative care link nurses were available across the hospital wards with some wards having 2. An SPC nurse told us that this was work in progress. On the training and education action plan (January 2015), we saw that one action was to 'identify and train a link nurse on each ward'.
- Feedback to the link nurses was through the end of life care quality and implementation group. However, attendance at this group was poor with no one attending in March 2015. The palliative care consultant told us that new ways to giving feedback were being discussed. End of life folders had been developed and placed on the wards. These would be used to support the link nurses on the wards.

End of life care

- The chaplain was a 'Sage and Thyme – communications training' trainer. The aim of this training was to provide nurses and midwifes with the necessary skills to manage difficult situations. Other training includes talks on 'Spirituality and religion', which we were told had recently been given to a group of healthcare assistants.
- The SPC CNS team was line managed by the palliative care matron. We saw records confirming that the CNSs had the necessary qualifications in palliative care including a Master's degree and Master's modules in palliative care.
- Mortuary staff told us that they organised a porters' training programme, which included using hoists, placing bodies correctly and completing the register. The mortuary staff told us the porters were good. We saw that no incidents had been reported relating to the transfer of deceased patients.
- In the mortuary, staff told us they had received no end of life or communication skills training and had only learned through experience. Appraisals were not regularly undertaken and staff did not find them useful.

Multidisciplinary Team working

- The CNS's and palliative care consultant told us that morning handover meetings took place in which key patient information and urgent information were discussed. Individual team members triaged the requests as they came in. A key worker was allocated to each patient.
- A weekly MDT meeting took place on alternate Tuesdays and Wednesdays. During the meeting, all current and new patients were discussed. Bereavement and any discharges were also discussed. A record of each patient discussion and a summary was placed in the patient's clinical notes.
- We were told that members of the SPC team attended the upper-gastrointestinal, lung and breast cancer MDTs.
- The Denmark Hill specialist nurse in organ donation (SNOD) told us they attended meetings at the PRUH. After families had had a conversation about organ donation, they were given time to make a decision. If the families could not decide, the process was slowed down; if a decision could not be made, the process was stopped.
- To support the transfer of patients from the hospital to the community teams, the SPC CNS and the discharge liaison nurse described the communication flows and systems that were in place, including engagement with GPs and the district nursing, and community palliative care team. If specialist palliative care was required at home, the SPC CNS made a referral to the community palliative care team.
- Documentation was in place to support the discharge of patients. This covered management options and plans, medication and any follow-up arrangements.

Seven day service

- The SPC core team provided a Monday to Friday 9am–5pm service. At weekends and bank holidays, the service was supported by telephone advice via the consultant on call.
- The NHS BT organ donation service led by the SNODs were available across the hospital, Monday to Friday, 9am–5pm. Outside these times, an on-call service was provided.
- The chaplaincy service was available Monday to Friday, 9–5pm. Outside these hours, the chaplaincy provided an on-call service.

Access to information

- Trust policy was that patients who were recognised as deteriorating or dying would be started on the end of life care plan. We were told by staff that this began after discussion with the consultant, multi-professional team, patient and relatives. An end of life care referral was raised by the ward. This alerted the SPC team to visit the ward the next day to review the care plan with the nursing staff.
- The hospital did not have access to an electronic palliative care coordination system (EPaCCS) that would alert healthcare professionals across care providers to the wishes and preferences of an end of life patient.

Mental Capacity Act, Consenting and Deprivation of Liberty Safeguarding

- The trust had a Mental Capacity Act (2005) policy that included guidelines about patients with advance decisions to refuse treatment. On Medical 3 ward, we saw evidence of a full discussion of a patient's medical condition and mental capacity with the family to ensure that the best interests of the patient were being meet.
- Across the wards we saw that paper 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders were in place. Trust policy stated that all patients should have

a DNA CPR decision recorded within 24 hours of admission. A treatment escalation plan was being piloted that would specify the ceiling of care and would be put in place when the DNA CPR order was made.

- The DNA CPR policy had been developed separately from the resuscitation policy by the SPC team. In March 2015, a snapshot audit was undertaken of 29 patients, 20 patients in the acute medical unit (AMU) and 9 from the elderly care wards.
- The findings of the audit were that the documentation at the PRUH was better and more comprehensive than at the Denmark Hill site. All forms were legible. However, more documentation on the team members involved in the discussion was needed and better use of review dates. On the AMU, only 9 of the 20 orders had all their sections completed, and on the elderly care wards none had all their sections completed. An action plan was developed from the snap shot audit that included cascade teaching for all grades of medical staff across the trust regarding decision and document recording, more training for junior doctors, developing a KWIKI webpage (completed) and producing a patient information leaflet.
- Across the wards we visited, we reviewed nine DNA CPR orders. We found all forms were placed at the front of the patients' notes for easy access. However, in five cases we found no discussion had been documented that the family had been informed and in two cases no discussion had been documented that the patient had been informed. Three forms were not countersigned by a consultant and there were no review date in six orders. On Medical 8 ward, we saw an order that was incomplete. No discussions with the patient or family had been recorded. The reasoning for the DNA CPR was unclear in the medical notes and it was also unclear whether the family knew about the prognosis, the possibility of supportive care or the DNA CPR. This variation in completing orders indicated that the trust policy was not being followed.
- There was no agreed DNA CPR policy in the wider local health community. This presented a potential problem when patients were transferred from the hospital to the community.

Are end of life care services caring?

Good

The clinical nurse specialists (CNSs) reviewed patients' care in a sensitive, caring and professional manner and engaged well with the patients. A specialist palliative care (SPC) CNS told us that they had no review criteria in place and that patients were reviewed daily to ensure that any symptoms were being managed and the patients were comfortable. When the patient was in the final stages of life, the SPC might visit more often and catch up with the family members. We spoke to a patient on Chartwell ward who was receiving end of life care. They told us the care and communication was good. We observed that drinks and a call bell were close at hand.

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The specialist nurse in organ donation (SNOD) told us that families of patients who donated organs received a phone call after organ retrieval to let them know the process has been completed. The families were invited to receive the St John award. This is offered to all families whose loved ones donate in the UK and is given posthumously to the donor, accepted on their behalf by a relative at a regional ceremony.

The chaplain told us that they visited the wards to support patients and relatives when requested. Their visits might include bedside rituals, bible readings, baby blessings or just being a listening ear.

We observed in the wards we visited that the names of the consultant and the named nurse were on the doors of the single rooms and above a patient's bed in a bay. This highlighted to all who was responsible for the care being delivered.

The SPC team conducted a patient satisfaction survey for patients who had been treated by the team during their hospital stay. The survey had been introduced to the PRUH.

End of life care

A bereavement carer's survey was undertaken across the trust. The survey was given to families during a bereavement visit and returned to the SPC team for analysis. We saw that the team was addressing the issues raised and had included these in its action plan

Compassionate Care

- During our inspection, we were able to observe several end of life patients being reviewed by the palliative care CNSs. They performed the reviews in a sensitive, caring and professional manner, engaging well with the patients. During a holistic assessment on Chartwell ward, the CNS reviewed how the patient was feeling, discussed their pain management and the medicines prescribed. The CNS told us that they had no review criteria in place and that patients were reviewed daily to ensure that any symptoms were being managed and the patients were comfortable. When the patient was in the final stages of life the SPC might visit more often and catch up with the family members.
- A patient on Chartwell ward told us the care and communication were good.
- The SNOD told us that families whose relatives donated organs received a phone call after organ retrieval to let them know the process had been completed. The families are then contacted 2–3 weeks later to update them on how the recipients were doing. This is repeated a year later. Families were invited to receive the St John award. This is offered to all families whose loved ones donate in the UK and is given posthumously to the donor, accepted on their behalf by a relative at a regional ceremony.
- The chaplain told us that they visited the wards to support patients and relatives when requested. Their visits might include bedside rituals, bible readings, baby blessings or just being a listening ear. The chaplain told us that the wards they visited the most out of hours were Chartwell, critical care, and Medical wards 7 and 8. Call-outs were mainly for end of life patients and speaking to distressed families.
- On the wards we visited, the names of the consultant and the named nurse were on the doors of the single rooms and above a patient's bed in a bay. In the accident and emergency (A&E) department, a registered nurse (RN) told us that the breaking of bad news took place in the relatives' room. This was undertaken by a senior member of staff. Nursing staff were not trained to break bad news.
- To preserve the dignity and privacy of patients who died in the ED, the nurse was able to show how a patient would leave the department. All the doors were closed and other areas were screened off. Staff were alerted that the patient was leaving the area to ensure that other patients and families remained in their cubicles.
- The SPC team conducted a patient satisfaction survey for patients it had treated during their hospital stay. The survey has been introduced to the PRUH. However. we were unable to review the results because the surveys had not been analysed by the time of our inspection
- The SNOD told us that, 3–4 months after a donation had taken place, the family were sent a questionnaire about their experience. We were told that feedback was good; however, we were unable to review the questionnaire during our inspection.
- A bereavement carer's survey was undertaken across the trust. The survey was given to families during a bereavement visit and returned to the SPC team for analysis. We reviewed the findings from the 2014 survey and saw that the comments were positive apart from raising concerns about delays in obtaining death certificates, a lack of facilities when families needed privacy and the bereavement office not providing a 7-day service. We saw that the SPC team was addressing the issues raised and had included them in its action plan.
- The mortuary technician told us that bodies that arrived at the mortuary were prepared by the nursing staff as stated in the 'Care of the body after death – last offices policy 2015'. Staff could only think of one incident when a wrist band was missing. We were told the process that was undertaken to rectify the situation to ensure that the body was correctly identified. We reviewed the mortuary incidents and saw that none involved the poor preparation of deceased person.

Understanding and involvement of patients and those close to them

- The six sets of medical records we reviewed showed that patients who were referred to the SPC team were actively involved in their care while relatives were involved in the management of the patient with the patient's consent. On Chartwell ward, we were told that when a patient's condition deteriorated a discussion took place with the family. If the patient wished to go home, all efforts were made to get them home if this was their preferred place of dying (PPD). This was

confirmed when an SPC CNS, after reviewing a patient, needed to request an urgent bed at a hospice because this was the patient's wish. The CNS was planning to return to the ward later in the day to speak to the patient's relative.

- On the stroke unit, we reviewed a set of nursing and medical notes. We observed that documentation of clinical care was good. However, we saw little documentation of discussions with the family. No end of life plan was in place.
- The ward manager on Medical 2 ward told us that they liked to include families as much as possible in caring for their relative but only as much as they wanted to be involved. Areas in which families supported their relatives included mouth care. They could also be asked to help their relatives at meal times. We were unable to observe this during our inspection.
- On the critical care unit, the ward manager told us that multidisciplinary (MDT) meetings took place and all decisions were communicated to patients and families during the daily rounds. However, we were unable to observe this taking place during our inspection.
- In the trust's bereavement policy, it stated that families should be given the opportunity to help in care after death. On the wards we visited during our inspections, ward managers told us that some families wished to be involved in care after death.

Emotional Support

- All the palliative care CNSs had completed the training necessary to enable them to give level 2 psychological support to patients and carers. One CNS we spoke to told us that they all received monthly 1:1 clinical supervision from a trained level 4 supervisor.
- The SPC team had no social workers who were level 3 practitioners and therefore able to support the psychosocial needs of patients, families and carers and to provide integrated bereavement follow-up. A palliative care consultant told us that, if support from a social worker was required, one from the Denmark Hill site would go over to the PRUH. We were unable to see evidence of this during our inspection.
- Support to families whose relatives became organ donors was available through the SNOD who visited from the Denmark Hill site. As evidence came to light that that a patient might die or active treatment be stopped in the next few days, the SNODS became actively involved and supported the family by being a point of contact for questions and concerns that might arise during the process.
- Bereavement centre staff conducted an interview with a family after the death of their relative. Staff told us that, after meeting the family, they were the point of contact if the family needed to speak to anyone in the year after the death. Staff told us that, if they had any concerns, they would contact the family's GP to access further support.
- Chaplains were available across both sites to provide spiritual and religious support when asked by a patient, their family or medical and nursing staff. One of the chaplains at the PRUH had the necessary skills to run staff support groups where members of staff could talk about their experiences. A group was currently taking place monthly in the stroke unit. There are discussions that a similar group might be started on the day surgical unit.
- A nurse in the ED told us that, if a sudden death occurred, the chaplaincy could be called if requested by the family to provide support. However, the chaplain told us they were not usually called to A&E. The SPC team were not involved in sudden deaths.

Are end of life care services responsive?

Requires improvement

Patient receiving end of life care are generally nursed in a single room in line with trust policy. We found little evidence of family rooms on the wards. However staff gave up their day room or other meeting rooms to provide a quiet place for relatives. The specialist palliative care (SPC) team recognised the shortage of quiet places for families and conducted a facilities audit. A list of available spaces was placed in the 'end of life folders' on the wards so that staff could signpost relatives to the nearest quiet room.

The sister on Medical 2 ward told us that there were no restrictions on when families could visit. We were told that relatives could stay overnight with their relatives. However, we saw no evidence that 'z' beds or reclining chairs were available

End of life care

No free parking was available to families and there were no food arrangements for family members who wished to stay with their relative.

The bereavement centre organised a deceased patient's documents, including the Medical Certificate of Cause of Death (MCCD), and their belongings. We were told that MCCDs are ideally available for relatives in the 24 hours after the patient's death, but this does not always happen. There was no audit information to show how long a certificate took to be released on average.The Princess Royal University Hospital (PRUH) had no bereavement service. There were no social workers or cancer counsellors based there to deliver a sustainable and effective service. All bereaved relatives were met by the SPC team member and referred to the appropriate community services. In February 2015, three complaints had been made, two of which were from the PRUH. We reviewed the complaints and saw that investigations had taken place and actions agreed to prevent the same situations occurring in the future.

Service planning and delivery to meet the needs of local people

- As part of the end of life care policy, those patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available. On Chartwell ward, we observed a patient receiving end of life care. They being nursed in a single room with en suite facilities. However on Medical 3 ward, we saw a patient being nursed in a bay. They were happy with this arrangement and did not want to be moved into a single room.
- On Medical 2 ward, the sister told us that they had four side rooms that could be used for end of life patients. This was also the case on the stroke unit, ITU and Medical 1 ward, where single rooms were available to ensure that patients' dignity and privacy were respected as they moved towards the last phase of their life.
- We found little evidence of family rooms on the ward. However, staff gave up their day room or another meeting room to provide a quiet place for relatives. On Chart well ward the charge nurse told us that no family room was available. The SPC team recognised the shortage of quiet places for families and conducted a facilities audit. The 'end of life folders' we saw on the wards had a list of available spaces was so that staff could signpost relatives to the nearest quiet room. In the minutes of the end of life strategy group meeting, there was reference to a facilities leaflet that was in the process of being developed. Although the trust had recognised the lack of quiet areas for families, we saw no evidence of how it planned to take this forward.
- In the critical care unit we saw that good facilities were available for families. This included an interview room, kitchen and a room where relatives could stay over. Shower facilities were available. The ward manager told us that they tried to keep patients on the unit as treatment was withdrawn to ensure that families received consistent support from the medical and nursing teams.
- On all the wards we visited, staff we spoke to talked of the need to extend visiting hours for families whose relatives were receiving end of life care. Staff on the stroke unit, critical care unit, Chartwell and Medical wards 1 and 3 confirmed that open visiting hours were available on the wards. The sister on Medical 2 ward told us that there were no restrictions on when families could visit. We were told that relatives could stay overnight with their relatives. However. we saw no evidence that 'z' beds or reclining chairs were available.
- In the minutes of the palliative care governance group meeting, we saw that free parking was not available for families whose relatives were at the end of their life. We were told by the charge nurse on Chartwell ward that there were no specific food arrangements for family members who wished to stay with their relative.
- In the ED department, we were shown three rooms that could be used to care for seriously ill patients and those who were dying. Patients could be cared for in privacy. However, if the rooms were not available, the patient was nursed in a bay with the curtains drawn. The relative's facilities consisted of a very small room that contained a sink, ordinary chairs and a jug of water. If the room was required for a grieving family, other people were asked to return to the waiting room.
- The SPC CNSs offered patients support, when necessary, and reviewed their care needs. Patient contacts ranged from 15–120 minutes depending on the needs of the patient and their families, with many end of life patients requiring more than one contact in a day. Palliative care medicine consultants reviewed complex cases and spoke with medical teams and carers.

Access and flow

- We were told that there was no formal system to facilitate the fast-track discharge of patients to their PPC

or PPD. The SPC team supported fast-track discharges. The SPC CNS explained that a multi-professional approach was in place, which could involve a discharge liaison nurse, physiotherapist and occupational therapist to ensure that patients were discharged in a timely manner with all the necessary support and equipment available. We spoke to a discharge coordinator who told us that they picked up referrals daily on the ward rounds and started the fast-track process.

- The SPC team told us that 51% of deaths occurred in the hospital, with 49% achieving their PPC/PPD. Patients were discharged to their home, a hospice or a nursing home.
- As part of the 'care of the body after death' policy, deceased patients were expected to be transferred to the mortuary within a 4-hour window. Staff on the wards we visited told us that deceased patients left within this time frame but there was no documentary evidence to support this.
- The SPC team aimed to see most referrals on the day of referral. Referrals could be self-referrals or referrals by professional groups via fax or the bleep system if urgent. Referrals to the team were classified as 'routine, urgent or emergency'. All referrals were triaged by a member of the team to ensure that all requests were appropriate and their urgency acted on in an appropriate time frame.
- The charge nurse on Chartwell Ward confirmed that the SPC team was involved, very responsive and helpful.
- At the PRUH, the palliative care consultant told us that the SPC team was 'under-resourced and busy'. We were told that there was no waiting list to see the SPC team. However, the team was unable to show us evidence of its responsiveness because it did not audit this.

Meeting people's individual needs

- The end of life policy stated that patients at end of life should be assessed by the medical and nursing teams to develop individualised care plans to meet the patient's individual needs. On Medical 3 ward, we reviewed a set of medical records. We saw little documentation in the medical and nursing notes to contribute to an end of life care plan or evidence of regular monitoring of comfort. This was confirmed on Chartwell ward where the charge nurse told us that no end of life care plans were used.
- A nurse (RN) on the stroke unit was able to describe the 'five priorities of care' and how they would be used to support care delivered to a patient at the end of their life. The RN felt able to discuss dying with patients and their relatives. To support the nursing staff, the SPC team had put together an information leaflet called 'Coping with dying'. This covered areas such as a patient's 'reduced need for food and drink, withdrawing from the world and changes in breathing.' We were told the leaflet was available on the wards. However, we visited wards where the nursing staff were unaware of them. The sister on Medical 2 ward told us that the leaflets had recently been introduced. However, we were told that the leaflets would be given out when staff felt confident to use them.
- The SPC team gave out a second leaflet called 'The palliative care team – information for patients and relatives'. This described what palliative care was, identified the members of the team and gave their contact numbers.
- The specialist nurse in organ donation (SNOD) told us that families whose relatives had been classed as brain stem dead and had consented to donate their relative's organs, said goodbye in the ITU before their relative went to theatre. Care after death took place in theatre. For patients who were non-heart beating donors, the families escorted them to the theatre anaesthetic room where the life support machines was turned off. The families stayed with their relative as their life came to an end. The team leader told us that cultural needs were guided by the family and any faith leaders. When the patient's heart stopped, the family had 5 minutes to say their goodbyes.
- In A&E, the family could stay as long as possible after their relative had died. Families were told they could help with the after care if they wished; however, we were told that this did not generally happen. The RN told us that, before the family left, they would make sure that the family were safe to get home. A bereavement leaflet would be given to the family to explain what would happen next.
- The bereavement centre organised a deceased patient's documents, including the Medical Certificate of Cause of Death (MCCD), and their belongings, as well as providing practical advice to the relatives on how to register the death and plan the funeral. The centre contained a private quiet room where staff could talk with relatives and they had privacy.

End of life care

- The bereavement centre staff told us there were systems for the quick release of deceased patients, if required for religious reasons. Out of hours, the ITU and the mortuary would be able to release the MCCD. We were told that the MCCD were ideally available for relatives within 24 hours of death, or the next working day if the death occurred over the weekend, except for those patients who were referred to the coroner. However, we were told this did not always happen and there had been delays in releasing MCCDs. We reviewed the actions from the end of life strategy group meeting (March 2015) and saw that they had been put in place to prevent further delays in this process. There was no audit information to show how long an MCCD took to be released on average.
- The mortuary had a viewing suite where families could go and spend time with their relatives after their death. Appointments could be organised through the bereavement office or mortuary, and were available Monday to Friday in the afternoon. We were told that on arrival at the hospital the relatives were walked down to the mortuary by the bereavement team staff.
- We were shown the viewing suite, which was decorated in neutral colours with no religious symbols in place. To reach it, a family had to walk through a courtyard that provided an area of calm and quietness. We observed that in the waiting area a call bell on the wall had the facing removed and all the internal workings were showing. We were told that the viewing area was due to be refurbished and, on reviewing the end of life strategy meeting minutes (March 2015), we saw that a project team was being put together to take this forward.
- Mortuary staff we spoke with told us that effective systems were in place to log patients into the mortuary. We were walked through the process and shown the ledger-type book that contained the required information. The book was completed appropriately and clearly. Confidentiality was maintained at all times.
- The mortuary staff told us that they were unable to provide an area for religious washings and that overnight sittings have never been requested.
- For patients who died without family or friends, the bereavement staff searched for any relatives with the help of the local council. The hospital arranged the funeral with support from the chaplaincy.
- The PRUH had no bereavement service. There were no social workers or cancer counsellors based there to deliver a sustainable and effective service. However, we were told that a social worker would come over from the Denmark Hill site if required. The SPC CNS met with any bereaved relatives and made appropriate referrals to the local community services.
- The hospital had a multi-denominational room that accommodated all faiths. This was open from 7am to 10pm daily but could be opened specially on request. We observed that the room could be divided, so that it could be used by different faiths. A curtain separated the area to accommodate male and female Muslim worshippers. There were prayer mats and a sign representing Mecca. Muslim prayers took place each Friday at 1.15pm. These were conducted by one of the hospital doctors.
- The trust did not have a separate religious or spiritual policy, but the remit fell within other policies (for example, the bereavement policy). Chaplaincy staff told us they followed the national guidelines for chaplaincy that had recently been introduced into the PRUH.
- Sacred texts were available from the chaplaincy if required on the wards. These included sacred texts for the Jewish, Buddhist, Hindu, Muslim, Sikh and Christian faiths.
- The chaplaincy was served by 7.3 wte chaplains (11 people) representing the Christian faiths. The chaplains were available 24 hours a day and easily contactable through the hospital switchboard for out-of-hours visits. Staff could contact them by telephone or in person to refer patients or ask them to visit.
- The chaplaincy had four lay volunteers who visited the wards. We were told that one volunteer provided support with Holy Communion. The team had asked this volunteer to become more integrated within the team.
- Volunteers could identify and offer initial pastoral support to end of life care patients but, if more complex needs were expressed, they would refer the patient to the chaplaincy. A training programme for the volunteers has been developed to ensure that they were aware of their role. It included how to manage difficult encounters, boundaries and information about trust policies. .
- A range of services took place in the chapel daily, including 9am prayers for the Christian community and a Eucharist on Sunday at 11am. Friday prayers took

place in the PRUH prayer room. Written information about chaplaincy services was available in leaflet form for patients and relatives and on the KWIKI webpage for staff to access.

- The chaplain told us that the lead chaplain was involved in the development of the end of life care, bereavement and last offices policies. The chaplain at the PRUH attended the Monday and Tuesday palliative care multidisciplinary team meetings where all patients on the end of life care pathway were discussed. If any areas of concern were highlighted, the chaplain would visit the patient and undertake a 1:1 assessment.
- Chaplains were involved in delivering regular training to staff during induction when they signposted staff to all the materials available. Spiritual care guidance was given at the induction of RNs, healthcare assistants and midwifes. The chaplaincy provided services tailored to patients' individual needs. For example, they conducted blessings and funerals of deceased patients who had no relatives.

Learning from complaints and concerns

- Any complaints about the delivery of end of life care were reviewed by the end of life strategy group. We were told by a palliative care consultant that in the past year only one complaint had been made about the workings of the SPC team. The process followed when a complaint was made showed that systems were in place to respond to complaints in a timely manner. We saw good governance structure and learning from complaints.
- Ward-based complaints about end of life care were also discussed at the end of life strategy group. . In February 2015, three complaints had been made, two of which were from the PRUH. We reviewed the complaints and saw that actions had been agreed to prevent the same incidents happening in the future.
- Bereavement centre staff undertook interviews with families after the death of their relative. Staff told us that, when meeting the families, if any issues arose about the care of their relative, the staff would contact the medical team involved and try to resolve the issue for the family.
- We reviewed the clinical effectiveness programme and saw that an audit was undertaken to ensure that patients receiving palliative care were coded properly to ensure that any complaints about care could be monitored appropriately. The audit tested whether the palliative care code (z51) was being used appropriately. Slight discrepancies were highlighted but generally patients were being coded correctly.

Are end of life care services well-led?

Requires improvement

The specialist palliative care (SPC) team at the Princess Royal University Hospital (PRUH) was not commissioned. A business case was submitted to the local clinical commissioning group but not approved. In comparison to the funded service at the Denmark Hill site, the PRUH team had no social workers or registrars and cover for annual leave was not possible.

The trust did not have a long-term vision for how end of life care would be delivered over the next five years. We were able to review the SPC team's action plan for 2014/15, which set out the work of the team. We saw that most objectives set were achieved and the team's action plan for 2015/16 was due to be developed at its day in June 2015.The trust had withdrawn the Liverpool Care Pathway (LCP) and introduced the 'five priorities of care' when caring for patients approaching the end of their life. The introduction of 'quality sampling' has been used to monitor the implementation of the 'five priorities' across all the wards, but they were not yet embedded.

The trust's end of life strategy group met every two months chaired by the director of nursing with attendees from palliative care and consultants from elderly care and the ITU.

In the mortuary, staff told us they had received no end of life or communication skills training and had only learned through experience. Appraisals were not regularly undertaken and staff did not find them useful.

A palliative care consultant told us that there was a good palliative care governance structure. The team carried out several audits that included quality sampling, bereavement surveys, patient satisfaction surveys and using the NICE opioid audit tool but the PRUH team could not find the time to follow them up and use the findings to improve the quality of the end of life care delivered.

End of life care

Vision and strategy for this service

- The director of nursing had been appointed as the nominated board lead for the development of end of life care and provided representation at trust board level for care of the dying. This appointment was made as part of the National Care of the Dying Audit of Hospitals (NCDAH) 2014 action plan.
- The SPC team at the PRUH was not commissioned. A business case was submitted to the local clinical commissioning group but not approved. In comparison to the funded service at the Denmark Hill site, the PRUH team had no social workers or registrars and cover for annual leave was not possible; this meant that the SPC service was unable to provide a comprehensive service at all times. A palliative care consultant we spoke to told us that they were reviewing how extra resources could be found to support the service, and that these might require the need to find new ways of working.
- We did not see any evidence of a long-term vision for end of life care across the trust, although we were able to review the 2014/15 action plan that set out the work of the SPC team. This covered areas such as introducing a system for identifying dying patients, developing and implementing a treatment escalation plan, quality sampling deaths within the trust and continuing the bereavement survey. During our inspection, we were able to observe the above work streams at varying levels of completion.
- The SPC team action plan for 2015/16 was due to be developed at the team away day in June 2015.
- The end of life strategy group set out a draft proposal for their work plan for 2015/16. The work streams the group proposed to cover included reviewing the commissioning intentions for 2016/17, supporting local care networks and the setting of local priorities, and establishing systems to oversee and measure progress. Local priorities would be set by May 2015 and reviewed in September 2015.

Governance, risk management and quality measurement

- The trust's end of life strategy group met every two months chaired by the director of nursing with attendees from palliative care and consultants from elderly care and the ITU. Agenda items discussed included monitoring performance such as complaints, the bereaved carer's survey, bereavement and the 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) policy, spiritual care, mortuary services, education and training, and review of the action tracker. After the March 2015 meeting, an action plan was developed.
- An end of life care quality and implementation group was established to discuss end of life care with other divisions across the hospital, and to act as a forum for feedback to end of life 'champions'. We were told by the palliative care consultant that attendance at the meetings was poor and this was confirmed in the minutes of the March 2015 end of life strategy group meeting where discussions took place on the best way to feedback issues related to end of life care. Suggestions were made to re-launch the group as workshops four times a year.
- We were told by a palliative care consultant that separate monthly service development meetings took place at the Denmark Hill and PRUH sites. These groups fed into the integrated bimonthly palliative care governance group.
- We saw that the SPC multidisciplinary team (MDT) undertook a variety of roles which included continuously updating its clinical governance programme, and regularly reviewing and updating guidelines, protocols and patient pathways. The team also considered reports on patient satisfaction, clinical effectiveness and risk management, and ensured that appropriate action plans were developed and implemented. Minutes and training records confirmed that this was taking place. The palliative care consultant told us that regular appraisals from the head palliative care consultant took place and that, apart from the funding issues, they felt supported when they became part of King's College NHS Foundation Trust.
- The specialist nurse in organ donation (SNOD) told us that the organ donation committee took place every 3 months. A palliative care consultant was a member of the group with the chaplain as the chair. The SNOD told us that data was reviewed and discussed and action plans updated.

Leadership of service

- There was good leadership of the SPC team at both sites from the palliative care consultants and the nursing matrons. However, cross-site integration of the teams was still 'work in progress'. We observed that the SPC team was visible, responsive and active in policy and audit.

End of life care

- The chaplaincy service had good leadership from the trust's lead chaplain. The chaplaincy team was visible, responsive and involved in policy and audit. The lead chaplain was an integral member of the end of life strategy group, the pan-london clinical strategic network for end of life care and chaired the organ donation committee. They were also involved in other groups including the patients' experience committee and the volunteers' steering group. This highlights the trust' recognition that religious or spiritual input is essential to the delivery of end of life care and the development of policy.
- Two members of the palliative care team at the Denmark Hill site had led on the implementation of the 'Schwartz rounds.' These had been established for staff to regularly come together to discuss the non-clinical aspects of caring for patients, including psychological, emotional and social challenges associated with their work in helping staff to deliver compassionate care. The SPC team had secured funding and the Schwartz rounds were being introduced to the PRUH in 2015. The group was in the process of identifying people to become facilitators and support the Schwartz rounds at the PRUH.

Culture within the service

- The SPC team members we spoke to were passionate about supporting both families and staff in end of life care. This was confirmed when we spoke to staff on the wards we visited during our inspection. They all showed a positive and proactive attitude towards caring for dying people.
- We spoke to staff about how supported they felt in their roles. They all said they felt supported and how approachable their managers were. In the bereavement office staff, told us they felt supported by their line manager and that appraisals were undertaken.
- The chaplain told us that everyone tried to do their best around end of life care: Patients' safety and quality are a priority here as it's a very human place. People want to get it right.'
- All the staff we spoke were positive about the service they provided for patients. Quality and patient experience were seen as priorities and everyone's responsibility, and this was very evident in the SPC team's patient-centred approach to care.
- On the wards we visited, we saw that the SPC team integrated well with nursing and medical teams. However, there was an overreliance on the SPC team to deliver good end of life care.

Public and staff engagement

- To ensure public and patient representation was established and maintained within the trust, a lay person was appointed to the board to champion end of life care.

Innovation, learning and improvement

- We were told the trust was not engaged in the NHS improving quality 'Transform programme'. The SPC team was actively involved in service improvement projects and undertook audits to monitor the quality of end of life care across the trust. A palliative care consultant told us that there was a good palliative care governance structure. The team undertook several audits that include quality sampling, bereavement surveys, patient satisfaction surveys and the NICE opioid audit tool but the PRUH team could not find the time to follow them up.
- The PRUH had participated in all four rounds of the NCDAH, which allows scrutiny of end of life care and encourages improvements in the care delivered.

Outpatients and diagnostic imaging

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

Information about the service

The Princess Royal University Hospital (PRUH) outpatients and diagnostic imaging department provided 207,515 outpatient appointments in 2013/14, and 73,377 of these were outpatient visits to the diagnostic imaging department. Clinics are mostly held in the outpatients department (OPD), with some clinics held in other parts of the hospital.

The OPD clinics were dispersed within the structure of the hospital. Many clinics were coordinated within the general OPD and others were managed by the clinical specialties.

The OPD runs clinics in breast care, colorectal, dietetics, general surgery, gynaecology, haematology, obstetrics, oncology and respiratory. The ophthalmology clinic was held in the West Kent Eye Centre and the haematology and oncology day service was provided at the Chartwell Centre.

We visited a range of clinics including surgical, medical, rheumatology, urology, gynaecology, orthopaedic, ear nose and throat, and therapy. We also visited the cardio-respiratory department (which undertakes cardiac investigations), the phlebotomy department and the therapies department.

We visited the x-ray and imaging departments including nuclear medicine, magnetic resonance imaging (MRI) and computerised tomography (CT) scanning. We also visited the on-site medical records office and the outpatients' booking office at the Denmark Hill site.

We spoke with 26 patients and their relatives, 12 members of staff including doctors, nurses, allied health professionals and departmental managers. We observed care and treatment and looked at 14 care records. We reviewed information provided by the hospital before our inspection. We did not look at outpatient services for children; this service is reported under the 'Services for children and young people' section of this report.

Outpatients and diagnostic imaging

Summary of findings

We found that the staff were highly motivated to meet people's needs, with reports of staff staying beyond the end of their shift. We were told by the senior managers of the department that there was a clear and proactive focus on improving quality and safety, and a determination to provide an excellent service for patients through the use of National Institute for Health and Care Excellence (NICE) guidance and evidenced-based care. Most of the clinical staff we spoke with told us their practices were underpinned by the use of NICE guidance and hospital best practices.

There were a significant number of vacant nursing posts and overreliance on bank and agency nursing staff. Nursing staff told us that some shifts had at least 70% of staff from an agency. The phlebotomy clinic was a very busy service and most GP blood tests were done in the phlebotomy department. The outpatient clinic staff were used to run the phlebotomy service and this left the main outpatient clinics short of their required number of staff.

We found that there were some inconsistencies in learning from incidents; for example, staff in the ophthalmology clinic had not been made aware of the recent 'never events' at the Denmark Hill location.

We had concerns about the overall facilities and environment of the department. The phlebotomy area was hot and had a flow of smoke from the public smoking area. Some chairs in the radiology waiting area were torn and not fit for purpose. In one restricted area of the imaging department, where it might be desirable to deter public access, there were no locks to prevent unauthorised access; also, a potentially hazardous substance was kept in an unlocked cupboard.

Medical records were not always available. There were occasions when almost 21% of patients were seen without their medical records and the clinicians had to use temporary notes for those patients whose records were unavailable.

The transfer of patient administration system (PAS) from one computer system to another had resulted in the loss or movement of some patients' information. The PAS is used for storing patient demographics, making appointments, timing the patient journey and tracking records.

There was a national problem with Choose and Book (CAB) and some PAS systems by creating duplicate patient registrations. The Trust put in place process to remove any duplicate registrations occurring in patient administration system (PAS).

There were a number of referral to treatment time (RTT) breaches in most of the clinical specialties, and the turnaround time for typing letters was up to three weeks late for some clinics.

Staff were proud of the work they had done to improve quality, safety and patient experience, and they were committed to sustaining improvement and innovation. The one-stop-shop for breast care was exemplary because patients were seen and had all their tests and investigations at the same place. Patients we spoke to were very complimentary about the staff and happy with their experiences.

Staff in the diagnostic imaging department were trained and worked with national radiological protocols and pathways that were linked to NICE guidance. Patients were given good information throughout their care and treatment and possible side effects if any.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Inadequate

There had been a significant problem with obtaining patient medical records for clinics. On average, full-sets of patients' medical records were only available 60% of the time, so staff often used a 'temporary folder' that contained minimal patient information.

Most staff were reporting on, tracking and learning from incidents. There were some inconsistencies in learning from incidents across the different locations, in that staff in the ophthalmology clinic at the Princess Royal University Hospital (PRUH) had not been made aware of the recent 'never events' at the Denmark Hill site. Never events are serious, largely preventable patient safety incidents that should not occur if proper preventive measures are taken.

Some of the chairs in the radiology waiting area were torn, which meant they were not fit for purpose and could not be effectively cleaned. In one area of the imaging department, where it might be desirable to prevent public access, there were no locks or keyless entry systems; there was also a potentially hazardous substance in an unlocked cupboard.

Medicines and prescription pads (FP10s) were stored in a locked cabinet. When clinicians wrote patient prescriptions the outpatients department (OPD) kept a log that identified the patient, the prescribing doctor and the serial number of the prescription sheet used. This ensured the safe use of prescription pads.

There were a significant number of vacant posts and an overreliance on bank and agency staff. The phlebotomy clinic was predominantly staffed by bank staff and it was a busy service. The phlebotomy area was hot and stuffy and we observed a flow of smoke from the public smoking area.

Incidents

- At the time of our visit, there had been no recent serious incidents or never events relating to the outpatient or imaging and diagnostic services at the PRUH.
- Incidents were reported using an online incident reporting system that enabled reports to be submitted from clinics. We were told that incidents were broken down by category and date, which allowed trends to be identified and action taken to address any issues or concerns.
- We saw evidence from one department of effective dissemination of learning after incidents. However, this was not consistent. For example, staff in the ophthalmology services had not been made aware of the recent never events at the Denmark Hill site. The never events involved the insertion of wrong lens and an incorrect measurement of patient details on Medisoft electronic system. There were no never events at the PRUH.

Duty of candour

- Information regarding duty of candour had been cascaded from the divisional managers to all staff teams. Staff told us information had also been made available on the trust intranet regarding duty of candour and their responsibilities for being open and transparent with patients. One member of staff we spoke with showed that they were aware of this information and how to access it.

Cleanliness, infection control and hygiene

- Staff demonstrated an understanding of infection prevention and control procedures and were observed to follow the 'bare below the elbow' protocol; personal protective equipment was available and appropriately used. Cleaning schedules were in place and up to date with details of when areas were last cleaned and when cleaning was next due. We observed examination couches being cleaned between patients.
- Hand hygiene stations were readily available, appropriately stocked and observed to be in regular use. We saw written reminders in one area about the cleaning process to follow in the event of a spillage of body fluids.
- One patient told us that his job made him very conscious of hygiene and cleanliness. He told us, "[I'm] very impressed with the state of the clinic; [it] looks clean and welcoming."
- In the main radiology waiting area, nine of the fourteen 14 chairs had badly damaged upholstery, which left the filling exposed and meant they could not be effectively cleaned. We were told that new chairs were in the process of being ordered.

Outpatients and diagnostic imaging

- We were told that infection prevention and control audits and hand hygiene audits were completed as part of the trust-wide audit programme, and most of the nursing staff we spoke with were aware of the audits and the audit reports.
- Cleaning audit scores met expected cleaning standards, with audit scores of between 96% and 98%. Areas that were found to be below the expected cleaning standards during an audit had a recheck sheet completed, highlighting the area of concern, and a re-audit arranged.
- Hand hygiene audits, which monitored the percentage of staff who washed their hands and applied antibacterial gel before and after providing care and treatment to a patient, were carried out on a monthly basis. The audit showed 100% compliance with required hand hygiene practices.
- Appropriate colour-coded cleaning equipment was available in the outpatients and diagnostic imaging department. We were shown the isolation procedure policy and staff explained the precautions needed when dealing with an infection outbreak.

Environment and equipment

- We saw that there was adequate equipment in the outpatient clinics. Staff told us there was no problem with the quantity or quality of equipment that was needed in the ophthalmology clinic. The resuscitation equipment in the OPD was in line with the national Resuscitation Council's recommendation; we noted that it was recorded as checked daily and ready to be used. We saw records of these daily checks and they were accurate at all times.
- Equipment was maintained, checked regularly and given a portable appliance test (PAT) sticker in line with the trust's policy. Labels on equipment stated when it was last checked. All equipment we saw had been checked within the past year.
- In the imaging department, we looked at the treatment rooms and found that they complied with the safety guidance on radiology. Personal protective equipment, such as goggles and lead aprons, were available and in use. The imaging machines were locked when not in use, and access to the room was restricted when treatment was taking place. Local rules drawn up by the radiation protection adviser was in place and a laser protection supervisor was appointed by the department.
- Staff told us that there had been some recent reconfiguration of the main waiting area of the phlebotomy department and the disabled access had been changed. This meant that people with limited mobility had to negotiate two sets of manual doors. People were witnessed struggling to open the doors. We were told that this issue was being examined so that an accessible solution could be put in place.
- Staff expressed concern that the number of chairs in the waiting area of the imaging clinic had also been significantly reduced from 65 to 49, apparently without consultation or reasons given. This resulted in patients standing most of the time when waiting for their appointment.
- We observed a flow of smoke from the public smoking area to the phlebotomy area, which was noted to be hot and stuffy.
- In one restricted area in the imaging department, we saw that there were no locks or keyless entry systems. This was discussed with the manager and we were told that locks had been ordered.
- In the imaging department, resuscitation trolleys had not been checked during the weekend for several months, despite frequent reminders to all staff to ensure that this was done. Record showed that the situation had not improved.

Medicines

- All medicines seen were in date and stored securely in a locked cupboard. FP10 prescription pads were stored in a locked cupboard and the keys held by the nurse in charge. (FP10s are prescriptions issued to patients to obtain their medications from the community pharmacy.) A record was maintained of all medication administered to patients during minor procedures in the treatment rooms. Each record included the name of the patient, the medication used and the dosage. All entries were noted to be fully completed and signed. When the drugs were checked, they were found to be in date and stored correctly.
- Medicines, including those requiring cool storage, were stored appropriately. Records showed that they were kept at the correct temperature so that they would be fit for use. Safe temperatures for fridges were recorded and a log of medication contents in the fridges was maintained.

- Staff were able to describe appropriate systems for managing pharmaceutical items that required extra precautions, such as those with radioactive properties.
- Protocols were in place for the administration of substances (e.g. contrast media), and staff were able to describe the protocols.
- In one area at the imaging department, an unlocked store cupboard was found to contain quantities of a Cytofix™ pump spray. We asked for this to be moved to a locked cupboard. (CytoFix products are ready-to-use cytological solutions containing alcohol and carbowax, offering consistent fixation results and subsequent staining to eliminate air-drying artefacts.)

Records

- Many staff (both clinical and non-clinical) told us that there had been a significant problem with obtaining medical records. They said that a clinic often started without full sets of notes for that clinic, and often there would be a 'temporary folder' that contained minimal patient information. Nursing staff we spoke with estimated that, in all the clinics, notes were only available 60% of the time on average.
- Clinicians told us that the availability of patient records was an issue. They said that every clinic ran with temporary sets of medical records for some patients. Although some diagnostic information, discharge summaries and most recent letters were available on the computerised system, medical records were important for establishing a full patient history and it was not always easy to access the last clinic letters from the computer system.
- The medical records department was a closed library. This meant that only staff with authorised swipe cards could access the facility. Staff in the library would retrieve medical records for clinics and inform clinic preparation staff when health records were not in the library. In these cases, the clinic preparation staff would locate and collect the relevant health records.
- Staff told us that, when health records could not be found in time for clinics, a temporary set would be created. This set would contain patient labels and copies of most recent clinic letters, referrals and relevant diagnostic results. When temporary notes had been used, library staff would marry these with the main health records.
- We saw that records in the outpatient clinics were kept in a separate room, stored in boxes, and always in sight of the reception desk.
- We visited the medical records department and staff told us that there had been significant effort to improve this issue of unavailable records. For example, a new medical records library at Orpington Hospital had been established so that records could be delivered to the clinics more quickly. Staff estimated the journey time was 10 minutes now, instead of 45 minutes previously when the records had to come from Thamesmead.
- The records service team manager told us that two months ago the department had introduced an ongoing programme of audit and root cause analysis for when notes were missing. This had resulted in extra medical records staff being recruited and standard operating procedures being implemented. We were told that a quarterly report on this initiative would be sent to the information governance steering group at the beginning of May 2015. We were also told by the medical records lead that there were plans to recruit additional medical records staff to support the current workforce.
- There was a system of monitoring and escalation in place via the patient records committee. Clinical and administrative staff we spoke with were sure that the system was beginning to improve.
- Staff told us that the migration of patient data to a new electronic records management system in November 2014 had caused significant problems. Some clinic dates did not migrate accurately. This meant that many people attended for an appointment on the wrong day and had an adverse impact on the hospital's performance on referral to treatment targets.
- There was a staff training and awareness session before the implementation of the patient electronic management system (PIMS), and staff told us they attended meetings in preparation for its introduction at the PRUH site. However, they highlighted a number of concerns, such as delays in accessing patients' records and subsequent delays to clinics. The number of contacts with the Patient Advice and Liaison Services (PALS) increased from 200 to 400 in 2014 after the implementation of PIMS.
- We were told that over 3,500 people unintentionally came off the clinic database and each appointment had to be manually restored by the booking staff. When we

visited, staff told us that occasionally a 'lost' patient (i.e. someone whose details had not transferred to the new system) would ring up to enquire about their appointment.
- One patient told us that, because of the different IT systems between the hospital sites, she had to have many of her tests repeated; this was a particular problem because of her fear of needles.
- The OPD manager told us that the problem was a 'connectivity' issue. The trust had developed a tool to mitigate it, but this had yet to be piloted.

Safeguarding

- There was a designated safeguarding doctor who had held the post for many years and was described by staff as supportive, knowledgeable and helpful.
- There was a designated safeguarding lead for Bromley clinical commissioning group. This was a statutory post. The postholder had local knowledge but had not undertaken a staff safeguarding supervisory role.
- We saw from training records of imaging staff that 96% had completed safeguarding level two training for adults and children. The manager for imaging was aware of the requirement for this training and had access to training records in order to follow up staff who needed to update their training. The nursing staff who worked in the imaging department had all completed their safeguarding training.
- Most of the clinical staff in the department had a good understanding of safeguarding children and vulnerable adults. Staff told us they were trained in level two safeguarding, had read the hospital's safeguarding policy, knew the safeguarding process, made their own safeguarding referrals and had the support of the safeguarding lead when necessary.
- An outpatient staff nurse was able to give us an example of when staff in the department had followed the trust's safeguarding policy and made an appropriate referral.

Mandatory training

- Corporate induction training was provided for all staff and compulsory for all staff to attend. There was also a service-specific induction for outpatients and imaging staff. We saw records held within the department that showed the induction records for new staff. These were noted to be comprehensive and up to date.
- All the staff we spoke with in all the clinics we visited confirmed that they had received their mandatory training in line with the trust's mandatory training policy. The training records reviewed confirmed that 90% of the staff had attended mandatory training in the past year.
- We were told that staff training was recorded electronically. Staff told us that training was delivered in both e-learning and face-to-face formats. Staff in the phlebotomy department were trained using competency-based assessment.

Assessing and responding to patient risk

- Emergency protocols were available and staff were able to describe how they would respond in an emergency. There were resuscitation trolleys in each area of the outpatient clinic. These were placed in accessible areas and checked by staff on a daily basis to ensure that the equipment was in date and fit to use. Emergency resuscitation equipment for children was also available.
- Radiology and imaging staff we spoke with in the imaging and diagnostic department knew who their radiation protection adviser and supervisor were. Staff were aware of the local rules for each area and where copies of IR(ME)R 2000 could be found in the department.
- Nursing staff told us that all patients who attended the clinics were seen when they arrived in the department by a nurse who identified any patients who were unwell or at risk, and appropriate action would be taken. We noted that patients who attended the clinic were greeted by the nurse who offered them assistance and support.
- The hospital had established systems and processes for responding to patient risk. Nursing staff were available in all the clinic waiting areas so that they would notice patients who appeared unwell or needed assistance. Staff we spoke with showed knowledge and understanding of patient risk, particularly for people with dementia or a learning disability, and elderly or frail patients with more than one medical condition.

Nursing staffing

- Members of the nursing staff told us that, since being taken over by King's College NHS Foundation Trust, steps had been taken to recruit new staff. However, we were told that there were a significant number of vacant posts and a reliance on bank and agency staff. Other staff told us that they believed there were problems with the agency to whom the recruitment process had been outsourced, because they were not recruiting fast

enough to fill the staffing shortages. We found at least one member of agency staff on duty who told us they were actively seeking employment in the hospital, but was unable to secure a job. We were told that all bank and agency staff were assessed before being left unsupervised.

- There were a significant number of vacant nursing posts and overreliance on bank and agency nursing staff. Nursing staff told us that some shifts had at least 70% of staff from an agency. The phlebotomy clinic was a very busy service and most GP blood tests were done the phlebotomy clinic. The outpatient clinic staff were used to run the phlebotomy service and this left the main outpatient clinics short of their required number of staff.
- The phlebotomy clinic was identified as particularly problematic with staffing shortages and overworking by staff. It was staffed by outpatient healthcare assistants and these were predominantly bank staff. A senior member of staff told us that nearly everyone in the local area who required a blood test came to the hospital, and phlebotomy services in primary care were minimal. We heard that it was not uncommon for staff to arrive at 7.30am and find around 30 people already waiting.
- The department always had a nurse on duty who had responsibility for resolving any staffing issues that occurred. Staff worked extra hours, through the hospital bank nurse system, to cover gaps in the duty rota. The sister or the band six nurse in charge had authority to organise bank staff hours or request agency staff when needed. We reviewed the number of qualified nurses and care assistants on duty and were told that the clinics were running with the minimum number of staff required. Rotas we reviewed showed that bank and agency staff were often used within the OPD.
- Each clinic had a nurse or healthcare assistant who was responsible for making sure that a patient's notes were complete, undertaking any initial procedures, such as weighing the patient, supporting the patient during the consultation and acting as a chaperone if needed.
- The matron and nurse in charge of outpatients were not included in the department's staffing numbers; they were able to supervise and assist staff as necessary.
- The department used a staffing contingency plan to assess daily whether they had sufficient numbers of nursing staff. The plan included a staff escalation protocol that instructed staff on procedures to follow when staffing levels fell below the level required to run the department safely. However, most of the nursing staff we spoke with told us this was not always the case and they often worked without the required number of staff.

Medical staffing

- The medical cover for clinics was arranged within the divisions, which agreed the numbers of clinics and patient appointments. We were told that the trust policy stated that medical staff must give at least six weeks' notice of any planned absence. A senior member of staff told us that doctors generally worked in line with this policy.
- All Specialities have timetables and rotas setting out what medical staff attend which clinics. Clinics are cancelled in line with the Trusts annual leave policy. However staff told us that in some clinics there was no rota setting out which middle- and junior-grade medical staff were expected to attend clinics to support consultants. Some clinics had two or three junior doctors, while in two clinics we noted that the consultant was the only doctor present. In those circumstances, it meant that patients often had to wait more than an hour to see a doctor.
- Medical staff told us that there was an insufficient number of medical staff in some clinics to meet the increased demand for appointments. This meant that clinics were being overbooked and patients waiting longer to be seen. Staff told us every clinic was consultant led. We found all the clinics on the day of our inspection had a consultant present, although they did not see all patients.
- Doctors we spoke with thought they had a good relationship with outpatient nursing and clerical staff. They said they felt well supported and could discuss issues with them.

Major incident awareness and training

- The trust had a business continuity management plan that had been approved by the management team. The plan established a strategic and operational framework to ensure that the hospital was resilient to disruption, interruption or loss of services.
- The hospital's major incident plan covered incidents such as winter pressures, fire safety and losses of electricity, the front-line system for patient information, information technology systems and internet access, staffing and water supply.

Outpatients and diagnostic imaging

- Staff we spoke with were aware of the hospital's major incident plan and they understood what actions to take in the event of an incident such as a fire. Most staff we spoke with had attended major incident awareness training within the past 3 years and were able to describe the OPD's role in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Clinical practice in the outpatients department (OPD) was based on National Institute for Health and Care Excellence (NICE) guidelines and patients were satisfied with the treatment they had received. The one-stop-shop for breast care was a multidisciplinary clinic and patients were able to access specialist breast care, treatment and support when they needed it at the same clinic.

Letters to GPs after clinics were up to two weeks late and clinics did not operate outside normal business hours, making access for patients more difficult.

Staff working in the clinics told us their managers encouraged their professional development and supported them to complete training. However, completion of training was not always possible because of staff shortages that made it difficult to undertake study leave. Appraisals were undertaken annually, but staff had no other form of formal supervision on a regular basis.

A multidisciplinary team (MDT) approach was evident across all the services provided by the outpatients and diagnostic imaging department. We observed a shared responsibility for care and treatment delivery. We saw patients receiving effective care and treatment in line with national guidelines. They were given sufficient information about their treatment and the opportunity to discuss any concerns.

Evidence-based care and treatment

- We were told that national policies, such as NICE guidelines, were followed when appropriate. For example, the care pathway for patients with cardiology related conditions were based on national guidelines. Clinical staff showed knowledge of the NICE guidelines relevant to their specialist areas.
- Staff in the OPD had access to policies and procedures that were kept on the trust's intranet. They were knowledgeable about which policies and procedures were relevant to their specialty and how to access them.
- Staff we spoke with were aware of the NICE guidelines and the importance of working within these. We were told by staff that they were supported by their managers to attend regional and national conferences that provided them with up-to-date information on current practice, which was shared with their colleagues on their return. Clinical staff in the imaging and diagnostics department were given support to attend Society of Radiographers conferences.
- The staff who worked in the imaging and diagnostics department were given up- to-date national guidance from professional organisations, such as the Society of Radiographers.

Pain relief

- The imaging department had a stock of pain relief and local anaesthetic for use when invasive procedures were been carried out. We saw that pain relief was discussed with patients during their consultation or treatment, and analgesia was prescribed as necessary and dispensed by the hospital's pharmacy.
- Patients in the OPD had access to pain relief when it was needed. Clinical staff reported that patients' pain was assessed and monitored to ensure that they received the appropriate amount of pain relief when in clinic. Staff told us that they could give paracetamol to patients if they were in pain, but all other analgesics had to be prescribed before being administered to them.
- Staff in the pain clinic told us that prescribed pain relief was monitored for efficacy and, when necessary, changed to meet patients' needs. This was discussed with patients as part of their ongoing management of pain.

Patient outcomes

- The department undertook its own patient satisfaction survey ('how are we doing?) using information collected from patients attending the department who said they would recommend the department to their friends and family. In November and December 2014, the scores were 94% and 96%, respectively.
- One person we spoke with said he was both a patient and a carer. He said that the hospital had been recommended to him and he was "very happy with the

clinical care". He also said; "I have never faulted the clinical care that [my relative] receives, and I know that she is also confident that the hospital is looking after her needs."

Competent staff

- Staff we spoke with were competent and knowledgeable about their specialist areas. All staff had participated in an annual appraisal in the past 12 months. During their appraisal, staff were asked to identify how they could develop their performance in the future. We saw a print-out that clearly indicated when a staff appraisal was due. We were told that this was usually flagged on the system to coincide with the incremental date to make the process robust.
- Staff told us they had regular training and there was cross-site learning from incidents. One member of staff said, "It is so much better since King's took over. We can recruit and I am now on a clinical course – access to training has improved." However, some of the nursing staff told us that, because of severe staffing shortages and the distance between the PRUH and the Denmark Hill location, they were unable to attend most of the required training provided.
- We were told that the diagnostic imaging department had a departmental induction programme for radiologists, radiographers and other staff working in the department that included orientation on the department's equipment. Each new member of staff was assigned a mentor, a colleague who would go through the controls with them when a piece of equipment was new to them; however, they said this was not recorded formally. We reviewed more recent induction and training records and they supported what we were told.
- We saw evidence that all newly appointed staff in the department had completed a corporate induction programme that included mandatory training as well as an overview of trust practices and procedures.
- Clinical staff received mandatory training in, for example, infection prevention and control, safeguarding, and health and safety. They were also given training relevant to their specialty, such as general surgery, orthopaedics and cardiology. Staff told us they were trained in the care of patients with dementia or a learning disability. We saw evidence of this in the mandatory training data submitted by the trust. However, some of the clinical staff told us that, because of staffing shortages, most staff struggled to get the time off to attend relevant study days.

Multidisciplinary working

- We saw some examples of multidisciplinary team working in the oncology and chemotherapy day clinic. There was a good working relationship with Macmillan nurses. This meant that patients had a good level of continuous support when undergoing treatment.
- The imaging and diagnostic staff worked collaboratively with medical and nursing staff from other areas (for example, the wards and the accident and emergency (A&E) department). Staff told us that multidisciplinary team working was good. They valued the opportunity to meet all grades of staff and felt that they "had a voice". A patient told us, "They work well as a team."
- We saw examples of multidisciplinary team working in the cardio-respiratory clinic. We noted doctors, clinical nurse specialists and technicians working as an effective team to support patients.
- There was evidence of cross-sector working and a close relationship with several charities, particularly with regard to services for people with cancer. For example, topics related to cross-sector working included the welfare advice service; care closer to home; work to improve the patient experience and pathway, and plans to redesign the chemotherapy unit.

Seven-day services

- The OPD operated a five-day service, Monday to Friday from 8.30am to 5.30pm.
- Seven-day services were offered in diagnostic imaging services such as x-ray, magnetic resonance imaging (MRI), computerised tomography (CT) scanning and ultrasound.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an up-to-date policy and procedure relating to consent to care and treatment. The policy and procedure informed staff that valid consent had to be obtained before treatment or examination, and set out how that consent was to be obtained and recorded. We saw from patients' records and discussion with patients and staff that consent had been obtained before treatment was given in all the clinics we visited.

Outpatients and diagnostic imaging

- Patients were asked appropriately for consent to procedures. They told us that staff always explained any procedure before carrying it out. We tracked two people for consent. Both of them confirmed that they knew what the process was and that they had consented. The records were appropriately completed.
- Staff were clear about their responsibilities in line with the Mental Capacity Act (MCA) 2005. We saw evidence from staff training records that clinical staff had completed training on the MCA and Deprivation of Liberty Safeguards (DoLS). Staff we spoke with confirmed that they had completed training. We were told that, when a patient's mental capacity was questioned, clinicians would assess their capacity and a best interest meeting would be arranged if necessary.

Are outpatient and diagnostic imaging services caring?

Good

Staff were caring and compassionate. They were seen to offer assistance to patients without waiting to be asked, and they worked hard to ensure that patients' needs were met in an holistic manner.

Patients were positive about the care they had received. Doctors, nurses and healthcare assistants spoke to them in a dignified way: they greeted them, introduced themselves using the "Hello, my name is…" technique, and apologised for any delay when escorting them into the consulting room.

Patients were greeted by the reception staff who ensured their specific care needs were identified and supported. Patients received a caring service because staff treated them with compassion, kindness and respect.

Positive feedback had been received by the trust from patients using the department. Feedback given to us by patients throughout our inspection was positive about the way in which they were treated by staff and how they were involved in their care and treatment.

Compassionate care

- Throughout our inspection, we observed staff providing compassionate care. One of the strengths of the outpatients and diagnostic imaging service was the quality of interaction between staff and patients. We observed staff offering to assist patients rather than waiting to be asked.
- A carer told us that the person he cared for was elderly and vulnerable. He said, "She is always treated with dignity and kindness and this is tremendously important."
- One agency clinical staff member was very thoughtful and attentive when taking disabled patients to the toilet. They took the opportunity to get the person a drink and then asked where in the room and in which direction the person would like their wheelchair to be positioned and face.
- A patient told us, "I have been treated with great care. I work in a care environment myself and the patient–nurse contact is superb."
- We spoke with reception staff in the imaging department who showed a clear understanding of their role. We observed them treating patients with courtesy and dignity, and signposting them to other waiting areas when required. Reception staff told us that, when patients arrived for appointments, their name, date of birth, address and telephone number were checked with them at the desk.
- Most patients told us their experience in the department was positive. One person said, "It's better than any other hospital I have been to. The consultant was very caring."
- Patient consultations took place in private rooms and we noted that sensitive conversations were never discussed in public areas. Staff told us that, if necessary, they would use a quiet room to discuss confidential matters.
- Patients we spoke with expressed satisfaction with the care and treatment they had received during their visits.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in their care. For example, they said they had been told what treatment options were available to them, and any risks or side effects had been pointed out. We saw that family members or carers could accompany patients into their consultation. This allowed patients to feel more at ease and to have support when making decisions.

Outpatients and diagnostic imaging

- Patients attending for imaging and diagnostic tests were given written and verbal information about their specific test; in addition, staff verbally explained the procedure to them.
- After their clinic attendance, patients were given an 'exit visa' which told them what the next step was (for example, whether they needed more follow-up or if they had been discharged).

Emotional support

- Patients and relatives we spoke with confirmed that they had been supported when they were given bad news about their condition. Nursing staff explained how they ensured that patients were in a suitably private area or room before breaking bad news to them. We were told that it was always possible to locate a suitable room for these discussions. Nurses were always available to help and support patients with information when they were in clinic.
- A pregnant patient told us of some specific concerns regarding her previous confinement that had made her anxious. She said, "The staff have done everything they can to reassure me… Now I am actually looking forward to the birth."
- The chaplaincy team told us that they made occasional visits to the outpatient areas and would always attend to see or counsel a patient, if asked.
- Information was displayed in the various waiting areas about any support services that might be appropriate. This included helpline numbers and support networks for specific disease areas.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The outpatients and diagnostic imaging department was monitoring service delivery issues that had an impact on care delivery. Staff had developed policies and procedures to monitor and reduce 'did not attend' appointments and long waiting times, delivery on the referral to treatment time (RTT) commitment and responsiveness to complaints.

The outpatient service was not always responsive to patients' individual needs and not all patients were seen within the national waiting time standard for clinics. We observed consistent delays in clinic patients being seen, regardless of their appointed time, throughout the two days we were on site at the hospital. Delays in clinics were not always made clear or explained to patients. The information board displaying waiting times was not prominently displayed where all patients could see it. Occasionally the waiting times stated on the board were not an accurate reflection of the actual waiting times.

The transfer of patient records from one computer system to another had resulted in the loss or movement of some patients' details. Medical records were not always available. There were occasions when almost 40% of patients were seen without their medical records and the clinicians had to use temporary notes for those patients whose records were unavailable.

Migration to the new patient electronic records system had caused some problems with the 'Choose and Book' NHS online booking system for patients.

Patients told us they were unhappy with the lack of parking facilities.

Staff were noted to be motivated to meet people's needs (for example, one patient told us that the clinic staff stayed behind after hours to ensure that all patients' needs were met).

The phlebotomy clinic was overstretched with long waiting times and no capacity to prioritise patients who were fasting, children, or elderly or frail patients. It had a seating area that was unable to seat the number of patients waiting for their blood to be taken. The patient journey through the department and prolonged waiting times meant that some patients had a poor experience of the service.

Service planning and delivery to meet the needs of local people

- Most staff told us that there had been a gradual increase in the number of patients accessing the outpatient and diagnostic imaging services at the hospital. Many of the clinical staff we spoke with thought that this had not been effectively managed and, as a result, patients were waiting longer for an initial appointment and longer in clinics to see the doctor. The managers were unable to provide evidence of how the increased demand was being managed or performance monitored.
- Some clinical staff the outpatients department told us that there was no system for ensuring that the number of doctors and specialist nurse practitioners matched

the needs of the patients in any particular clinic. This resulted in longer waits for initial appointments and overbooking of clinics, leading to longer waiting times. Staff told us that patients were experiencing longer waiting times in most clinics, particularly in the ear, nose and throat, oncology, haematology and neurology clinics, because of clinics being over-booked.

- We noted that no extra clinics had been organised to deal with the increased number of referrals. Staff told us that this was because of the limited number of doctors and nurses available to run these clinics.
- We were told by the nursing staff that patients attending outpatient appointments could be offered drinks when clinics were delayed. However, the clinic protocol for delays did not indicate that this was the case, or how long a clinic needed to be delayed before patients were offered refreshments.
- Patients and other visitors had access to a coffee shop and restaurant area in the main hospital entrance lobby. However, patients told us they did not use this because they were afraid of missing their appointment.
- The trust aimed to inform a patient's GP in writing of the outcome of their consultation and any ongoing treatment that was required within five working days to ensure that appropriate care and treatment were provided. During our inspection, we found that this target was not being met and GP letters were frequently delayed for up to 10 working days.
- The outpatients department (OPD) offered one-stop clinics in some specialties such as breast and chest clinics. These clinics were staffed by a specialist nurse and a consultant. For example, the one-stop breast clinic had joined the oncology, breast surgery and diagnostic elements of the pathway along with home care support to enable people to have a rapid diagnosis and day surgery when required. Specialist nurses offered a counselling service for patients as well.

Access and flow

- Hospital Episode Statistics for July 2013 to June 2014 showed that 207,515 outpatient appointments were made. We noted that 91% of patients attended either their first or follow-up appointments. The data showed that the hospital's ratio of follow-up to new appointments was better than the England average.
- Most patients who attended the OPD were referred by their GP. Other patients were referred other hospitals or other departments within the hospital. All referrals for outpatient appointments were managed by the outpatient booking team (OPAC) at PRUH. This team allocated appointments and sent out appointment letters to patients. Managers and staff told us that GP referrals requiring urgent attention were identified and fast-tracked.
- All referrals for PRUH and associated sites were registered at the central booking team at PRUH. All referrals from GPs, consultants and A&E staff (including 2ww referrals) were managed by the outpatients booking team (OPAC) located at The PRUH. Choose & Book referrals were managed by the same OPAC team at PRUH. Choose & Book referrals were all directly bookable (capacity allowing) at PRUH and related sites. There is no indirectly bookable Choose &Book at the PRUH site. All Choose & Book services were set with 'polling time frames' that allowed the services to manage their 18 week timescales.
- Staff told us that clinics were occasionally cancelled by consultants at short notice. This meant inconvenience and delays for patients. Of the total number of appointments made, 1% had been cancelled by patients and 2% by the hospital from July 2013 – June 2014. Both these figures were better than the England average of 6%, respectively. Some of the nursing staff we spoke with were not aware of the hospital's performance in relation to cancelled appointments; others were aware but could not provide evidence of the underlying causes. However, senior managers were aware of the situation and actions were being taken at the trust-wide level to address the issue.
- We were shown a 'clinic cancellation and change request form', which was used within the division to keep track of the nature and extent of clinic cancellations. The OPD had daily briefings and used the technique of 'team huddles'. These were quick, responsive briefings to review work, make plans and move ahead rapidly.
- The data also showed that 6% of patients did not attend their appointments, which is better than the England average of 7%, and the trust average of 9%. We were told by trust managers that the hospital's 'did not attend' rate was continuously monitored to enable changes and adaptations to be made to minimise waste of resources. For example, texting and phone calls had been used to remind patients of their appointment date and time. Measuring the non-attendance rate is

important, because non-attendances mean that resources are not being used well and can have a negative impact on patients receiving services at the hospital.

- We were told that the volume of people attending the phlebotomy department sometimes meant that people had to wait. We did not observe long waits on the day we visited. Patients in the OPD waited up to 30 minutes during our visit.
- The trust's RTT for non-admitted patients (incomplete pathways) was 96%, which was higher (worse) than the national average of 94% for patients starting treatment within 18 weeks of referral from April 2013 to November 2014.
- Cancer waiting times were similar to the England average for all the three measures at trust level for 2013/14 (we were not provided with PRUH-specific cancer waiting times). The percentage of people seen by a specialist within two weeks of urgent GP referral for all cancers was 95%, and the percentage of people waiting fewer than 31 days from diagnosis to first definitive treatment for all cancers was 98%. The percentage of people waiting fewer than 62 days from urgent GP referral to first definitive treatment for all cancers was 86%. All these figures were consistent with the England average.
- The NHS data for diagnostic waiting times from April 2013 to November 2014 showed that the trust performed worse on the percentage of diagnostic patients waiting more than six weeks for appointments the trust score was 5% compared with the national average of 2%.
- We found that patient waiting times varied in different clinics from a few minutes to over an hour, and we observed consistent delays in patients not being seen at their appointed time in some clinics. Information about waiting times was not always updated to reflect the true waiting times. Even though waiting times for patients to be seen were long in some clinics, we observed good patient flow in the main waiting areas of others. A senior sister in the OPD told us that the main challenges in the service were regular delays, patients' waiting time and the overbooking of appointments in almost all clinics. However. There was no systematic action being taken to address the situation.
- One member of staff told us that outpatient clinic flow was not always good because of overbooking and other occasions when medical staff arrived late for clinics.
- Before our visits, we received information from external organisations about patients' dissatisfaction with waiting times, and this was evident when we were on site during our inspection. Most of the patients we spoke with complained of waiting longer to be seen and no accurate information on waiting times was available.
- The manager and staff in the imaging department told us that, although they were short of staff, they were able to deliver a good service to patients that involved working extra hours. Staff told us diagnostic test results were available promptly to support consultations. We spoke with manager of the radiology department who told us that, most of the time, the department was able to provide reports electronically within the trust reporting protocol of 24–48 hours

Meeting people's individual needs

- Written information was available in several languages and in large print. Access to telephone translation services or an interpreter were available for patients.
- Wheelchairs were available at the entrance to outpatients for patients who required them.
- One patient who attended regularly told us that, when her condition changed, the clinic staff stayed behind after hours in order to meet her needs.
- There was a range of written information available for patients in the outpatient waiting areas. Some of these leaflets had been produced by the trust and others had been produced by external organisations such as Cancer Research UK, the British Heart Foundation and other medical charity organisations.
- Staff told us they had been trained to identify people with dementia and how to give them extra support (for example, by giving people more time to talk and making sure that patients understood the details of their treatment).
- Staff ensured that patients who were distressed or confused by the OPD environment were treated appropriately. Patients with a learning disability or dementia were moved to the front of the clinic list. When necessary, the OPD staff liaised with ambulance transport staff to ensure that this process ran smoothly.
- Staff told us that, when a female patient asked for a female doctor to examine them because of cultural or religious preference, this request would always be respected.

Outpatients and diagnostic imaging

Learning from complaints and concerns

- We were told by the directorate manager that a robust complaints process was in place, complaints were investigated and relevant findings were passed on via staff meetings.
- Information on how to make a complaint was available in the waiting areas. We were told that informal complaints were managed by the OPD matron or nurse in charge and resolved if possible at that stage. If they were unable to resolve the complaint satisfactorily, the patient or relative would be directed to the Patient Advice and Liaison Service (PALS), which would help them to make a formal complaint.
- There were leaflets and information available for people on other topics of concern, and patients could also contact PALS.
- Complaints were discussed at departmental level and also at directorate clinical governance group meetings. For example, we were told there was a huge increase in the number of complaints as a result of the problems generated by the migration of data in November 2014; IT staff had worked hard to develop solutions and manual fixes, and had meetings with staff to share their findings.
- We reviewed four complaints received and action plans arising from the investigation of those complaints. One action from a complaint was that the outcome of the investigation was to be shared at team meetings. However, some of the staff we spoke with could not recall when actions from complaints had been shared with them.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

There was a determination and focus on providing an excellent service for patients. There was also a clear and proactive focus on improving quality and safety, and the provision of inter- and multi-disciplinary clinics was not unusual. Staff were proud of the work they had done to improve quality, safety and patient experience, and quick to point out where they felt they could do better. They understood the principle of the duty of candour and we saw evidence of this in practice. The staff were committed to sustaining improvement and innovation.

The leadership, governance and culture prompted the delivery of person-centered care. Staff were supported by their local and divisional managers. Risks were identified and addressed at local level or escalated to divisional or board level if necessary. However the working relationship with main hospital at Denmark Hill site needed further development. Never Events in Ophthalmology in Denmark Hill were not shared with the ophthalmology department at the hospital.

Staff in the outpatients and diagnostic imaging department considered their line managers to be approachable and supportive. Most of the front-line staff we spoke with understood the vision of the hospital and they were able to show how this was implemented in practice.

Staff in all outpatients and diagnostic imaging areas said their managers were visible and provided clear leadership. Both staff and managers told us there was an open culture; they felt empowered to express their opinions and considered they were listened to by the management. Clinical staff told us they enjoyed their work and felt that it made a difference to how patients felt about the hospital.

Vision and strategy for this service

- Staff were able to discuss their roles and responsibilities confidently. They were clear about the overall goals of the department they worked in. There was a determination and focus on providing an excellent service for patients.
- Senior managers told us what their vision for their service areas was. Most of the staff we spoke with were aware of 'King's value' and 'Team Kings', which. Sought to ensure that everybody at the trust was valued equally. There was shared objectives and a strategy to achieve an improved service provision across all the trust sites. A trust dashboard for outpatients was available to help managers and clinicians to make improvements to the service.
- The imaging and diagnostics department was working on succession planning because of the merger and the number of vacancies across all the trust sites.
- Strategies for service improvements were in place including delivering on referral to treatment targets and improving responsiveness to complaints. Progress against targets was monitored to ensure that service

improvements were made in a timely manner. Staff were able to confidently discuss their progress on service improvements along with areas that had been identified as still requiring improvement.
- Staff were confident about the vision and values of the organisation. One member of staff told us, "Everything we do is based on the values of the trust." Another said, "Sometimes information from the top of the organisation gets missed as it comes down to floor level; however the staff engagement was good."

Governance, risk management and quality measurement

- There was a clear and proactive focus on improving quality and safety. Governance meetings were held monthly and attended by managers of the outpatients and diagnostic imaging department. There were also specialty governance meetings held for each division, clinic or directorate. The outcomes from these meetings were shared with staff during staff meetings and monthly bulletins. The standing agenda for these meetings were departmental risks, waiting times, and staff shortages and delays.
- There were regular team meetings to discuss issues, concerns and complaints across the division; however, some nursing staff told us they did not always received feedback at these meetings about incidents and lessons learned from their line managers.
- We were told the hospital had a risk register and managers were responsible for updating this with their departments' risks. Managers told us they were aware of the risks in their departments and were monitoring and managing them. We were given service-specific risks data associated with the outpatients and diagnostic imaging department. These showed the monitoring of risks by the trust.
- Risks were identified and addressed at the local level and escalated to the management when necessary, however this was not consistent across the trust and some departments of the hospital did not talk to each other across the various sites of the trust and at the trust wide level. Some departments did not have a close working relation nor cooperation with their counterpart at Denmark Hill site; for example never events in ophthalmology in Denmark Hill were not shared with the ophthalmology department at the hospital.

Leadership of service

- The staff we spoke with told us that the director of nursing was always helpful and supportive, as was the head of nursing for outpatient services. Staff said they could approach their line manager and senior managers with any concerns or ideas. The trust had a programme of 'Ward to board – Go see visits', where board members visited clinical areas to interact with staff.
- Most of the staff we spoke with told us they were able to discuss a range of issues with their line managers and felt able to contribute to the running of the department.
- Staff stated that the senior management team was visible and understood the staff operational issues. Most of the clinic staff told us that they felt supported by the senior managers. One person said, "Things have improved a lot since King's took over. It was the right thing for us."

Culture within the service

- Staff were proud of their services, and of the work they had done to improve quality, safety and patient experience. They were also quick to point out where they felt they could do better, and what plans they had in place to improve the process for patients.
- Staff were aware of their responsibilities in relation to duty of candour. For example, we were told about a recent 'near miss' incident. A near miss is when no harm occurred, but the potential for future harm had been recognised. The patient had a condition that meant they were unaware of the incident, and the service had developed a plan to fully disclose the incident in an appropriate way.
- All the staff we spoke with in the department told us that communication between different professionals was good and helped to promote a positive culture within the department. A consultant we spoke with told us they thought the communication between the different professionals was "excellent" and that it helped promote a "very positive working environment". Clinical staff we spoke with told us they felt able to raise concerns and discuss issues with the managers of the department. All staff we spoke with were professional, open and honest, and were positive about working at the hospital. Staff acted in a professional manner; they were polite, honest and respectful.

Public and staff engagement

- Staff told us they would have liked to have been consulted more with regard to decisions that affected

their services (for example, the changes to the IT system, the reconfiguration of the outpatients department (OPD) and the management of staffing issues. One member of staff told us, "King's do not understand how a district general hospital works."

- Patients attending outpatient clinics were able to provide feedback through the 'How are we doing ?' survey. Although this feedback was analysed and shared amongst staff. Feedback posters were displayed in the outpatients department which included Friends & Family Test (FFT) scores, positive comments, negative comments and 'You said – we did' with information on what the department had undertaken to improve information about clinic waiting times, e.g. updated 'in touch' waiting boards so that patients were informed about waiting times..
- Patients we spoke with were happy with the way had communicated with them. Many of the patients we spoke with had come to the department from other healthcare providers. They all said their experience at this hospital was better.
- The trust newsletter ('@Kings') for staff and the public included information about changes taking place across the trust such as how complaints were managed, information available to patients, significant events occurring and new innovations at the trust. For example, there was information regarding this inspection in the '@Kings' newsletter. Information was also provided regarding specific departmental changes.

Innovation, improvement and sustainability

- Senior managers told us there were plans in place to deliver on the trust's referral to treatment targets, responsiveness to complaints, and improvement in the quality of the patient experience, and they were confident that the improvements could be delivered. However, these improvement plans had not been fully implemented the time of our inspection and not all staff were aware of the plans.
- Because of staffing shortages across the nursing workforce, there had been few opportunities to implement innovative activities. Staff were more concerned about maintaining the service and keeping patients safe.

Outstanding practice and areas for improvement

Outstanding practice

- Recent data from the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP, had given the PRUH stroke service a Level A ranking. This is the highest possible rank and only eight per cent of stroke units in the country currently achieve it. This is a significant improvement as the hospital was previously rated as Level D and has risen to Level A in 18 months, making it one of the most improved stroke services in the country.Recent data from the Royal College of Physicians' Sentinel Stroke National Audit Programme (SSNAP), had given the Princess Royal University Hospital stroke service a Level A ranking. This is the highest possible rank and only eight per cent of stroke units in the country currently achieve it. This is a significant achievement as the hospital was previously rated as Level D and has risen to level A in just 18 months, making it one of the most improved stroke services in the country.
- Pets As Therapy (PAT) dogs is an initiative to help patients who may be feeling low after suffering a disability following a stroke, or who may have been in hospital for a long period of time. The stroke ward had introduced pet therapy and a dog and their owner visited the ward weekly. They visited patients who were unable to communicate and found they often made huge efforts to communicate with the dog.

Areas for improvement

Action the hospital MUST take to improve

- Continue to work to improve the availability of medical records in the outpatients department and medical care wards.
- Work with key stakeholders to improve patient flow throughout the hospital to reduce waiting times in the ED, cancellation of operations and delayed discharges.
- Improve the system for booking and managing waiting times in outpatient clinics to reduce delays for patients and clinics running over time.
- Improve the environment in the surgical assessment unit.
- Review and improve record documentation to ensure it is fully completed and in line with national guidance including DNACPR orders.

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Action the hospital SHOULD take to improve

- Continue to recruit to substantive posts and ensure that there is always an appropriate skill mix of staff on duty
- Continue to embed the processes for monitoring and improving the quality and safety of care provided including incident reporting and learning from incidents
- Continue to improve the rate of staff appraisal and attendance at mandatory training
- Ensure all medicines are stored and secured in line with trust policy
- Improve the monitoring of hand hygiene in services for children and young people
- Ensure all equipment (including resuscitation trolleys) is cleaned, maintained, checked and secured in line with trust and national policies
- Continue to work to resolve the problems with IT system to ensure patient information is managed effectively and safely.
- Improve multidisciplinary working in medical care and services for children and young people.
- Improve staff awareness and understanding of their role and responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
- Continue to work with commissioners to ensure there is adequate funding and resources for the End of Life service

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Patient pathways and plans were not always followed. Patients experienced risks to their care and treatment due to cancelled operations, delayed discharges, long waiting times for a bed to become available once a decision to admit them had been made and delays in outpatient clinics. Regulation 12 (2) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The surgical admissions unit was found to be unsuitable for its intended purpose. The area afforded little privacy for patients who were having blood taken, anaesthetic assessments and surgical consent all within public view and hearing. Confidential information could be heard when staff went through the theatre checklist with patients. Regulation 15 (1) (c)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Information about patient care and treatment was not always fully recorded including information related to do not attempt cardio pulmonary resuscitation orders (DNACPR) and check lists for surgery.

Medical records were not always available in outpatient clinics and medical wards.

Regulation 17(2) (c)